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The path of compassion in forensic psychiatry

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ABSTRACT

We aimed to deepen our understanding of the concept of compassion in caring for patients with mental illness in forensic psychiatric inpatient care settings. Qualitative analysis was used to illuminate themes from interviews conducted with 13 nurses in a prior study. The audiotaped interviews, which had been transcribed verbatim, were analyzed following a hermeneutic approach. Results revealed the main theme of "being compassionate in forensic psychiatry is an emotional journey" and three themes. Overall, compassion was seen as a changeable asset, but also an obstacle when absent; sensitivity to one's own vulnerability is necessary to overcome that obstacle.

Introduction

The wellbeing of nurses is the foundation of forensic psychiatric care, which involves working with mentally disordered people who have been involved in criminal activity or have encountered other legal issues. Forensic psychiatric nursing care is often provided in prison hospitals and other secure institutions, and it can be a struggle to work with mentally ill patients in such environments and maintain good management of one's own emotions, being compassionate, consistent, and staying connected to the patients. (Sturzu et al., 2019). While challenging, providing care within a forensic setting creates unique opportunities for nurses to affect the wellbeing of patients (Rydenlund et al., 2019) and alleviate the suffering of offenders with severe mental illnesses (Nedopil et al., 2015). To be effective, this requires relationship-based care (Encinares et al., 2005; Schafer & Peternelj-Taylor, 2003). However, establishing relationships can be one of the greatest challenges for forensic nurses (Austin, 2001) as it involves making sense of an incomprehensible world and developing relationships based on empathy, genuineness, and compassion (Møllerhøj & Os Stølan, 2018; Wyder et al., 2015).

According to Kanov et al. (2004), compassion is a process involving three key elements: "noticing" another's suffering, "feeling" the others pain, and "responding" to that persons suffering. It is also described as an intentional response to gain an in depth understanding of a person, recognize their needs, and ameliorate suffering through relational understanding and action (Sinclair et al., 2018). Letting compassion guide your actions towards the suffering of others goes beyond gaining the attention of the other to attuning to oneself and engaging an ethical compassion-based action (Halifax, 2014). Compassion and self-compassion is closely linked, as it involves admitting that suffering, failure and inadequacies are part of being human, that all people, oneself included, are worthy of compassion (Neff, 2003).

Compassion is re-emerging as a major topic in the domain of ensuring quality in care (Tveit & Raustol, 2017). Studies indicate the importance of nurse's attuning to vulnerability when taking part in the lives of others (Hammarström et al., 2019). Lögstrup (1997) states that vulnerability is a fundamental condition of human life, meeting another person is an interhuman act, where both parties should be guided by their sensitivity. Conversely, not being able to compassionately understand expressions of suffering can obstruct the building of stronger relationships and thus hinder a patient's recovery (Hsu et al., 2012). Compassion involves empathy and concern and, in nursing, is both a resource and a necessity (Mills, Wand, & Fraser, 2015), but it can also become an obstacle to overcome. Considering the vulnerability of patients and the demands on the nurses who see to their care, compassion is arguably nursing's greatest value (Halifax, 2014).

Compassion is also a principal component of caring for patients who suffer from mental illness (Crawford et al., 2014), and nursing is based upon compassionate encounters with others, even in challenging situations (Chang et al., 2005). However, striving away from paternalism and towards compassion can be especially challenging in forensic inpatient care units (Young, 2018). Nurses working in forensic psychiatry

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often struggle to remain empathetic and provide compassionate care; thus they risk depersonalizing the nurse-patient relationship (Sturzu et al., 2019). The forensic psychiatric environment involves working with patients who often oppose care (Selvin et al., 2016). Rushton et al. (2009), asked, "How can nursing be based upon, and continue to be based on, compassion when facing the multifaceted and complex encounters in today's care?" For example, how does one access compassion when caring for offenders who may have abused children and whose expressions of suffering involve a longing and affinity with catastrophic consequences (Sjögren, 2004). Forensic care also means facing aggressive patients and intimidations (Greer et al., 2019), feeling unsafe, and, at times, having your very existence threatened (Hörberg et al., 2012). Coping with stress affects wellbeing and when facing threats people instinctively focus on self-defense (Crawford et al., 2014). Interfacing with aggressive patients can awaken emotions such as anger, fear, grief, and humiliation (Carlsson et al., 2006), posing challenges to sustained compassion. Hence, emotional regulation may influence encounters and nurses' behaviors towards patients within a forensic setting (Oostvogels et al., 2018).

