The meaning of significant encounters in forensic care

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Abstract

Background: Research in forensic psychiatric care focusing on person-oriented care is ambiguous about matters of quality. The encounters between a healthcare professional (HCP) and patient could influence how connections and relations emerge between the caregiver and the patient.

Objectives: To better understand caring aspects, this study explores significant encounters in forensic psychiatric care from the perspective of HCPs.

Method: This study is based on 34 written narratives from HCPs from two forensic psychiatric hospitals in Sweden. The narratives concern significant encounters with a patient. These narratives were analysed according to methodologies developed by phenomenological and reflective lifeworld research.

Findings: The essence of a significant encounter is a temporal extended phenomenon that both precedes as well as is a consequence of the actual encounter as it occurs. The encounter is unforeseeable and being open to an encounter also means to be vulnerable as it is not predetermined how someone will respond. The significant encounter is an act of sharing, and HCPs may come to understand more about their patients as well as about themselves. Moreover, these encounters seem to create repercussions and hope for the future care.

Conclusions: The everyday activities of forensic psychiatric care are not trivial activities. Rather, they are important aspects of health care as these everyday encounters can deepen the relationship between the HCPs and their patients and help both the HCPs and their patients develop a sense of hope for the future.

Keywords: encounters, forensic psychiatry, narratives, phenomenology.

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Background

It is hard to imagine nursing care without imagining a patient. In health care, many encounters occur every day between patients and healthcare professionals (HCPs). These encounters range from short clinical interactions without much emotional involvement to extended interactions where the HCPs go beyond their duties as professionals (1). The encounter could also be on a continuum from a caring encounter with a focus on healing and alleviating suffering (2) to an uncaring encounter characterised by a lack of humanity and indifference (3, 4). Forensic psychiatry research is characterised by both caring and uncaring encounters, but forensic psychiatry remains an under-researched field (5), especially concerning person-oriented care (6). Because forensic psychiatric care is at the interface of law and protection for society and psychiatric care and patient’s recovery, all aspects of the care and treatment given to patients in forensic psychiatric care need to be reported as exhaustively as possible.

In Sweden, a person who has committed a criminal offence due to mental disorder and is a danger to public safety can be sentenced to compulsory forensic psychiatry (7). As such, forensic psychiatry has two aims: treatment of the patient and protection of the public from further harm (8). To protect these patients from harming themselves as well as others, these patients are often cared for in special secure settings. In Sweden, forensic psychiatry focuses on illness management and recovery and risk assessment for future criminality. However, unlike in many other countries, in Sweden forensic psychiatric care is not a time-limited punishment.

Research in forensic psychiatric care that focuses on the person-oriented care is ambiguous about the quality of the care and often there are elements of both caring and uncaring in the same studies. Although patients in forensic psychiatric care often are willing to participate in...
their care, HCPs do not always encourage patients to participate in their care (9). Patients can experience good care that leads to change and recovery or poor care that leads to no changes or worse outcomes. (10) Although HCPs in forensic psychiatric care can help patients reconcile their situation and alleviate their suffering, these outcomes can be undermined by the actions of colleagues, leading to a more alienated and asymmetric relationship with patients (11). Hörberg and Dahlberg (12) found that patients experience insecure care when their care is contingent on the level of satisfaction of the HCPs rather than of the patients, suggesting that forensic psychiatric care should be guided by input from patients rather than the HCPs, a focus that requires the organisation and the care culture to support caregivers in developing a more caring attitude towards their patients (13). Rydenlund (14) has shown that it is possible to establish a stable caring relationship when HCPs understand their patients’ vulnerabilities. If the art of caring is highlighted in the encounter, then it becomes important to reflect on the central concept of encounters within forensic psychiatric care.

The encounter could have importance for both the patient and the HCP long after the actual encounter (15). Fredriksson (16) found that during the caring encounter a connection and relationship emerges between the patient and the caregiver. These meaningful encounters have the potential not only to nourish fellowship and a mutual responsibility but also to create life-changing realisations (17). If the HCPs can establish a caring and attentive presence, their patients will be encouraged to reciprocate, consequently becoming closer to the HCPs (18). For patients, a good encounter with an HCP is experienced as ‘being seen’, with the HCP exhibiting a genuine interest in their life, and a poor encounter with an HCP is experienced as being unsafe, affecting their recovery in a negative way (19).

The meaning of care is aimed at supporting and strengthening human health, and this requires genuine caring and trusting encounters (14). To better understand caring and trusting encounters in forensic psychiatric care, this study explores more closely the ‘caring space’ between the patient and the HCP, the space where patients seem to develop health.

