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RESEARCH ARTICLE

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Professional vulnerability in mental healthcare contexts: A focus group study of milieu-therapists' experiences

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Abstract

Aims and objectives: To gain insight into how the workplace influences milieu-therapists' vulnerability in the mental healthcare context.

Background: Mental health services have experienced substantial changes. Reduced institutional treatment capacity is replacing the development of locally based treatment. Changes in external conditions in mental health services have influenced the working conditions of nurses and milieu-therapists.

Design: Qualitative design. The study complied with the COREQ checklist.

Methods: Focus group interviews.

Results: "Vulnerability due to unpredictable and threatening working context" was the common key theme that emerged in both contexts. Two key themes were different and opposite. In municipal mental health care, "Alone and unprotected" and in institutional care, "Together and protected."

Conclusion: The participants from both specialized and community mental health care, experienced vulnerability at different levels interpreted as a contradictory relationship between the healthcare system and their own ideals of what professional practice ought to be.

Relevance to clinical practice: This study contributes to extended knowledge and understanding about the experienced influence of the working environment on professional vulnerability of nurses and milieu-therapists` in mental health services. The impact of contextual conditions on health professionals' working conditions has multi-professional relevance for milieu-therapists and managers of mental health services, and it is an important topic in health and social higher education.

KEYWORDS

focus group study, mental health care context, milieu-therapists, , professional vulnerability

1 | INTRODUCTION

This article focuses on the experienced influence of the working environment on professional vulnerability of nurses and milieu-therapists` in mental health services. In a recent study of milieu-therapists' experienced vulnerability in relationships with severely mentally ill patients (Bachmann, Michaelsen, & Vatne, 2016), the challenging work conditions in mental health services became visible. In this project, vulnerability was defined as openness to exposure to or susceptibility to physical injury, emotional violation, attacks and/or criticism (Purdy, 2004) that might be a threat to one's identity and the need for both self-protection and protection from others (Spiers,

2000). Findings from this study highlighted that milieu-therapists experienced the workplace context as an important antecedent to their vulnerability and a hindrance to practice in concordance with the professional standard of care. It is important that patients are treated in a therapeutic way, which presuppose that milieu-therapists` work in a supportive professional therapeutic environment. The milieu-therapists' workplace conditions influencing their vulnerability is the theme we elaborate in this article.

What does this paper contribute to the wider global clinical community?

- Changes in the external conditions of mental health services have influenced working conditions of nurses and milieu-therapists in mental health care.
- Experienced vulnerability can be linked to contradictory relationship between the healthcare system where nurses and milieu-therapists work and their own ideal of what professional practice ought to be.
- The influence of the working environment on professional vulnerability is of relevance and importance to clinical practice in nursing and inter-disciplinary work, as well as supportive leadership in the organizational culture.

2 | BACKGROUND

2.1 | Milieu-therapists' workplace contexts in mental health

In Norway, like Western countries generally in the 1990s, service to people with severe mental health issues has undergone substantial changes. The main outcome of the Norwegian coordination reform (Norwegian Ministry of Health & Care Services, 2009) is reduced institutional treatment capacity replaced by the development of locally based treatment such as district psychiatric centres and home treatment. These changes are in line with all countries in the European regions that have adopted strategies or action plans aiming to deliver the shift from institutional psychiatry to community-based mental health care (WHO, 2015). Although institutional and home-based care exist "side by side," community-based care has become the main form of treatment (Norwegian Directorate of Health, 2014). Health authorities' goal for community-based mental health services involve expectations for the further development of a recovery-oriented perspective and more active involvement of service users in their own recovery process (Norwegian Directorate of Health, 2014). Against the background of Norwegian coordination reform, the length of hospitalization in specialized services is reduced and the demand for mental health services in the community has increased. In addition, the number of service users with more complex mental health problems in community-based care has increased (Ose & Kaspersen, 2015). In Norway, the entry conditions for specialized treatment in hospitals have become more stringent because the number of psychiatric beds has been reduced significantly, as in most European countries (WHO, 2015). These changes in the external conditions of mental health services have influenced health professionals' working conditions.