Forensic nurses who face perplexing behaviors need to manage emotions to avoid resorting to restrictive strategies that could infringe on a patient's freedom and involvement (Davies et al., 2016). Helping nurses understand themselves may provide them with insights that allow them to empathize a patient, regardless of challenging behaviors, see the patient is a person (Oostvogels et al., 2018), and gain greater insight into the patient's lifeworld (Hörberg, 2018). To support the wellbeing of psychiatric nurses and ensure the quality of care for patients, further understanding and clarification of the concept of compassion are needed (Tveit & Raustol, 2017). Therefore, the aim of this study was to gain a deeper understanding of nurses' compassion in providing forensic psychiatric inpatient care.

Materials and methods

This study employed qualitative research, as it is appropriate when exploring an issue that needs further explanation to gaining a detailed, complex understanding, derived from the stories of people (Creswell & Poth, 2018). An understanding will appear through the fusion of horizons of participant and researcher, together reaching a shared understanding (Fleming et al., 2003). A hermeneutic interpretation was used, which means the researchers reflected on the own understanding, and the knowledge upon which it is based (Gadamer, 2004) in approaching the content of the interviews. A bridge of understanding is thereby created through a hermeneutic circle where preunderstandings are constantly questioned (Gadamer, 1976).

Procedure and setting

This study was based on the data collected in a previous study (Hammarström et al., 2019). Narratives are unique data in that they are collected primarily for single use but can also be stored with the intent that they may be valuable for secondary use in future research. Our secondary supplementary analysis involved a more in-depth investigation of an emergent that was not fully addressed in the previous study (Heaton, 2004). The data were derived from narrative interviews with 13 participants at one forensic hospital in Sweden where nurses encounter patients, the majority of whom are male, who have been transmitted to forensic care—with a background of violent crimes—and who suffer from various mental illnesses.

Participants and data collection

The participants were selected using purposive sampling, with the inclusion criterion of having experience caring for patients with mental illness in forensic inpatient care. The participants' ages ranged from 28 to 67 years (median (Md) age = 36 years) and they had worked in forensic psychiatric care between 5 and 46 years (Md = 11 years). The interviews lasted from 41 to 60 min (M = 48 min) and were recorded individual interviews with open-ended questions (Mishler, 1986). The participants were asked to narrate about their lived experience of encounters with patients with mental illness in forensic inpatient care. The main questions included, "Can you tell me about an encounter with a patient that evoked negative feelings?" and "Can you tell me about an encounter with a patient that evoked positive feelings?" Further questions included, "How did you feel?" "Can you tell me more?" and "Has that happened before?" In our first analysis (Hammarström et al., 2019), the questions provided an opportunity to understand the range of feelings and vulnerability nurses experienced when encountering their patients. We found that the nurses tried to empathize with patients' experiences and displayed competence in assessing patients' expressions. Their strategy fostered self-reflection, situational assessment and compassion for patients. The identification of the narratives' potential of providing information about development of compassion argued for a secondary analysis. The first author transcribed the interviews verbatim. The participants (10 men and 3 women) consisted of 5 registered nurses and 8 assistant nurses. In the presentation of the results, all staff were referred to as "nurse" to conceal identities.

Ethics

Interviewees were informed about the study verbally and in writing. All interviewees provided written consent, which was stored by the first author. Partaking was voluntary, and confidentiality was guaranteed. The data used during the secondary supplementary analysis did not contain any identifying details about the participants. All participants were provided with the first author's and supervisors' contact information. Ethical approval was granted by the regional ethical review board (no. 2018/157-31) and was conducted per the Declaration of Helsinki (WMA, 2008). Permission to conduct the study was granted by the head of the clinic.