Aim

The aim of this study was to explore meanings of significant encounters in forensic psychiatric care from the perspective of healthcare professionals.

Method

This study uses narratives from HCPs that describe significant encounters in forensic psychiatric care. One reason for collecting data from narratives is to acquire a limited description of a certain event and to obtain data that are optimally undisturbed by the researcher (20). This can be problematised by emphasising that narratives are created relationally and that there always is an actual or imagined receiver of the narrative that could influence how the narratives are constructed (21). In nursing and caring science, the benefits of using narratives to explore caring phenomena have been confirmed by several researchers such as McCance, McKenna (22), Galuska, Hahn (23).

Participants

The participants were HCPs (n = 34) working at two forensic psychiatric hospitals in Sweden. Inclusion criteria were HCPs working within forensic psychiatric care and within various professions such as nurses, physicians, therapists, curators, assistants and psychologists who were in daily contact with patients. The mean professional experience of forensic psychiatric care of the included HCP’s was 11 years. The participants’ narratives (n = 32) were collected over six months (Table 1).

Data collection

The forensic psychiatric hospitals were contacted by a letter that explained the aim and procedure of the study, and the Chief Executive Officers gave written approval for conduction of the study. Two of the researchers (KR and PR with help of contact persons) then informed the heads of department about the study and also established contact with participants who fulfilled the inclusion criteria. The participants were given the following guidelines: write down an encounter with a patient that you experienced as a significant encounter. The experiences could be challenging, transitional or just everyday events, but they should be of significance to the participants in some way. The narratives were written by hand or using computer software and were between 1 to 5 pages long (average 718 words).

Table 1 Participants

<table>
<thead>
<tr>
<th>Forensic hospital A</th>
<th>Forensic hospital B</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Physicians</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Therapists</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Curators/social workers</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Assistants</td>
<td>5</td>
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<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>17</td>
</tr>
</tbody>
</table>
Analysis

Data were analysed according to phenomenological and reflective lifeworld research (RLR) practices as presented by Dahlberg, Dahlberg (20). Briefly, RLR makes possible a reflection on underlying meanings of human existence. A central aspect in this search for meanings is the openness of the researchers. As such, a so-called ‘bridled attitude’ from the researchers (20) is crucial for problematising and reflecting about assumptions. This strategy is done to let the phenomenon reveal itself fully. The texts were read and reread by the three researchers to identify significant descriptions of the phenomenon. The related meanings were grouped into clusters. From these clusters, patterns were identified to find the essential meaning structure of the phenomenon. This strategy was done as a movement between parts and whole (20). This study focuses on significant encounters in forensic psychiatric care and describes the phenomenon’s meaning structure. The structure was constituted by the essential and more general meanings as well as contextual nuances and more individual meanings as they appear in the narratives. The analysis was carried out with a critical questioning and bridling attitude by all three researchers and as such triangulation of the analysis process was continuously being performed.

Ethical considerations

The ethical principles from the World Medical Association (24) were applied. According to Swedish law, (25) the approval of an official research ethics committee is not required for this kind of research. Written permission to conduct and record the interviews was obtained from the hospitals, the department heads and each participant.

Findings

The results are first presented as the essential structure of meanings and then followed by its constituents. In the citations, A and B refer to the forensic psychiatric hospital and the number to HCP.

Essence

A significant encounter is a temporal extended phenomenon that both precedes as well as is a consequent of the actual encounter as it occurs (Figure 1). The significant encounter cannot be predicted but occurs spontaneously where both HCP and the patient create the conditions for the encounter. The encounter could happen in everyday situations or in planned meetings, but it is impossible to plan for a significant encounter as they are unforeseeable. Rather, encounters are understood as everyday possibilities in situations where an opportunity arises, that is often only understood as being an opportunity in retrospection of the situation. It is also essential that an act of opening up is necessary for the significant encounters to occur. Consequently, the HCP becomes vulnerable because they do not know whether or how the other one will respond. Yet, this risk-taking act creates the possibilities for the encounter to become meaningful and the response is expressed in words as well as in bodily expressions. In the actual encounter, the HCPs locate themselves meaningfully in the ongoing interpersonal world with the patient and share an experience, like a conversation, a place, an interest or emotions. This shared space can, from the HCPs perspective, be characterised as uniting or tying patients and HCPs together. A consequence of the encounter is an understanding that affects future care situations. Here, insights arise concerning a deeper understanding of a patient’s life or the life of the HCP, as well as the values and awareness that their own actions affect their patients. The significant encounter has repercussions, an effect in a longer perspective. It could be a turning point characterised by an understanding of the patient’s inner world, a deepened relationship with the patient and an increased hope for the future care. This recognition could also prepare the HCPs for encounters with other patients.

