

REVIEW ARTICLE

“They can do whatever they want”: Meanings of receiving psychiatric care based on a common staff approach

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Abstract

This study deepens our understanding of how patients, when cared for in a psychiatric ward, experience situations that involve being handled according to a common staff approach. Interviews with nine former psychiatric in-patients were analyzed using a phenomenological-hermeneutic method to illuminate the lived experience of receiving care based on a common staff approach. The results revealed several meanings: discovering that you are as subjected to a common staff approach, becoming aware that no one cares, becoming aware that your freedom is restricted, being afflicted, becoming aware that a common staff approach is not applied by all staff, and feeling safe because someone else is responsible. The comprehensive understanding was that the patient's understanding of being cared for according to a common staff approach was to be seen and treated in accordance with others' beliefs and valuations, not in line with the patients' own self-image, while experiencing feelings of affliction.

Key words: *Common staff approach, phenomenological, hermeneutic, nursing, psychiatry*

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Background

Many studies have investigated staff attitudes toward patients in psychiatric care (i.e., Deans & Meocevic, 2006; Gibb, Beautrais, & Surgenor, 2010; Husum, Bjørngaard, Finset, & Ruud, 2010; Pollard, Gelbard, Levy, & Gelkopf, 2008; Tsai, Salyers, & Lobb, 2010) and patient experience of particular types of care (cf. Johansson, Skärsäter, & Danielsson, 2009; Lilja & Hellzén, 2008; Määttä, 2009; Thibeault, Trodeau, d'Entremont, & Brown, 2010). However, apart from two earlier studies by the authors of this paper (Enarsson, Sandman, & Hellzén, 2007, 2008), no other identified studies focus on patient experience of care based on a common staff approach to the individual patient. Such an approach to the individual patient can be seen in situations where a patient in some way challenges the internal order of the ward, and staff try to correct the patient's behavior by applying a common approach. This common

approach starts in a staff-predefined order, but it is always adapted and applied individually to individual patients when they challenge this order. The common approach may be detected by the patient in the constituent actions of staff members when, for example, staff members do not speak to the patient, restrain patient actions, or adopt a strict 24-hour scheme controlling every move the patient makes with the aim of restoring a staff-predetermined level of order.

To understand what constitutes a common staff approach, how it emerges and is used by psychiatric staff, and how staff members experience applying such an approach to individual patients, two earlier studies were conducted. The first aimed to describe and understand the social processes in a long-term psychiatric care context that lead to a need among staff to formulate a common approach and apply it when dealing with individual patients (Enarsson et al., 2007). The main findings were that in

community-based psychiatric group dwellings when internal order is perceived to have been disturbed, staff feel the need to preserve or restore that order by formulating and implementing a common approach to individual patients. In doing this, staff members negotiate with each other to reach an agreement on how to behave toward individual patients. Data also indicate that when a common staff approach is applied, staff often have difficulties applying it over time. A second study sought a deeper understanding of how psychiatric staff, when caring for psychiatric patients, experience situations that include a common staff approach toward an individual patient (Enarsson et al., 2008). The comprehensive understanding was that nurses face a difficult choice: to focus either on their relationships with colleagues or on the situation of the patient who seems to suffer when a common staff approach is used. The nurses became aware of their own and colleagues' bases of evaluation when relationships were strained, and they also became sensitive to both the patient's suffering and their own suffering when they felt they were judged by patients and colleagues. These two earlier studies (Enarsson et al., 2007, 2008) demonstrated that a common staff approach is not part of a properly formulated care plan; instead, it seems to be a way to control a patient when staff feel exposed and pressurized by the patient's actions. The aim of this study was, therefore, to illuminate meanings of a common staff approach when applied to the caring of in-patients in psychiatric care as narrated by the patients.

Method

Research context and participants

The phenomenon of the common staff approach in psychiatric care is probably best studied through narratives about ward admissions and about putting relationships between the patient and staff members to the test (Hellzén, 2000). Another assumption, based on previous research, was that a common approach presupposes a group of carers who decide to apply such an approach (Enarsson et al., 2007). The inclusion criteria for the present study were therefore that the patient should (1) have been admitted to psychiatric in-patient care for a minimum of 2 weeks within the last 10 years, (2) be willing and able to participate, and (3) be able to communicate in Swedish. The study was performed in a county in central Sweden. The selected clinic, one of two in the county, serves approximately 135,000 inhabitants. All hospital-based psychiatric care is administered by the clinic, which has four psychiatric teams and four psychiatric wards.