Analysis

Understanding of the text was gained through a systematic analysis in the Gadamerian hermeneutic tradition and went through four steps according to Fleming et al. (2003). During the first step, the text was read as a whole. Based on preunderstandings of earlier conceptualizations of compassion (Halifax, 2014; Kanov et al., 2004; Sinclair et al., 2018) and other research findings (including findings from our first study), the first author articulated the fundamental meaning of nurses' experiences of compassion as a response to patients' suffering. The fundamental meaning was later reflected upon by all the authors. In the next step, the fundamental meaning (*nurses' response to patients' suffering*) guided the identification of sentences and content in the text that could be related to or convey meaning about nurses' response to patients' suffering. Each sentence was examined to expose the meaning of understanding; themes and subthemes were formed. In the third step, a hermeneutic movement was conducted. Each sentence or setting was related to the text as a whole, thus gaining an expanded understanding of the whole text.

The hermeneutic circle was essential to gaining an understanding; each sentence and its subthemes and themes were related to the initial fundamental meaning of the text as a whole which, then, shed further light on the understanding of the text as a whole. The fourth and final step included finding passages that gave further insight into the phenomenon and clarified the mutual understanding between researchers and participants. The entire process was repeated numerous times until the authors settled upon a shared understanding, at which point the circle was closed.

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Table 1
Overview of main theme, themes, and subthemes.

Main theme	Being compassionate in forensic psychiatry - an emotional journey		
Themes	Recognizing suffering and need for support	Responding to patients suffering	Reacting to one's own vulnerability
Subthemes	Suffering is obvious	Complying with the patient	Becoming persistent
	Suffering is hidden	Persuading the patient	Becoming resigned
	Suffering is frightening	Adapting oneself to the patient	Feeling shame

Results

The results are presented in one main theme: being compassionate in forensic psychiatry—an emotional journey, which entailed three themes—recognizing suffering and need for support; responding to patients suffering; reacting to one's own vulnerability—and subsequent subthemes (see Table 1).

Main theme: being compassionate in forensic psychiatry—an emotional journey

The nurses' narratives described an emotional journey and an inner negotiation. The fundamental meaning of experiences revealed the nurses' interpretations and responses to patients' suffering and their own vulnerabilities, where compassion could be seen as an answer to suffering. Caring for patients in forensic psychiatry meant meeting individuals who committed serious crimes and may have been suffering from severe mental illness for long periods of time. A nurse's ability to interpret the pleas of their patients was crucial for developing compassion. In patient encounters where nurses perceived an appeal for help, the nurses experienced compassion for the patient. Encounters that awoke negative feelings of dislike or uncertainty were those that involved struggling with deciphering the patients suffering. However, letting suffering make an impression made it easier to develop compassion. Despite how expressions of suffering made an impression and affected compassion, it was changeable over time. The emotional journey fluctuated: nurses either protected themselves from their own vulnerability by turning to control and rules or they became sensitive and compassionate.

The nurses' narratives revealed an inner negotiation between their own reactions to a patient's expression and the care that was professionally expected and personally wanted. This negotiation reflected their response to their own suffering as much as their response to the patient's suffering.

> "It feels sad when you don't reach them. It feels hopeless when you have tried so much, and it is useless… with some patients it may take several years before they trust you… But enduring and staying in it can make you come closer to each other in the end."

The emotional journey and inner negotiation are further described in the themes and subthemes.

First theme: recognizing suffering and need for support

The first theme reflected what the nurses recognized as suffering and a need for support. The nurses described being in a complex environment with contradictory tasks, caring, guarding, and protecting while at the same time connecting with the patients and alleviating suffering. Despite the complexity, nurses viewed each patient as different. Expressions that made impressions forced them to turn their eyes inward and face emotions that were triggered.