In Norway, milieu-therapists are employees working in specialized institutions and community settings. They have completed three years of an undergraduate education program in nursing or social work. Some of them complete an additional year of specialized education or a 2-year master's degree in mental health. In recent decades, the role of milieu-therapists has been redefined to encompass a more client-focused perspective on what occurs in the interplay between patients and the milieu-therapists. In their professional role, where the therapeutic use of the professional's self is emphasized as important in developing a mutual relationship between the provider and the patient, an example to be socially involved with service users, a point also considered important from the patients' perspective. (Topor, 2005; Kristiansen, Hellzen, & Asplund, 2010).

2.2 | The culture of mental health practice

In general, one important goal of mental health care is to establish a safe, therapeutic environment that is conductive to providing high-quality care (Bowers, Stewart, Papadopoulos, & Iennaco, 2013). The nurse participants in the work of Ward and Gwinner (2015) considered safeguarding to keep someone free from harm as an essential nursing skill. A review of Hamrin, Iennaco, and Olsen (2009) examined ecological factors that may contribute or lessen the likelihood of inpatients violence. Their study revealed that violence results from the complex interaction among patients, staff and culture of the unit. Despite the milieu therapeutic ideals of being client- and relational-focused, psychiatric hospital ward work has generally been described as a culture dominated by a medical model with symptom-oriented approaches. By defining the patient's treatment needs, milieu-therapists do things for the patient, teach and support the patient and anticipate the patient's agreement (Hummelvold & Severinsson, 2001; Klevan, Davidson, Ruud, & Karlsson, 2016; Kristiansen et al., 2010; Vatne & Fagermoen, 2007). Behind these cultural descriptions, the ward atmosphere reflects a high level of aggression and conflicts, resulting in the use of coercion, seclusion and manual restraint (Vatne & Fagermoen, 2007). Against this background, professionals perceive the use of coercion as a necessary component of mental health care regulated by law, even though the objectives of the legislation are to prevent and limit the use of coercion in treatment (Norway, 2017). Another characteristic is that treatment is 24 hr per day, seven days per week, with the milieu-therapists working in teams where they support and protect each other (Vatne & Fagermoen,

TABLE 1 Characteristics of the informants

Characteristics	Participants (*N* = 13)	Range
Age		26–52
Gender		
Male	3	
Female	10	
Registered nurse	8	
Social worker	3	
Social educator	2	
Care setting		
Specialist mental health care	8	
Community mental health care	5	
Number of years working		2–25

2007). Looi, Gabrielsson, Savenstedt, and Zingmark (2014), investigating staff members' reasoning about their choice of actions in challenging situations, found that their aims were to keep the staff safe and calm the patients. The safety goal involved not being alone with the patients. The authors described a routine-focused reasoning, expressing that coercion is presented, as "It's what you do" or "Do as the physicians say." Therefore, both the efficient prevention of risk or damage and the importance of following the protocol and use of formalized agreements directed the professionals' actions. A discipline-oriented focus based on the belief that "the patient has to learn" characterized the professionals' attitude, implying keeping a distance by not responding to the patients, this finding was also supported by Bachmann et al. (2016) and Vatne and Fagermoen (2007). To improve the milieu for psychiatric inpatients Espinosa et al. (2015) concluded in their literature review a more therapeutic milieu could occur through a long-term culture change.

The context and body of laws on home-based care in the community has characteristics different from those of institutional treatment. Coercion is not allowed and the milieu-therapists adopt an individual approach, working alone with patients, governed by what the patients permit or tolerate in terms of caring actions; services mostly involve day care. A report from the Norwegian Labour Inspection Authority (2018) emphasizes that working alone in a community-based setting is a concrete risk factor. A focus group study by Kristensen et al. (2010) reveals home-based service as a context where carers had an overwhelming workload, primarily in restrictive situations they found overwhelming and frustrating. They found the professional role as not unlike the role of a parent, with the norm of being an individual who is highly involved in the patient's life. However, the informants expressed that they had inadequate knowledge about how to handle challenging situations. Attempts to reconstruct mental health nursing from professional-controlled care to a home-based client-centred perspective are still incomplete (Magnussen, Severinsson, & Lutzen, 2003).

This culture is in line with Bang (2013), who states that cultures contain norms for how to behave and what the culture deems to be acceptable actions and attitudes, as illustrated in international research on milieu-therapists in their context of home-based care and institutional practice. Bang (2013) highlights that organizational culture exists as an inconsistency between defended values such as person-centred care and lived values such as "distancing themselves" based on experiences of defended values as "overwhelming and too much" (Bachmann et al., 2016). Gabrielsson, Savenstadt, and Olsson (2016) found in their study that the nurses were unable to improve poor circumstances in nursing practice. They promoted their own survival by refuting or redefining their responsibility.