Constituents

The unforeseeable significant encounter. The encounters characterised as significant by HCPs are unplanned, spontaneous, and often connected to everyday situations. They emerge in the patients’ room, when medicine is
delivered or when relatives visit, or outside the patient’s room:

As I come into the ward, I see her, the patient, proud as a rooster almost running out of her room towards me, with a big smile and declares that she during the day actually managed to go to the grocery shop all by herself. I have never seen her so happy! (B2)

A significant encounter emerges from everyday situations and does not seem to have an explicit or implicit aim to be significant. It is not a planned or arranged encounter, not even a reflected encounter, although the encounter’s significance arises within the confines of the time and space of the shared moment.

There are some narratives where a meeting is planned; however, the meaning of these encounters is not planned and occurs as the encounter unfolds. The narrative below describes a scheduled meeting in a patient’s room. The meeting is scheduled due to the patient’s aggression and intimidation against fellow patients. The HCPs are aware that the patient has been convicted of attempted murder of an HCP. The meeting begins with the patient presenting a hot and frenetic monologue. The HCP suddenly discontinues the patient:

He became silent. Just looked at me and I was also quiet (and a little bit scared) waiting for my words to fall in. He seems surprised and then said: I have never thought of it in that way before. (A9)

The HCP was worried about how the patient would respond to the questions, but the situation becomes significant. As a result of the interaction, the HCP experienced a strengthened relationship with the patient that had significance for the patient and the HCP.

The very act that leads to the significant encounter arises unplanned, but it is often based on a sense of an inner demand or an intuition of the situation:

I felt I had to put my arms around her to let her cry out in my arms. When this happened, I felt that she was relaxing, and she had an exhaustive cry. (B3)

The ‘inner demand’ to hug the patient was not predetermined, but the sense of the situation was compelling.

The significant encounter as an opening. In the narratives, the significant encounter precedes the response. The narratives show how HCPs can provide a helping hand, ask a question or do something unexpected that leads to the encounter becoming significant. That is, when the HCP and the patient are both open to sharing a significant encounter. This type of interaction was evident the following narrative:

A late-night patient, who had previously had difficulty expressing feelings, came to the office. She was very sad and was crying uncontrollably. (B3)

From the HCP’s perspective, the patient was open to the HCP’s response to her emotional state, and this created the conditions for a meaningful encounter.

This shows that a significant encounter carries a risk or makes the parts in it vulnerable. Being open to an encounter means being unsure how the others will respond to this openness. That is, it is never predetermined what a significant encounter will lead to. In one narrative, the HCP faces the patient where the patient is about to start fighting:

Then I stood before him, with open arms, and cried out the patient’s name and say ‘what the hell’. So I open my arms more like a hug. Then the patient hugs me, and the situation turns out not to be perceived as originally loaded. (A3)

The HCP stands in front of the patient with his arms open, risking physical harm, but the actual action, which is not planned, leads to a significant encounter that results in the confrontation being averted.

In the narratives, the response to openness is often reflected in concrete bodily emotions or actions. There may be eye contact that had not existed before, a pat on a shoulder or a conciliative handshake:

The patient took me by the hand, and I remember that he patted me on my shoulder. He looked me in the eyes and said I was a good person. It was an unexpected reaction, but something compelling happened then. (A2)

Healthcare professional experienced that through the touching, the patient and the HCP expressed their faith in each other. Clearly, a significant encounter is more than just words for both patients and caregivers. The bodily response appears necessary when comforting patients, an act that confirms to the patients that the HCP acknowledges their pain.

The significant encounter as an act of sharing. Healthcare professional describes how the significant encounter unites patients and HCP through their shared experience. For sharing to occur, ‘something’ needs to be shared by both patient and HCP, such as a walk in the rain:

We continued the walk, but now with a feeling of togetherness since we had shared a very special moment [. . .] and from that day we had a special relationship. We were friends; we were no longer just patient and staff because I had been admitted [into the patient’s world]. (b10)

The shared experience, described by the HCP, opens up the relationship and provides an impetus for the patient to allow the HCP into his or her private world. Other common points of contact found in the narratives include fishing, cars and music:

The patient asked a lot about what kind of music I liked, which I responded to, and it turned out that I and the patient had quite different music tastes.
There, somewhere in the music, the conversation, and the encounter, we found each other. We sat next to each other on the patient’s bed and listened to music. A great deal of time was spent listening to the music without the need to talk to each other. (A8)

Sharing music, in silence in this case, leads to a significant encounter, a shared experience to call on to create a sense of belonging. This shared experience also creates a contact area that facilitates the relationship and the significant encounter according to the HCP:

We had a common interest in fishing. You could talk about fishing gear as well as which lakes that were particularly good for different types of fish. In this way, a gateway was created to discuss care issues, but also world events, how they could be seen in different ways. (A13)

The common interest in fishing becomes a way to enter the patient’s world, further establishing a relationship with the patient.