Located in the same city as the clinic is a Fountain House, a place where former psychiatric patients can spend their daytime hours, meet other people in the same situation, and gain support for their recovery (Norman, 2006). The house is run by volunteers diagnosed with psychiatric illness, supported by a small paid staff.

The people invited to be interviewed were no longer receiving in-patient care but were all still in contact with psychiatric open care units. The interviewees were recruited either through the clinic or the local Fountain House. In both cases, all those who agreed to participate in the study were interviewed.

Contacts at the clinic were mediated through a nurse who was responsible for education at the clinic and who provided oral and written information about the study to the staff who cared for the patients. The staff members were requested to ask patients whether they were interested in participating and to pass along to the interviewer the names and phone numbers of those who were. Only one person was recruited in this way and then interviewed. At the Fountain House, contacts were mediated through the manager who provided oral and written information about the study directly to the members. Those interested in participating in the study were encouraged to contact the interviewer. Nine people were recruited from the Fountain House, though it turned out that one person had no in-patient experience and was later excluded. The final sample consisted of nine people, eight women and one man, aged 31–67 years (mean, 37 years).

Data collection

The data were collected through narrative interviews (Polit & Hungler, 1999) using broad open-ended questions (Patton, 2002). Interviewees were asked to speak freely about situations where they felt a common staff approach had been applied to them. To investigate the target phenomenon, we used a “re-enactment” technique (Drew, 1993) in which interviewees were encouraged to narrate one or several self-experienced situations in as much detail as possible. Each interview lasted 30–60 minutes and was tape-recorded and transcribed verbatim. The opening question was “Can you tell me about an occasion when you felt that the staff treated you according to a common approach?”

Nine interviews were conducted at the Fountain House and one in an interviewee's home. In total, 10 people were interviewed, though only nine interviews were analyzed because one person did not meet the inclusion criteria having had no in-hospital experience. The interviews were carried out over a period of 9 months in 2008. First, two pilot

interviews were carried out, the results of which clearly indicated a need to explain the research question more clearly to the interviewees. The pilot interviews then became part of the study.

For interviewees who had difficulty understanding what was meant by “common staff approach,” we presented clarifying examples based on prior research EXPERIENCE (e.g., Enarsson et al., 2007, 2008) such as various staff members articulating similar positions or giving the same answers when asked for permission to go out, smoke, or eat at irregular times. These clarifying examples often stimulated interviewee narratives.

Analysis of data

A phenomenological–hermeneutic approach, inspired by the philosophy of Ricoeur (1976), was used to illuminate the patient’s lived experience of being cared for by staff applying a common approach (cf. Enarsson et al., 2008). Ricoeur (1991) states that whenever there is a language of symbols and metaphors there is also hermeneutics. An individual act must be seen in light of a relationship, which in turn must be seen in light of the individual act. A text bears a meaning (i.e., utters meaning), which the reader then reduces, seeking his or her own meaning depending on the phenomenon to be illuminated (i.e., utterance meaning). The method combines phenomenological philosophy with hermeneutic interpretation in a dialectic process that moves back and forth between understanding and explanation culminating in a comprehensive understanding (cf. Ricoeur, 1991). The method was developed for use in nursing research in the Department of Advanced Nursing, Umeå University, Sweden and in the Unit of Nursing Science, University of Tromsø, Norway (Lindseth & Norberg, 2004) and has been used in several qualitative studies, for example, Rasmussen, Sandman, and Norberg (1997), Skovdahl, Kihlgren, and Kihlgren (2003), and Graneheim, Isaksson, Ljung, and Jansson (2005). In the present analysis, we sought the utterance meaning; that is, what the text talks about. We have conducted two previous studies of a common staff approach (cf. Enarsson et al., 2007, 2008), and all three of us have experience from working in psychiatric care facilities; however, this experience is from several years ago as we currently work mainly as researchers, teachers, and administrators. Because we are not active psychiatric carers, we do not have a staff perspective and are likely to be more sensitive to the patient situation; this pre-understanding probably influences our interpretations.