2.3 | Theoretical framework of professional vulnerability in health

Vulnerability has a wide range of perspectives and meanings. The Concise Oxford dictionary defines vulnerability as "exposed to being attacked or harmed physically or emotionally (Pearsall, 2001)." Spiers (2000) refers to a closer inspection of vulnerability as a sensitive experiential phenomenon. She presented the emic perspective of vulnerability as the individual person's interpretation of the experience, which relates to the "state of being threatened and a feeling of fear of harm." This understanding can be seen in relation to the work of Rogers (1997), who illuminates the experience of vulnerability from the individual perspective in a specific situation. Rogers (1997) further claims that a person is balancing on a dynamic continuum between personal and environmental components. A person who is not particularly vulnerable in one environment may experience great vulnerability in another. Carel (2009) put forward the responsive vulnerability of nursing staff faced with patients` more than ordinary vulnerability, as in mental health services. Angel and Vatne (2017) highlight that the core of vulnerability seems to lie both in the patient and in the nurse and that extended understanding of vulnerability may help to reduce vulnerability due to nurse–patient relationship.

According to Heaslip and Board (2012), there are multiple reasons that practitioners experience vulnerability. For example, close relationships with patients, the unpredictable nature of patients or disease in mental health services, the dynamics of the team and the environment where one works (i.e. as a solo worker or in an emergency department). Professionals play an essential role in caring for people, but act in very spatial-temporal proximity to them. Thus, it is important to investigate professionals' own view of how mental health contexts influence their professional work. The research question asked in this study is as follows: How does the workplace environment influence milieu-therapists' experience of vulnerability?

3 | METHODS

3.1 | Participants and settings

This study has a phenomenological hermeneutic approach based on data from a recent study of milieu-therapists` lived experiences of their own vulnerability in interaction with patients in mental health services

TABLE 2 Focus group construction

Focus group	Municipal services	Specialized services	Profession
1	2	2	Nurse *N* = 3 Social Educator *N* = 1
2	0	3	Nurse = 3 Missing = 1
3	3	3	Nurse = 2 Social Educator = 1 Social Worker = 3
Totally	5	8	13

(Bachmann et al., 2016). During data analysis, the theme of *working contexts influences on vulnerability* emerged, which is the foundation for this article.

The data collection method was focus group interviews, which are considering being an efficient and flexible means of gathering qualitative data and is especially suitable when exploring a particular phenomenon involving contradictory interests (Knodel, 1993; Plummer-D`Amato, 2008). The educational manager of a master's program in mental health care recruited the informants purposively by e-mail from a group of master students' and made the composition of the groups. Inclusion criteria were variation of informants with working experiences from mental health institutions or community-based mental health care. The goal was to mix the groups such as milieu-therapists from both municipal and specialized mental health services were present in each group (3–6 master students in each). Eighteen students from different professions in the field of mental health care were invited. Four informants did not accept the invitation. Fourteen informants accepted the educational manager's invitation. Thirteen students (Table 1) with experience in municipal and specialized mental health services (2–25 years) accepted and gave written-informed consent to participate. One participant was missing from one of the focus groups (Table 2). The focus group interviews took place in a meeting room at the university college. The first and second author conducted all focus group interviews. Both with previous experience from specialized mental health services and both educators at a bachelor program in nursing when collecting the data. The first and second author varied between the role of moderator and observer. The atmosphere was mainly open, but a few times the moderator motivated participants that were silent to speak forward and followed up unclear and possibly suppressed statements. In agreement with the group, one dramatic theme was described as confidential and excluded from the study. The interviews were audiotaped and transcribed verbatim by the first author, following the interview. The study complied with the Consolidated Criteria for Reporting Qualitative Research (COREQ), (Tong, Sainsbury, & Craig, 2007). (See Appendix S1).

3.2 | Data collection

The educational manager of a master's program in mental health care divided the participants into three groups (3–6 master students in each). All the focus group interviews, which took place in 2013/2014, had a duration of 1.5 hr. The first and second author started each focus groups interviews presenting professional occupation and background of the research project. Examples of questions asked were "How can we understand vulnerability from the health professional's perspective" and "Tell us about a situation in which you were interacting with a patient and felt vulnerable." For clarification and encouraging exploration, the researchers asked follow-up questions. We chose a thematic inductive analysis with a "bottom-up" approach (Braun & Clarke, 2006) to the contextual descriptions of the mental health professional's experiences related to their everyday practice.