Suffering is obvious

Feelings of compassion were easily aroused when the nurses perceived that a patient was really in need of help. Sometimes these expressions were clear and obvious, such as when a patient threatened to end his or her own life. One nurse talked about a female patient who expressed suicidal thoughts:

> "She wanted to change her life; she told me she wanted to live. She didn't want to die. You could see she was withdrawn, from the beginning she didn't want to share, but she trusted me. We formed some kind of bond."

Other times the patient's expression of suffering was not so visible, in which case the expression was interpreted based upon the nurse's professional experience caring for patients with mental illness. Once a good relationship was established, it awoke a feeling of being wanted and needed, giving the nurse a sense of success.

> "He was often walking down the hall with his hood down, staring at the floor. He often turned to me and eventually we had a good relation after all…when you have managed to reach someone, you feel needed and you want to do good."

Suffering is hidden

Sometimes a patient would not show any desire to be helped or cared for. Instead, such a patient would withdraw and spend most of their time alone in his/her room, leaving nurses wondering how to approach the patient. In these situations, nurses expressed that the patient's suffering was evident to them. However, when the patient kept their distance, that is, when the patient does not want contact with the nurse, it was hard to comprehend what they wanted and what the expression of suffering stood for. Having the patient at a distance made it hard to communicate and establish a relationship, as getting to know the person is the essence of being compassionate.

One nurse said:

> "Some patients just lay in their bed or keep their distance. It's apparent that they aren't feeling well, I can see that. But it's almost impossible getting to know them when they don't want to speak to you."

Other patients were perceived as unwilling to take part in some sort of daily activity. Not being able to get close to the patient obstructed the nurse's ability to understand the patients suffering. These caring encounters were seen as negative and a foundation of frustration, constantly repeating caring activities without getting any response.

> "One thing that's difficult is when the patient is hiding from us. Some of them just stay in their rooms, making it hard to reach them. Of course, they feel bad, but it makes it hard to know how to help them, like we don't have the right tools, it's frustrating."

Suffering is frightening

At times, nurses found themselves in situations where their very existence was threatened. When the patient's expression of suffering was provocative and threatful, nurses experienced feelings of insecurity and fear.

> "You have to remember that you're dealing with patients with a severe mental illness, but every time I talk to this patient he either focuses on how bad I am as a person or he's angry about something. It just doesn't make any sense."

Being confronted by violence and intimidation awoke a sense of

anxiety and fear within the nurse. Not being able to decipher the patient's suffering could end up in nurses finding themselves in situations they do not know how to handle.

> "I remember this time, this guy wasn't feeling good. He was very psychotic at the moment. I tried to talk to him, I was calm and collected and approached him. Without warning, he jumped me; I didn't see it coming and I got scared."

Second theme: responding to patients suffering

The nurses' narratives exposed the process of making sense of and gaining meaning from encountering patients in forensic psychiatry. Despite facing different types of encounters, the complexity of care was always present and the nurses must carefully control their responses to the various expressions of suffering.

Complying with the patient

In some encounters, the nurse responded immediately to expressions of suffering with compassion, in a way that felt obvious and natural. Providing care for patients who explicitly requested help felt right and left the nurses with feelings of having done a good job.

> "When they come by themselves and want help, it goes without saying that you are there for them, it sorts of becomes a proof that you have done the right thing when they themselves want help."

In encounters with patients, the nurses expressed that adherence made it simpler to maintain control of the situation and to give care, which awoke feelings of enthusiasm. Taking advantage of these meetings seemed to be valuable and strengthened nurses in future encounters.

> "It's much easier to help them when they want to receive the help I can give them…it also makes it easier to motivate myself and stay committed".

Persuading the patient

In situations when patients hid their suffering or opposed help and did not realize it would be for their own good, the nurses spent a lot of energy on trying to persuade and influence the patients to adapt to the care. The nurses found it tedious having to treat and guide patients who were consistently reluctant. Although the nurses' responses were grounded in concern for the patients, these experiences influenced how the nurses engaged with them in the long run.