The analysis starts with a naïve reading of the text to formulate a superficial interpretation of its meaning in relation to the main study question (i.e., what it means to be subjected to a common staff approach). Ideas generated in this first step provide the starting point for further analysis. The next step is a thematic analysis of the text, which is read several times, line by line, and sorted into meaning units based on various narratives of experience, guided by the aim of the study and the naïve understanding of the text. The meaning units (i.e., pieces of text) are then coded, condensed, and grouped into sub-themes and themes (Table I). In the final step, aimed at formulating a comprehensive understanding, the text is again interpreted as a whole in light of understandings gleaned from the naïve reading, the structural analysis, and the authors’ pre-understandings, by means of a theoretical framework; that is, theories that can provide the perspective needed for a deeper understanding of the phenomenon studied.

Ethical considerations

The Regional Ethics Committee of Umeå, Sweden approved the study (permit Dnr 07-182M). Written consent was asked for and obtained from each participant. Special attention was paid to explaining the purpose of the study to the interviewees; attention was also paid to the vulnerable situation interviewees were in when invited by staff (at the psychiatric clinic) or the house manager (at Fountain House) to join the study. All participants were given time to reflect on whether they wanted to join the study, and it was their decision to contact the investigator for an interview. One person first agreed to be interviewed but later declined, stating that her nervous condition made it impossible to participate for the moment. Given that the interviews might evoke feelings of discomfort concerning situations experienced, the interviewer on a few occasions asked the interviewees whether they wanted to abort or take a break; in all cases, however, the interviewees wanted to continue. In addition, all interviewees were told they were welcome to contact the investigator later if they wanted to discuss something related to the interview, though no one took advantage of that opportunity. Some background data such as name, gender, and place have been altered to preserve interviewee anonymity.

Results

Naïve reading

Participants describe the common staff approach as difficult to identify directly; rather, it is something

Table 1. Examples of meaning units, condensed meaning units, sub-themes (when present), and themes.

Meaning units from transcribed text	Condensed meaning units	Sub-theme (when present)	Theme
Well, you know, it was—they [i.e., the staff] were about to have their morning meeting. Then, then I was sitting in the corridor as usual, and then I was listening because the door was open. And then, then I overheard them discussing the patients, so I realized that they were arguing about how to handle me.	I overheard because the door was open. They were discussing me—I realized they were arguing about how to handle me.	—	Discovering that you are subjected to a common staff approach
Because they [i.e., the staff] kept saying things to me and insinuated I should go a step further [and cut myself deeper]. They might talk like this: “Well, shouldn’t you cut yourself a bit more, because it is only childish?” And such stupid things as “You know how to do it, don’t you? If you are going to do it, do it properly.” And then . . . they told me those crazy things.	They kept saying I should go a step further and cut myself. Those crazy things.	Feeling that no one cares	Becoming aware that no one cares
I was not allowed to wear a tight dress or high-heeled shoes. It was not appropriate, the staff told me. And I felt no, changing my taste in clothing? . . . and it ended up [with] me wearing ordinary shoes and plain pants and so on . . . I think they wanted to protect me [from incidents with male patients], but it is my taste in clothing. And I like my body and so on. I got a little bit [angry]. I did not want to change how I dressed. Of course you become disappointed when you are not allowed to be the person you are used to being.	I was not allowed to wear a tight dress or high-heeled shoes. I got a little bit [angry]. I did not want to change how I dressed. You become disappointed when you are not allowed to be the person you are used to being.	—	Becoming aware that your freedom is restricted
And so, I was only allowed to visit the library once a month, and then they [i.e., the staff] decided what books I was allowed to have. I think it was because they wanted to have control over me and restrict my life all the time. When I wasn’t allowed to read, I started to write instead. And that was no good either . . . And they took my painting away because they thought I would hurt myself with the paintbrushes, but that has never happened. There were really no grounds for that action . . . And then you feel your own ability to make decisions getting smaller and smaller, and it is awful. You know you are completely in their hands—	I was only allowed to visit the library once a month. They wanted to have control over me—you feel your own capacity gets smaller—and it is awful. You know you are completely in their hands.	Being powerless	Being afflicted
It was just that they [i.e., the good staff] cared. And that you felt you were a little . . . you were accepted by them, in a way. I remember I could not sleep well at nights for a while. And then I was invited to sit with the staff on night watch, by the coffee room. I could sit there and they talked and joked with me. And we had a pleasant time. And it felt in a way, yes I felt they cared about me—even though I was a patient.	And you felt you were accepted by them. I was invited to sit with the staff on night watch. Yes, I felt they cared about me—even though I was a patient.	—	Becoming aware that a common staff approach is not applied by all staff
Somehow they saw what I needed. Yes, they might have talked it over—I believe they had talked it over. I don’t know, but I got that feeling—yes I did.	They saw what I needed. I believe they had talked it over.	Feeling safe	Feeling safe because someone else is responsible