3.3 | Data analysis

The analytic process in inductive thematic analysis is a "bottom-up" way to identify themes or patterns in data (Frith & Gleeson, 2004). The themes identified are strongly linked to the data themselves (Patton, 2015), meaning the data analysis is data-driven (Braun & Clarke, 2006). During the inductive thematic analysis in this study, all three authors searched across the dataset from the different focus groups to find repeated patterns of meaning composed of four analytical steps, inspired by the step-by-step guide of Braun and Clarke (2006)(examples in Table 3). Phase 1, "familiarizing yourself with the data," is about being familiar with all aspects of your data, started in the transcription of the interviews and continued through reading through the text several times. What became obvious to us in this phase was the professionals' descriptions how they were influenced by the patients' behaviour and the differences in the context and working culture of home-based and institutional care. During all three interviews, experiences related to mental health services as a system were evoked. Phase 2 involved the identification of initial codes, defined as features with data that appear interesting to the analyst, which is "the most basic segments, or elements that can be assessed in a meaningful way regarding the phenomenon." Examples of codes identified in home-based care included the professional's insecurity on the job related to being alone with patients, not knowing what could happen and feeling alone with professional assessments. In the specialized service, despite the participants' insecurity, we identified the norm of showing confidence, not showing emotions and leaning on the ward's "house rules." A lack of supervision and debriefing became a code in both contexts.

Phase 3 (3, 4 and 5 in Braun & Clarke, 2006) involved sorting the different codes into potential themes. In this process, we collated all the relevant coded data extracts in broader levels of themes searching for relationships between themes and between different levels of themes (e.g. main overarching themes and sub-themes within them). We refined the themes and mapped them in a framework

TABLE 3 Example Phase 1–3

Phase 1 Field note Familiarizing with the data	Phase 2 Generating initial codes	Phase 3 Searching for themes, reviewing, Naming themes,
Work conditions have an impact in experienced vulnerability by milieu-therapists' in home-based and institutional mental health care	Contextual conditions Vulnerable when working all alone Vulnerable in a tough working culture	Alone and unprotected Together and protected

(presented in Table 4). A theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning in the dataset (Braun & Clarke, 2006). At the end of step 3, we identified the "essence" of each theme. Then, for each individual theme (step 4), we conducted and wrote a detailed analysis and identified the "stories" each theme told us in relation to the research questions.

3.4 | Ethical considerations

The Norwegian Data Protection Official for Research (NSD) approved the study (reference number 35986). Informants received written and oral information about the requirements for participation in the study and depersonalization of the data. All informants gave their written-informed consent to participate in the study.

4 | RESULTS

We present the results in sections. The first section describes the common key theme for the community-based and specialized mental health services. The second and the third sections provide deeper insight into two key themes (which are different and opposite in the two contexts) of workplace conditions' influence on professional vulnerability and professionals' perspectives on community-based and specialized mental health services, which are presented separately.

4.1 | Vulnerability due to an unpredictable and threatening work context

In general, the participants discussed changes in working conditions for milieu-therapists in mental healthcare services. In one of the focus groups, the participants revealed that their workplace conditions had changed in recent years in both municipal mental health care and specialist health services. They indicated that their working conditions had become tougher and tougher, characterized with much more acting-out behaviour, violence and synthetic drug abuse among patients and service users. The tougher work conditions affected them as practitioners. Several indicated that they perceived it as difficult to determine where to set limits in demanding situations. This affected their perception of the working condition as being more uncomfortable and unsafe and they questioned what to do as health professionals in caring relationships.

One of the informants in the municipal health service reflected on these changes based on "heavier cases." They tried to be two professionals during home visits, which for various reasons were difficult to implement. In practice, the nurses had to visit their service users alone.