> "It's hard when they just disappear from you and don't want to receive the help we can give. You want what's best for them, you want them to move forward. Because it's about what you have to cope with yourself, too. It's tedious to have to nag the patient."

Adapting oneself to the patient

When nurses found themselves in a situation, in front of an unpredictable patient, they had to first adapt to the situation, not letting fear, anger or frustration take overhand. Despite being worried the nurses did not show this to the patients. Instead, they tried to show a façade of calm and comfort.

> "Sometimes it happens that you are at the front of a situation and have to confront someone. That is extremely intimidating. Then it's hard. Then it's so…I do not want to communicate to the patient that I am afraid. I want to hide it, while this feeling is stirring up inside me. I don't have so many tricks other taking a deep breath, far down in the belly... Try to keep control of my voice."

Making the effort of gaining control of the situation was not only an act of what's best for themselves, not making a decision based only on the effect, but also on what was best for the patients, an act of what was best for the other, an act of compassion. However, if the nurses were unable to maintain control of themselves and they let their emotions take over, they rapidly took a step back in order to be able to give a more adequate response to the patient's expression of suffering. This allowed them to regulate and adapt to the situation, thus gaining control of both themselves and the situation.

> " I notice that he often turns to me, it's me he wants to talk to; you have to think about the patient's situation. I always try to think that they are ill, that's why they are here. At the same time, it's a protection for me not to take everything that happens personally when they choose to take out their bad feeling on their surroundings…if my feelings take over I will most certainly not be able to handle the situation, then I must take a step back"

Third theme: reacting to their own vulnerability

Becoming persistent

It was clear that the nurses invested a lot of time and energy in providing the best possible care for the patients. When they received positive feedback from the patient and succeeded in gaining contact and mutual respect, this meant both self-respect and renewed commitment. This investment could be seen as the nurses' attempts to alleviate their own frustration and suffering in times when patients did not cooperate. Sometimes it was just the passing of time that led to a changed situation.

> "It took time, we had to take many walks and car rides, but eventually he started to trust me, we got to know each other, all the hard work paid off. We developed a special bond, I got to know the person behind his illness and crime… I got a whole different understanding of him as a person. I really wanted what's best for him."

Caring in a forensic setting meant being confronted with non-comprehensible expressions. Having time on your side helped the nurse to respond to the patient's plea. Feelings of hopelessness decrease and the nurse could more easily unravel the patient's suffering as well as her own.

> "It's not as hopeless as you might think, sometimes the patients who are the most ill are the ones you develop most compassion for over time; you just have to get to know them, but it takes time".

Becoming resigned

The opposite of becoming persistent was also a topic in the interviews with the nurses. Being in an environment where they are not seeing any results during long periods of time, awoke feelings of discouragement and difficulty in feeling empathy. In this way, experiences of criticism and resistance could feel like a state that could never be changed. Feelings of failing both as a human and a professional were admitted and could result in low involvement and even resignation.

> "Much of this job can be uphill. You get so much negative critic and criticism from the patients; it affects you over time. All the nagging makes you go from being engaged and empathetic to getting a bit of numb and cold in the end."

Nurses expressed difficulties staying dedicated and feeling compassion when facing negative comments and resistance during great periods of time. At some point, it seemed like they just had to convince both themselves and the patient, about the direction of the care.

Feeling shame

Nurses shared narratives about encountering patients that not directly awoke feelings of compassion; instead, they were perceived as intimidating or arduous. Nurses felt they had to care for them, feeling compassionate, despite the initial unpleasant emotions that occurred. A feeling that was experienced as difficult to handle and awoke a sense of

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shame.

> "Of course, some patients you like more than others. Some can be quite intimidating or annoying, I've found myself struggling to feel for some of them. It's not something that you're proud of, rather the opposite."

Sometimes the nurses struggled with setting their own emotions aside and had to admit that they were not always proud of their own handling. One of the nurses was embarrassed that she was unable to handle emotions of not being compassionate.