that is apprehended only as a part of ongoing treatment. Their narratives reveal that being cared for according to a common staff approach makes them feel that no one cares about their suffering. It arouses feelings of scorn and humiliation, abandonment and alienation, a sense of being deprived of the possibility of needed conversation. One's freedom is experienced as being restricted when one is not allowed to move about freely and there is an unspoken demand to obey staff. The patients relate feelings of being powerless and experiences of being treated as a less intelligent person. Furthermore, being cared for according to a common staff approach means they become aware that nobody really knows how to help them. However, they also realized that not all staff on the ward applied the common staff approach. Finally, for some, being cared for according to a common staff approach also meant safety and the confidence that someone else was responsible for their well-being, the feeling that "whatever happens they will be there for me."

Structural analysis

Six main themes emerged from the analysis, some of which had associations with sub-themes:

- Discovering that you are subjected to a common staff approach
- Becoming aware that no one cares
- Becoming aware that your freedom is restricted
- Being afflicted
- Becoming aware that a common staff approach is not applied by all staff
- Feeling safe because someone else is responsible

Theme: Discovering that you are subjected to a common staff approach

Patients who discover that they are subjected to a common staff approach know that the staff will try to treat them uniformly in certain situations. The common staff approach is described as being difficult to recognize and is often seen as an integral part of care, because the intention of the approach is experienced as being hidden. For example, a sudden, unexplained decision may be made to restrict the patient's ability to move about freely. Sarah tells of how she became aware that she was being subjected to a common staff approach:

Well, you know, it was—they [i.e., the staff] were about to have their morning meeting. Then, then I was sitting in the corridor as usual, and then I was listening because the door was open. And then,

then I overheard them discussing the patients, so I realized that they were arguing about how to handle me.

Another patient, Greg, had a similar experience of staff secrecy. He guessed that the staff had decided on a common approach for him, but he was unable to verify his suspicion. He also expressed feelings of anger toward the staff whom he felt were talking and making decisions over his head.

Theme: Becoming aware that no one cares

Another meaning of being cared for according to a common staff approach is becoming aware that no one seems to care about your suffering. The patients narrate their experiences of scorn and harassment and their feelings of abandonment and alienation.

Sub-theme: Feeling that no one cares

Being exposed to a common staff approach means experiencing the staff as uncaring. Betty describes how the staff jointly decided to ignore her request for support when she was experiencing anxiety. They neglected her suffering and even encouraged her to continue to hurt herself:

Because they [i.e., the staff] kept saying things to me and insinuated I should go a step further [and cut myself deeper]. They might talk like this: "Well, shouldn't you cut yourself a bit more, because it is only childish?" And such stupid things as "You know how to do it, don't you? If you are going to do it, do it properly." And then ... they told me those crazy things.

Sub-theme: Feeling emptiness concerning one's person

Being subjected to a common staff approach means feeling emptiness concerning one's person, experiencing that staff have decided to minimize efforts to establish any caring relationships. Linda has had such an experience:

I thought because I felt like that in a way, if someone had sat by me and talked a little with me, and so on, instead of just "Do this and that." It could have been someone who would sit by me and try to calm me down. I think it would have been better. There was no one who asked directly [how I felt]. No, instead just "Back to your room." And so I had to stay there.