The significant encounter creates understanding. In the narratives, the HCPs describe why they perceived the encounter as significant and how this perception led to a better understanding of the patient. The understanding is related to knowledge about the patient’s life and situation. The encounter created new insights into the patient’s lived experiences. In one narrative, the HCP writes about her own fears in a situation where a patient, whose hands and feet were firmly restrained, is transported to the hospital ward by heavily equipped police officers. For some time, the HCP was alone with the patient; however, she discovers that the patient was:

An ordinary man who never would hurt a fly while he was sitting there’. (B13)

The caregiver comes to realise that her fear clouded the encounter before she was able to see that her preconceived ideas of the patient were incorrect.

Similarly, one HCP narration relates a significant encounter as the experience of realising that a patient could not understand the extent of his or her crimes or acts. Although the HCP was horrified by the patient’s crimes, she was eventually able to understand the impact of the patient’s mental disability:

And I realized: He did not understand [. . .] the infinite love of his daughter, and the bottomless grief over her death that should have been his, he will never experience (B7).

In this realisation, HCP experienced sadness because of the realisation that he would never be able to understand the terrible deed—that he had (actually) killed her.

The narratives also illustrate how the HCP gained understanding into her own motivations, values and beliefs:

The encounter gave me several opportunities to evaluate and re-evaluate how I myself was thinking about my own values (B7).

The encounter resulted in that HCP understands themselves better and an awareness that their own actions affect their patients.

The repercussions of the significant encounter. A significant encounter creates what could be described as repercussions for the HCPs long after the encounter. The encounter serves as a turning point for the future care. This turning point could be a commonplace event given an important role. In the narratives, HCPs often relate that the repercussions of the encounter deepened their relationship with the patient. These encounters allowed the HCPs to see their patients on the ‘inside’ or ‘be part of their journey’. According to the HCPs, during these encounters, the HCP and patients share something. In one narrative, this sharing is described as the patient having come to a turning point where his self-confidence has been strengthened:

To be able to explain to the patient that he has many good qualities and get to experience that sight when it dawns on the patient that it is actually so, that is something that I will always carry with me (B12).

The HCP perceives a turning point when the patient realises that he has good qualities. The encounter also means that the encounter has meaning for the HCP as it is now part of HCP’s own life experience. Recurring in the narratives are experiences of being invited into the patient’s world, strengthening their relationship with the patient. In these cases, the caregiver sees hope for a patient’s situation that had previously seemed hopeless.

An HCP describes this type of encounter as a ‘feeling of happiness’. The encounter, in this case a cooking situation, reminds the HCP that previous experiences of cooking situations have been loaded with negativity for the patient. This insight gives a new starting point for this exercise and creates a hope for the future.

As a consequence of the significant encounter, HCPs can also learn something about themselves that impacts their future. In one narrative, the HCP describes an encounter in which it seemed like the patient for the first time understands the conditions of his care:

The encounter also came to pave the way for future encounters with patients where I came to be, and I am still more open and clearer in my communication. (B7)

The HCP dared to be straight and honest in the conversation, an attitude that became part of future encounters.

The repercussion of the significant encounter can sometimes be seen only retrospectively. In one narrative, the HCP describes a journey to a patient’s mother:
It all became a successful journey and it still happens that the patient talks about it when we meet even though it has been six, seven years since then (A16).

The journey was a significant encounter, but it was only after the encounter that the journey was confirmed to be significant. However, significance can also be perceived in the present moment as well as create hope for future realisations:

I was also pleased with the sense of hope that I experienced for the patient’s future. Sometimes it feels very hopeless about patients’ possibilities and abilities, but at such encounters, a light is turned on and it feels meaningful (B14).

The significance here is that the actual encounter with the patient gave the HCP hope that the patient’s condition would improve (Fig. 1).

Discussion

The result’s main findings show that the essence of the significant encounter is preceded by an openness between the HCP and the patient. HCPs experience that, for both parties, there is a vulnerability inherent in the situation that creates an opportunity for an unplanned and unpredictable encounter. In the encounter, HCPs describe an experience that may lead to the HCP and the patient gaining insight about themselves and each other. The encounter creates repercussions and hope for the future care both during the encounter and long after the encounter.