> "Well, I must say, that it's hard sometimes to care for these patients. They have done terrible crimes and can be quite threatening. But at the same time, it's my job to take care of them, wanting that's best for them, and when I can't. It feels kind of strange, it doesn't feel professional, like something you don't want to talk about."

Discussion

The present study focused on exploring and interpreting nurses' compassion when caring for patients with mental illness in forensic psychiatric inpatient care. This study presented one main theme: "being compassionate in forensic psychiatry - an emotional journey", which was further broken down to three themes: "Interpreting the patients suffering", "Response to patients suffering" and "Response to own suffering", which was further described in six subthemes.

The main theme gives insight into the emotional journey nurses went through when encountering patients with severe mental illness in a context that can be focused around control and coercion, over long periods of time. The nurse's narratives entailed that compassion is not static, but instead dynamic and changeable derived from the nurse's own ability to interpret and respond to the patients suffering. Letting the patient's expression make an impression and thus responding to their own suffering. Being compassionate seemed to be closely linked to the nurses' ability to cope, respond, and reflect upon patients who are forthcoming, withdrawn, or being erratic. Nurses were invited to share the patients suffering; this meant confronting their own feelings of not knowing or being unable to help, thus also risking acting in order to alleviate their own suffering and not only the patients suffering. Staying compassionate could be seen as a key component of being able to endure and making expressions of suffering understandable.

The result contained narratives about encounters between nurses and patients, where the nurses are interpreting the patient's suffering, which actualizes that giving is in a dialectic relationship with receiving, caring seems to be a mutual dependency. Where nurses not only are giving and the patients are receiving, but also the other way around. As stated in the theme, patients' expressions of suffering are either perceived as a cry for help, patients fleeing or becoming unreliable. Being in an asymmetric, mutual ethically challenging relationship with the patients, also means challenges perceiving the other and maintaining professionalism when there is a risk of being rejected or not understanding (Hem & Heggen, 2004). Compassionate response towards the other starts with gathering attention and recalling intention, an internal process that allows compassion and reliance to emerge in the nurse-patient encounter (Halifax, 2014). Encounters in forensic psychiatry invite the nurses to always be ready to shift focus being able to gain a deeper understanding of expressed suffering, which is gained from a hermeneutic conversation together with the patient (Rydenlund et al., 2019). Factors of understanding one's own profession and oneself illustrate how the confusion of nurses about their own roles and responsibilities must be made clear through self-reflection in order to improve psychiatric nursing (Hem & Heggen, 2004). Nurses' narratives also described the development of compassion and not being taken for granted. Being able to understand "the other" is based upon a mutual, sincere, and honest relationship. When facing ethically challenging encounters over long periods of time, personal chemistry and establishing a mutual ground to understand the other can just be too difficult, and facing aggressions can become a substantial problem (Mourse et al., 2018). Being in "togetherness," finding meaning over a long time, means becoming relatable and understandable (Olausson et al., 2019). To understand suffering, nurses ascribe meaning to erratic behavior, as finding the cause of suffering is a way to make it comprehensible (Vincze et al., 2015). Being confronted with suffering can have a serious implication for nursing; interpreting and attending to the patient's suffering allows for establishing a more compassionate connection, seeing the "whole person" and not just the illness (Kanov et al., 2004).