Theme: Becoming aware that your freedom is restricted

Being cared for according to a common staff approach also means becoming aware of your restricted freedom. For example, you may not be allowed to visit certain rooms (e.g., the kitchen, nursing station, and other staff areas), use the cellular phone, or decide how to dress. One must obey without question. Marilyn says:

I was not allowed to wear a tight dress or high-heeled shoes. It was not appropriate, the staff told me. And I felt no, changing my taste in clothing? ... and it ended up [with] me wearing ordinary shoes and plain pants and so on ... I think they wanted to protect me [from incidents with male patients], but it is my taste in clothing. And I like my body and so on. I got a little bit [angry]. I did not want to change how I dressed. Of course you become disappointed when you are not allowed to be the person you are used to being.

Theme: Being afflicted

Being cared for according to a common staff approach can also be understood as being afflicted; that is, being afraid, powerless, compelled to obey, punished when staff are displeased with your behavior, treated as a less intelligent person, and talked to as if you are a child.

Sub-theme: Being afraid

Being afraid means never knowing what the staff might decide upon—compulsory care, for example. Fatima describes being afraid of the staff, which meant that she tried to minimize her contact with them:

I was a little afraid of them [i.e., the staff] all the time [because I had been restrained by force earlier]. I locked myself in, in my room as often as possible. I had a single room.

Sub-theme: Being powerless

Being afflicted is understood to include being deprived of the opportunity to govern your own life when forced to obey the staff. For example, Greg relates his feelings of powerlessness when staff decided what books he was allowed to read or when he was forced to go to bed at a certain time decided by the staff:

And so, I was only allowed to visit the library once a month, and then they [i.e., the staff] decided

what books I was allowed to have. I think it was because they wanted to have control over me and restrict my life all the time. When I wasn't allowed to read, I started to write instead. And that was no good either ... And they took my painting away because they thought I would hurt myself with the paintbrushes, but that has never happened. There were really no grounds for that action ... And then you feel your own ability to make decisions getting smaller and smaller, and it is awful. You know you are completely in their hands—they can do whatever they want with you.

Sub-theme: Being compelled to obey

Being afflicted also includes the feeling of being compelled to obey and being ordered about by the staff. Sibyl says:

This and that: you will go, go to your room ... and put on a long-sleeved sweater—you are not allowed to walk around like that [i.e., with scars on your forearms]. Yes, precisely, compelling you to obey! So if I cut myself on my face or on my neck, I was not allowed to leave the room at all.

Patients can also feel compelled to obey when their opinions are not taken seriously and they are talked down at and treated like children, evoking feelings of anger and sadness. Greg says:

No it, it is like this—I think I deserve to be asked or spoken to when a decision is about to be reached concerning me. There is the catch, you know [i.e., that the staff have no confidence in your ability to make good decisions about yourself]. No, yes it feels like that, yes it does, it really does. It is very, very miserable indeed, because you get both angry and sad.

Another aspect of feeling compelled to obey is the shame some patients are made to feel. This may occur when staff members express disappointment in a patient's inability to live up to their expectations or when their expectations are very low. Mary feels ashamed when the staff's expectations are low and they express their lack of belief in her:

Yes, they [i.e., the staff] did [express their disappointment in me]. I was hopeless and they were disappointed and so on. And then because I wanted to go to university—and they knew that, that it would never work for me. They said so—"because you are not that smart, you are not" ... I felt like giving them a punch in the nose.

Sub-theme: Being punished

Being afflicted is also understood to include being punished for failing to live up to staff expectations, for example, receiving physical restrictions or being neglected by the staff. Amy tells of such an episode:

I had those periods when I was unable to talk. I was mute, said nothing. I did not talk to a single person, went inside myself. But then they [i.e., the staff] tried to force me to talk on their terms. No, but they . . . “Now you will talk! If you don’t talk, we will not talk to you.” But I didn’t talk anyway, so nobody talked to me . . . Yes I was [punished] . . . It felt terrible; I was unable to have any contact.

On the other hand, if patients behave as they think is expected and desired by staff, they may be rewarded with more social interaction with staff. Some patients who described being punished even said, “You have to forgive them; they do not know any better.”