In many ways, these results are in line with previous work on encounters, but they also diverge from the literature in some respects. For example, although the encounters were unplanned as described by Nåden and Eriksson (2) the patients and HCPs were open to the possibility of the encounters and simultaneously vulnerable. This vulnerability could be exploited by either party, but they confirmed one another’s importance, making the encounter potentially significant. Rather than planning for such situations, HCPs should focus on what precedes a meaningful encounter such as an action that creates possibilities for these situations to happen. It is difficult to avoid the natural desire to immediately reflect and apply a preunderstanding, but these desires can actually inhibit an open encounter. The vulnerability is necessary for the parties to move past their preunderstandings and develop the trust that openness to the encounter will be meaningful. This finding deepens the previous knowledge that caregivers need to reflect, know themselves, and be open and willing to communicate (17, 26).

The results show how repercussions of these encounters are experienced by the HCPs as affecting both the patient and the HCP. When a significant encounter provides an HCP with a new understanding, the HCP’s ethical commitment and new realisations are evident in the next encounter. These short-lived encounters could also be described as intense moments where both the patient and the caregiver share a mutual space and where time lacks meaning (27). In the narratives, the mutual space is put in concrete form when the HCP and patient share a special moment and interests. This sharing has important practical implications for forensic psychiatric care. The everyday activities that transpiring in forensic psychiatric care are not just trivial activities to make time pass; rather, they are activities that HCPs and the care organisations should value and encourage by allowing HCPs and patients to interact in less formal situations such as walking, playing cards and listening to music. These activities are common entries into an emerging relationship that could result in repercussive effects such as creating a hope for the future or deepening the relationship with the patient. These are activities that should be valued equally and as seriously as any session with a psychologist or a medical doctor.

Previous research confirms that encounters can have consequences for HCPs and patients (15) and confirms our results that significant encounters can result in gratefulness (17). Moreover, HCPs can learn about themselves and their patients in ways that will benefit not only the patients but the HCPs (28). Sometimes the insight could be that in forensic psychiatric care the patients cannot grasp and understand the extent of their criminal act and the caregiver understands that the patient is unable to suffer. This insight in the patient’s life has contextual importance, a finding that has not been addressed in previous research.

Swedish forensic psychiatric care is described as being paternalistic and punitive (29). However, we would like to problematise this claim. According to Swedish law, forensic psychiatric care should be a balance between two often contradictory aims: the patient’s need for treatment and society’s need for protection. These aims are framed by laws that focus on security where the patient is isolated from society, most often against their own will. However, inside this frame the care presupposes a caring perspective that respects the patient’s dignity (30) and seeks to relieve patients of their suffering (11). What sometimes seems to be uncaring is a manifestation of the legal constraints placed on forensic psychiatry in terms of security and protection of society. Therefore, caring in forensic psychiatric care can result in extreme situations. It is difficult to care for a person who does not want to be cared for. Hörbeg and Dahlberg (12) argue that the forensic psychiatry’s tendency for correction and discipline could be part of an overall general psychiatric or mental health culture. We take this view a step further. We suggest that all care work in psychiatry as well as in general health care has an inherent possibility to be caring or uncaring and that uncaring in psychiatry is more obvious than in general health care. As the narratives in this study show, in agreement with Vincze, Fredriksson (11) HCPs need courage to witness and take part in their patients’ suffering. Although uncaring is more visible in
forensic psychiatric care, significant caring situations in forensic psychiatric care takes more personal engagement and courage than in other areas of care.

Limitations
Written narratives about significant encounters were chosen as a method because human beings experience and interpret life as if they were characters in a story (31). This approach is not without problems. The written narrative approach means that the participant is creating the material for analysis without any possibility for the researcher to clarify or probe for details. The participants were asked to write down a significant encounter with a patient, so the participants define the meaning of significant encounter. It is possible that the participants’ construction of the narratives could also be influenced by the audience to whom they are directed (32), meaning that the participants could have written a polished version for the researcher. However, the participants showed great interest in the study and this interest was reflected in the participants’ expressed desires to develop a better understanding of their caring situations.

Conclusions
Typically, forensic psychiatric care focuses on patient goals and following care plans; however, significant encounters are unplanned and unpredictable. This study found that significant encounters require engaging in the everyday activities common in forensic psychiatric care. These activities are often necessary for significant encounters, and they can strengthen the overall care that takes place in forensic psychiatry. These encounters must be viewed as important for the success of overall forensic psychiatric care and highlights the need to enhance the caring perspective.

Conflicts of interest
The authors declare that they have no conflicts of interest.

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