The second theme further entails the dynamics of compassion: when the nurses must form a response to patients suffering, an expression of how the patient is suffering is interpreted. This theme further entails the mutual dependency that comes from a nurse trying to give a respectful response to the patient's suffering; this also describes how nurses must respect themselves in order to be able to respect the other. How nurses approach the patient is of great importance (Gustafsson et al., 2013). Nurses try to establish trust and normality in their bond with the patient—a bond that is a foundation of care (Gildberg et al., 2012). Nurses also feel a responsibility for responding to the patient's behavior adequately in order to correct bad behavior (Kumpula et al., 2019). If suffering is not understood correctly, the response may further inflict suffering, especially when the response is in form of a demand or ultimatum (Vincze et al., 2015), given in order to keep the calm in a turbulent environment (Salzmann-Erikson et al., 2011). Our results indicate that a nurse's response to suffering is rooted in compassion when suffering is well-defined or even when the patient is avoiding nurses. However, when the patient's suffering is hard to grasp or comes disguised as threats and violence, it challenges the nurses to feel the others pain and give a compassionate response. Being compassionate means suffering with, connecting to the others hurt, noticing pain means feeling something for the other, but compassion also involves the will to do whatever it takes to alleviate suffering (Kanov et al., 2004). Our findings suggest that despite finding themselves in encounters that are experienced as tedious or uncertain, the nurses did not surrender or distance themselves; despite the obvious risk, nurses stood their ground, not abandoning the patient in need. Instead, nurses adjusted to the demand with the intention of being professional (Vincze et al., 2015).

"Response to own suffering," which is the third theme, reflects upon how the patients' suffering affects the nurses over time. There is an evident risk of nurses confusing a patient's suffering with their own suffering, which creates the danger of the patient becoming a means for the nurses to alleviate their own suffering. Our findings suggest that time is of the essence, and compassion is not static. When the patient's plea becomes understandable and the response to suffering is adequate, nurses become motivated. However, when suffering becomes difficult to understand, nurses narrate of struggling with staying compassionate. Our results imply that caring means facing vulnerability—not only the patients' but also their own. When nurses are entrusted with the patients' stories of suffering and are expected to alleviate and respond accordingly, there is a risk that nurses hide behind a façade to not unveil their inner fear and shame (Fredriksson & Lindstrom, 2002). In contrast, nurses who have the courage to care without knowing can provide a change in influencing compassion and ascribe meaning to the patient's life (Vincze et al., 2015). Experiencing self-conscious emotions in forensic psychiatry needs to be regulated; otherwise, the person can become impaired of feeling compassion, emotions such shame and guilt can arise instead and take overhand (Verkade et al., 2019). Being compassionate also means being faced with emotional and existential distress, an in-depth view of personal uncertainty, which seems inevitable when providing emotional support (Sinclair et al., 2018). But could also be seen as a sign of self-compassion, as nurses allowed themselves to see and relate to the others suffering in accordance to oneself, not suppressing own painful feelings. As reacting to own

vulnerability means realizing that suffering and own letdowns are shared with others, reducing the degree of blame and judgment, as kindness and understanding are generated for all who are in pain, including oneself (Neff, 2003).

The results of our study can be understood as nurses, during their emotional journey, in their contact with the patients are touched on an interpersonal and intrapersonal level. Our study indicates that compassion on an interpersonal level means that the nurse makes a move, takes the initiative to understand the patient. On the intrapersonal level, the nurse takes in the patient's suffering, which means allowing themselves seclusion and distance to examine their own thoughts and reflections about the patient and they are careful not to infringe upon the patient. The Danish philosopher Lögstrup (1997) says that being a human means living with demands and different challenges. As human beings, we become challenged and exposed to expectations. This means that we as human beings live in the light of the expectations of ourselves and of others about taking care of ourselves and each other. This means that, as professionals, nurses need both knowledge and humanity in relation to both patients and colleagues. Lögstrup (1997) also states that vulnerability is a fundamental condition of human life and that meeting another's expression is an interpersonal act where each of the actors turns to each other in a meeting between people where we are guided by our perception and vulnerability.

Caring and sensitivity belong to each other and come to concrete expressions in difficult care situations where we feel insecure and ask ourselves “How should I act?” Such situations demand sensitivity. To gain experience and gain insight, attention is central. Lögstrup (1997) states that it is not enough to know the demands, the law, and the rules, as they are rarely complimentary. The demand can be met through insight and sensitivity and is in itself possible to fulfill, but it does not determine the intent of our actions. The demand points to the care responsibilities we have for each other and is a call to use our imagination to interpret and understand the situation and to be able to answer the question “How should I act?”