Being punished also means having to put up with staff using abusive language including shouting, teasing, and offensive remarks. For example, one patient described how he was teased by the staff whom he thought were hoping to provoke an outburst, a cause for punishment:

They were heavy-handed, inhuman I thought. Sometimes they would tease me for not being able to leave the ward, hoping I would have an outburst . . . There were two male [staff] in particular with whom I didn’t have good relationships.

Theme: Becoming aware that a common staff approach is not applied by all staff

One meaning of being cared for according to a common staff approach is becoming aware that individual staff members have their own interpretations of the content of the approach. Some staff are seen by the patients as wedded to the approach, insisting on rules for the patient regardless of whether or not they help. They are described as wrong, stiff, cold, primitive, and unable to grasp the individual patient’s situation. Other staff members can override the approach, see the suffering, and act in a manner that puts the well-being of the person ahead of upholding the common approach. Amy says:

It was just that they [i.e., the good staff] cared. And that you felt you were a little . . . you were accepted by them, in a way. I remember I could not sleep well at nights for a while. And then I was

invited to sit with the staff on night watch, by the coffee room. I could sit there and they talked and joked with me. And we had a pleasant time. And it felt in a way, yes, I felt they cared about me—even though I was a patient.

Theme: Feeling safe because someone else is responsible

There is also a more positive meaning of being cared for according to a common staff approach; that is, feeling safe because someone else (i.e., the staff) is responsible for your well-being. It is also the feeling that the staff wants what is best for you as a patient even though your freedom may be restricted as a result of staff actions.

Sub-theme: Feeling safe

Feeling safe means that the patients experience that staff are responsible for them. This is the case even though this also means that patients are subjected to force in the form of compulsory medication and movement restrictions, because patients are aware that these measures are meant to prevent them injuring themselves. Feeling safe also means believing that when staff agree on a common approach it will help patients regain their health:

Somehow they saw what I needed. Yes, they might have talked it over—I believe they had talked it over. I don’t know, but I got that feeling—yes I did.

Feeling safe means that rules and routines established by others are experienced as something good; for example, a good daily rhythm may be enforced by not being allowed a cup of coffee at night. Some patients also narrated that the *absence* of a common staff approach evoked feelings of insecurity and disappointment.

Sub-theme: Feeling cared for

Feeling safe also means feeling the benevolence of the staff as a whole, feeling protected and helped, and feeling that the staff will apply the common approach because it is in your best interest. Linda describes this feeling:

Yes, but they have common rules, they have those all the time. They were of the same opinion really. Yes, I know they cooperated to the full . . . It is the feeling you get—that they act as a group . . . Some things turn out well if you just behave. But why [do staff have a common approach]? Because it

helps you recover, that is really the reason. That is the whole reason—they want to make you well.

Feeling safe is also the feeling, upon later reflection, that the common staff approach led to something good, although it did not feel that way when you were subjected to it. It is the feeling that when the staff apply a common approach, you will not be abandoned and forced to manage on your own: outbursts will be dealt with appropriately, for example, by imposing restraint when necessary, again and again until the patient feels better.

Comprehensive understanding

Our interpretation suggests that, for the patient being cared for, a common staff approach means being seen and treated in accordance with other people's beliefs and valuations, no matter how far these might be from one's own values and self-image. A common staff approach also leads to an unequal division of power between patients and staff (cf. Johansson, Skärsäter, & Danielsson, 2006). Patients can experience a common staff approach as being both positive and negative, and patients' suffering when being cared for in this way can be expressed in various ways, and if no one sees or hears these expressions of suffering, the suffering could well be extended (cf. Weil, 1995).