In a discussion of what the working conditions in community mental health services would look like in the future, Peter made the following statement:

> It depends on if we are able to work here in ten years. The service users can be extremely sick, but not sick enough for hospitalization. Therefore, we are stuck, not having enough expertise to cope with situations

TABLE 4 Framework of mapped themes

Municipal home-based mental health care	Common themes	Specialized and institutional mental health care
Alone and Unprotected	**Vulnerability due to an unpredictable and threatening work**	**Together and protected**
Everyday work alone with the patients in their homes Long-lasting relationships without a safety net Care based on voluntariness and the premises of the service users	Contextual conditions	Everyday work based on teamwork in short periods of hospitalization facilitated with alarm possible to call for support Care possibly based on coercion and rules
Person-centred care Individual involvement in patients over time Being the only one for some patients Boundless care overwhelming burden	Norms and beliefs Consequences: Insecure in how to handle good care In need of supervision and debriefing Not being seen and protected by management	Rule/protocol directed care Emotional distancing themselves from the patients Sharing the responsibility Acting across own professionalism Macho culture

> we meet, not being enough people to take care of the service users. It`s challenging… to sit and wait for service users to go over the edge.

4.2 | Vulnerability in home-based mental health care – Alone and unprotected

The most common way the milieu-therapists carried out a home visit in home-based mental health care was alone. They experienced vulnerability linked to being alone and unprotected in situations involving very ill, unstable service users. Kari's story is an informant's condensed description of a regular home visit in a rural municipal mental health service. During the visit, the service user, whom the nurse knew very well, became angry and the situation escalated. The nurse felt the was situation unpleasant, became afraid and wanted to withdraw from the aggressive patient:

> He stood up and came at great speed towards me and I knew that I just had to get out. I ran into the front door, it was locked. I felt my heart beating - luckily, I could just turn the doorknob. Then, I ran out the door and down the stairs, but he came after me. When I ran away from the house, a big armchair landed one meter in front of me - and I knew OK, I need to cover myself. I had to call the police to get away from there. In retrospect, I feel discomfort when I'm near the service user alone.

This situation visualizes how a home nurse working alone might be physically unprotected. Anne, another informant in the same focus group who was also from the community service revealed another issue related to being alone in a single relationship over time:

> The most difficult part of my job is not to feel vulnerable in relation to threats and stuff, but to be in relationships over time. To be the only person the patient trusts and applies to. I have a guilty conscience if I have a sick kid when I know the service user does not receive visits when I am out sick. I want to give something of myself, but it is too much sometimes. To carry all these stories should be their corner stone - I think that's the worst.

Individual involvement with specific service users over time led the professionals to caring more extensively than is expected from a professional. One nurse, Camilla, discussed a situation where she was the only nurse on duty in the municipal service during an evening weekend shift. A service user with mental health problems, who was not on her list that evening, found her at work. He requested a car ride. She reported:

> Then, I actually had 20 minutes and thought OK. We sat in the car and drove away. I soon realized he was very psychotic and he started shouting, showing many symptoms. I asked if we could call someone to help him, because I really did not have time to take care of this breakdown then and there. I tried to call his family, but no one answered. Then, he calmed down for a while and we drove a little further. I regret that I did, but I drove on. The service user started to hit the windows of the car and shouted that he could not live anymore. Then and there I knew it had gone too far, but I ended up making short appointments with him all night between my other duties. We remained in this situation for many hours.

One of the informants in the same focus group expressed her vulnerability in relation to a patient who had not allowed her to exchange private information in the professional collegium. As a good professional, she was maintaining the confidentiality of the service user`s life stories week after week. Ultimately, she had to lock in her emotional experiences of misery and she had no way to unburden herself to her colleagues.

The situations presented above underline the essence of being alone and unprotected in the home care context. However, they also illustrate the nurses' lack of professional boundaries. It seems that they were squeezed by a professional dilemma, working in line with their ideas about person-centred care and being too much of a container for the patients' mental problems. Without the ability to take care of their own needs, they were led into a condition that over time they could not bear.

4.3 | Vulnerability in institutional mental health care: Together and protected

The informants working in institutional mental health care pictured their working place as secured by an alarm and their supportive colleagues if a violent situation were to occur. We identified the norms in this context as "showing confidence, not showing emotions and leaning on the ward's house rules" despite their feelings of insecurity. One example is a nurse discussing her work in an acute care setting where the employees could be exposed to acting-out behaviour. In the following story, Liss reflects on her own "typical behaviour" in acting-out situations:

> In situations in which patients are acting out, I feel no fear. Im not afraid of being 'punched', so to speak. I do think Im capable of standing up. I notice my heart rate increases, my body language and my voice might change slightly and I might swallow a bit hard. These characteristics could be mistaken with fear. Some colleagues will surely become very angry in such situations, but for me it is more a state of physical readiness in my body.