The challenge lies in how nurses, in their sensitivity and interpretation and through their involvement in meeting the patient are able to “open their eyes” and see the other. By using his/her imagination and his/her sensitivity, the nurse can figure out how to act in the situation. As Lögstrup (2014) writes, education is of minor importance, what is more important is interpersonal interactions and one's contact with and view of their own personal vulnerability, their courage to approach the other, and personal wisdom.

Limitations

As stated by Fleming et al. (2003), objectivity in hermeneutic research can be seen as an ideal that is difficult to achieve, interpreting text and analyzing is done form own horizon. This article does not only challenge the authors' pre-understanding as a whole. But also the pre-understanding of the interpreted text, since this is a secondary supplementary analysis (Heaton, 2004). The text was viewed as truthfully and as new. This article presents findings from a secondary analysis of interviews with focus on the lived experience of nurse-patient encounters (Hammarström et al., 2019) and not directly about compassion. When researching a phenomenon like compassion the intention was not to describe or explain it, but instead to understand the experience of it as expressed in narratives of lived experience. Asking explicitly about compassion would have provided a different type of knowledge. In order to deepen the understanding of compassion in the forensic psychiatric context, perhaps new narrations are needed on specific interview questions about compassion. Achieving trustworthiness and understanding of the text was accomplished when the authors achieved a consensus of the whole and the parts of the text (Gadamer, 2004). First, the author conducted all the interviews, transcribed the text, and conducted an initial analysis. The authors draw upon various nursing perspectives and experiences, two of the authors have worked as nurses in forensic psychiatry. Although all of the authors are nurses with various experiences from different fields within nursing which lead to rich discussions, which was viewed as an asset. Dialogues which also played a major part in order to curb and handle pre understandings, not letting pre understandings getting in the way but instead becoming a foundation of understanding the studied context and phenomenon. All the authors contributed to the making of this manuscript. The first author was known to most of the participants which could suggest that participants being careful and watchful to disclose own limitations. Being known can also be seen in the light of trust, where participants could speak freely, and, hopefully, truthfully. Conducting interviews in a familiar setting also challenged the first author's pre-understanding to become truly objective.

In secondary research there is always the pending risk of problems with data “fit as the used data was originally collected for another purpose. However, qualitative data sets that are relatively unstructured tends to be rich and diversified. Allowing researchers to determine which topics to further investigate. Problems with data “fit” are especially current when data is missing, data is derived from a deductive standpoint or when there is a divergence between aims of the two studies as well as methods. It is less likely to be an issue in supplementary secondary analysis where the focus of the second inquiry is on matters which are, by definition close to the original work. Reusing own data is also an advantage as the author is “close to own data” (Heaton, 2004).

These findings do not represent a total belief, instead, they should be viewed as points of view on nurses' lived experiences of encounters with patients with mental illnesses in forensic inpatient care. We must also take into consideration the fact that forensic psychiatry is controlled by laws that vary worldwide; hence the findings of this study should be viewed as lived experiences in the Swedish context.

Conclusion

Caring for patients with mental illness in forensic psychiatric inpatient care means being confronted sometimes by incomprehensible expressions of suffering. Being able to understand these expressions facilitates compassion and enables nurses to give adequate responses and simplify care. When suffering is difficult to unravel, nurses still stood their ground, not abandoning the patient in need, which could be seen as a sign of compassion. Time seemed to be of the essence, and being faced with suffering over long periods of time also meant risking relating to rules and laws instead of becoming sensitive to their own vulnerability and patients' expressions of suffering and, thus, realizing the laws' true intents. Time influenced compassion to be seen as dynamic and unfixed; nurses were forced to handle and regulate their own emotions. In order to achieve a sense of trust and mutual dependency, breaking the pattern, sensibility and compassion could be seen as that link. Therefore, it seems important to create a permissive environment where it is allowed for nurses to be given the opportunity to reflect and act based upon their own wisdom.

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Declaration of competing interest

The authors declared no conflict of interest when conducting this study.

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