Discussion

The literature on general psychiatric nursing care regards the nurse–patient relationship as being important (Morrison & Burnard, 1991; Tschudin, 1995). The communication between nurse and patient and the nurse's support of the patient are described as the basis of psychiatric nursing care (Dexter & Wash, 1997). When investigating the nurse–patient relationship, it is important to examine and attempt to understand the experience of being a patient in a psychiatric context. In this study, being cared for according to a common staff approach, as narrated by the patients, can be understood as being constrained within a structure of control. Once the patient's desired behavior is enforced by a common staff approach, the patient risks experiencing the psychiatric world as immutable, characterized by power and authority. Being in an environment where one has to endure a common staff approach could increase one's suffering by adding feelings of desolation and loneliness. However, our findings also identify the positive side of a common staff approach in that it creates feelings of safety in the patient. When a common staff approach is used, individual patients often find themselves

caught in a world where communication with staff becomes one-sided; that is, comprising monologues in which staff have the voice and power (cf. Bakhtin, 1984; Good, 2001). The patient's voice risks going unheard and unwanted, and the patient seems to have no choice but to try to endure, running the risk of affliction far from the state in which *I* meets *Thou*; that is, in an ontological dialogue (cf. Bakhtin, 1984; Buber, 1970; Weil, 1995).

According to Weil (1973), affliction is more serious than suffering as there may be no way back if one is touched by it. Being afflicted means being physically, socially, and psychologically tormented by so many threats that one's life may be extirpated and one's spirit destroyed. By fragmenting the time experienced, one tries to protect oneself and handle the present moment (Weil, 1995, 2007). This framework for interpretation is also used by Hellzén (2000), for example, in interpreting being in a vulnerable and exposed position.

The sense of someone else's commiseration can accompany the experience of safety when someone else is responsible and may counteract the patient's decline. Knowing that someone wants what is best for you, that someone cares, and that someone will help you gain control over your everyday life all create connectedness with the world outside the psychiatric context. Through a feeling of affinity with others, the patient may get a vague notion of possible recovery, a feeling that offers a moment of relief from the everyday life of an in-patient (Olofsson, 2000). The patient is lifted up by others and purged (cf. Weil, 1986), and might be able to see beyond subjectivity based on how he or she is constructed or positioned as a psychiatric patient (cf. Willig, 2000). However, experiencing safety when someone else is responsible can also be interpreted as the patient's submission to the caregivers in an unreflective mode of obedience.

Willig (2000) argues that people are constructed and positioned. All people are involved in social processes in which each actor is assigned a limited set of rights and duties in connection with a certain role. Being positioned refers to the dynamic balance of real communication (cf. Holloway, 1984). Being positioned in a particular role means that certain types of action are available while others are not—a sort of positioning that could be seen as close to the Foucaultian concept of discipline. People are disciplined into a context—here, in-patient care—by professional power over them, most notably in that the person's length of stay depends on professional judgment (cf. Foucault, 1987).

When being cared for according to a common staff approach, patients are forced to live in a milieu over which they have no control. There is no choice other than to accept and learn the invisible rules and

boundaries that staff impose (cf. Lilja & Hellzén, 2008). Becoming a psychiatric in-patient is described by many former patients as confusing and scary (Jonsson, 1996; Rippere & Williams, 1985). Hughes (1990) and Lilja and Hellzén (2008) highlight the need to resist giving up and to fight for one's identity when becoming a psychiatric in-patient, instead of simply adapting to the psychiatric context and becoming a non-person, a character—a diagnosis.

It seems that when the patient experiences staff as being totally unaware of the patient's pain and suffering, a deep divide opens between patients and staff (cf. Enarsson et al., 2008). Instead of staff helping the patient toward recovery, as psychiatric staff are supposed to do, there is no contact between the two parties. The present study finds that the situation becomes even more serious when patients experience feelings of being put down, for example, compelled to obey, punished, violated, and threatened with affliction. In meetings with other people and especially when professional helpers participate in patients' lives, the parties involved must feel related to as people, not just as characters with predetermined capacities (cf. Baracken & Thomas, 2005). When a person becomes afflicted, the person breaks down (cf. Weil, 1973). When a patient is mistreated by psychiatry and by staff who do not fulfill their needs or offer consolation, the staff help to initiate a process of affliction.

One cannot oppose the affliction process by diminishing or minimizing oneself and one's needs. Consolation is needed to open a path toward an unsullied state of purity and wholeness (cf. Weil, 1995). The staff on whom the patient depends must provide consolation to help the patient become capable of beginning the recovery process. According to Amering and Schmolke (2009), experiences of discrimination can lead to self-devaluation, shame, secrecy, and social withdrawal making it even more difficult to overcome existing barriers to relationships, employment, and housing and seriously hindering the recovery process. Instead, good mental health work should be based on meaningful relationships between professionals and patients (Baracken & Thomas, 2005). This work involves human encounters focused on issues such as hope, trust, dignity, encouragement, sense-making, empowerment, empathy, and care. If these meetings are marginalized or neglected, no treatment will be experienced as helpful (cf. Secker, Benson, Balfe, Lipsedge, Robinson, & Walker, 2004; Weil, 1995, 2007).

Weil (1986) writes that when affliction threatens a person's life there is a thirst for pure goodness that is essential for the possibility of cure (p. 94). When a person suffering from severe mental illness is

met with authentic encounters and regarded and respected as fully human although with mental health problems, the person gets a brief glimpse of what it means to be purified. The degraded spirit allows no more decline in self-image and self-esteem, and the person feels dignity is regained. Only as such can a person regain control and begin the recovery process. It seems that interpersonal relationships are essential for a patient's positive experience of the care episode (cf. Merkouris, Papathanassoglou, & Lemonidou, 2004).

As we see it, the patients in this study expressed suffering that seemed to afflict them deeply; as Weil (1973, 1995) wrote, "*le Malheur*," the evil, goes beyond understanding and is brought upon a person who is not heard by others. It is not only the pain, but also the evil in the form of domesticated terror that attack the person. Our informants stated that the care experience affected them deeply; some expressed their fear of staff and said they might not seek psychiatric care again even if they felt in need of it.

The psychiatric hospital health care environment is often characterized by control, yet few studies have examined the rules and routines on psychiatric wards and their importance to patients and staff (Alexander, 2006). Being exposed to a common staff approach can be seen as being subjected to a structural exercise of power (cf. Foucault, 1983, 1987, 2003).

Good (2001, p. 210) writes, "Whose voice owns mental illness? And who hears it? How much of linear routines of busyness is a defense against an open dialogue with patients?"

Methodological considerations

A narrative method was used in this study. The intention was to focus solely on the meaning of being cared for according to a common staff approach as narrated by patients and former patients. In a phenomenological study, the questions asked are never quite the same when repeated because the preconditions change from person to person and time to time (cf. Polit and Hungler, 1999). It must be borne in mind that, though one person's experience can never be another's; through interpreting narratives we can arrive at the meaning of lived experience (Ricoeur, 1976). The researcher's prior experience must also be taken into consideration. In this case, the authors have pre-understandings that might influence their interpretations as they have experience from working in psychiatric care facilities. This interpretation is only one of several possible ones, and the results of this study cannot be generalized but should be seen as comprising a contribution to an ongoing discourse (Ricoeur,

1976, pp. 79–80). It should also be noted that this study was performed in a single country in northern Europe with a specific culture and specific social norms.

As stated earlier, the phenomenon of interest has not been examined in any earlier studies (Enarsson et al., 2007). When searching for participants for this study, only one person was recruited through the clinic. Maybe it was difficult for staff to match existing patients with a common staff approach after the facts given about the phenomenon sought after, or maybe recruitment was considered an extra burden among many other tasks and was, therefore, considered a low priority by staff. In any case, when we directly invited former patients to participate in the study through the local Fountain House, several people were immediately willing to be interviewed. Do patients and staff regard the patient experience of receiving care according to a common staff approach differently? If so, were patients and staff then differently motivated to help with this study? Jansson, Sonnander, and Wiesel (2003) have demonstrated that staff and patient views regarding the patients' primary needs differ while patients are under care. For example, Ricketts and Kirshbaum (1994) have demonstrated that staff were much more strongly convinced of the vital role of psychiatric care plans in achieving good results than patients were. Psychiatric patients for their part tend to emphasize relationships and equality in contact with professionals: staff should be genuine, warm, and human (cf. Pejler, Asplund, Gilje, & Norberg, 1998; Pejler, Asplund, & Norberg, 1995) and have faith in the patient's ability to recover (cf. Topor, 1997). This split in attitude between staff and patients may explain why so few interviewees were passed on through the clinic.

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