Informants working in institutions told they experienced expectations that they be strong, endure and persevere. The workplace

culture gave little room to talk about insecurity. It was important to be secure and safe for patients and colleagues. Milieu-therapists' who felt unsafe at work, were labelled by professionals as weak. Colleagues wanted to know if "you are a person you can count on and who doesn't run away in challenging situations." One explained that he experienced his colleagues' attitude as "if you have nerves, then you have nothing to do here." In a way, these norms expressed a kind of macho culture.

However, this macho culture influenced the professionals' caring attitude and approach and challenged the professional ideals of person-centred care. By correcting patients' behaviour and keeping them in a seclusion unit, patients could make comments and have outbursts that were difficult for the professionals to forget. One nurse recalled a limit-setting situation where a patient made tortious comments about a close relative, which affected him. One of his colleagues offered him assistants to handle this situation by "taking the patients physically." He did not take his colleagues' advice because he thought he would regret it later. He continues:

> One year later, I think I was right. It was better for my own conscience. The patient whom my colleague offered me support to 'take physically' has been hospitalized several times since this incident. He has questioned me about health professionals who use or abuse their power when interacting with patients.

4.4 | Acting across one's own professionalism

The work culture in institutional mental health led the nurses to a dilemma between the house rules and their own professionalism. Several informants expressed despair about having to act in a manner that conflicted with their own professional standards and in some situations, with what was legal. Their professional identity was challenged when the interests of house rules were prioritized at the "expense" of what they thought would be the best for the patient. They stated that "the house rules sometimes forced them to act unprofessionally," as illustrated by the following example from Kate:

> I work night shifts and often I have to say to the patients who need a cigarette, 'I understand that you need to go out now, but I am not able to follow you out according to the house rules'. Sometimes when I feel pity for the patient, I violate this rule and I allow them to smoke. However, to prevent them from running away, I ask them to leave their shoes inside the ward. I often ask myself what is actually best and worst in a situation like this.

This dilemma is a nurse's assessment of the risk of acting-out behaviour if the patient is denied the right to smoke. The risk of escape if she breaks the rules is solved by taking the shoes from the patient.

One of the informants reflects on the house rules: management often makes the rules, but in concrete situations the individual nurse must choose the best approach. If he or she breaks a "house rule," the next day the milieu-therapist must be prepared for negative comments and various critiques:

> I think some of it depends on how well suited you are to bear breaking house rules. For example, a recently graduated nurse would 'be taken' much harder by the system than one who was well established on the ward.

In the following discussion in the focus group, it appeared that the strict house rules influenced the professional's vulnerability according to whether colleagues and management corrected or accepted their practice, along with the development of a professional relationship with the patients.

4.5 | In need of debriefing and supervision

Informants from both contexts discussed debriefing and counselling. Several informants raised the need for "drowning releasing thoughts and emotions" that had been built up in connection to specific situations. They described challenging experiences as "being stuck in your body" or "doing something with you." However, they experienced debriefing as incidental and not formalized:

> We have debriefing after special incidents, but not as a part of a routine. It`s more like 'are you in need of a debrief, do you have needs?' It is difficult in such situations to confirm that you are. It should have been a part of the routine and not up to the individual.

Several stated that because of the lack of systematic debriefing, the system had "abandoned them" and that after dramatic situations they were not sufficiently safeguarded. They missed opportunities for debriefing and "to be framed" after challenging and threatening situations. However, in the absence of formal support and debriefing, it was good to have colleagues to "empty into."

> Luckily I have a friend who also works in mental health services. I call him when I need to clear myself sometimes. This is my way of mastering my situation.

In one focus group, they reflected on why debriefing was put aside when it was such an important tool@

> At the end of a shift, people are in a hurry and want to go home. One should perhaps set aside a quarter of the shift if there has been a lot of acting out, so people can get the situation out of their systems before going home.

One of the participants said that she had a good experience with a fifteen-minute debriefing before she went off her shift. This was part of the routine at her ward independent of how the shift had gone. One quarter also provided the opportunity to give positive feedback to colleagues in plenary session. "It is important not to get into vulnerability all the time, one must give opportunity so that robustness, joy and positivism can sprout and grow."

4.6 | Not being seen and protected by management

One informant reported a very traumatic and violent situation where she as a professional practitioner had many thoughts and questions that she wanted to take up with her manager. In reflecting on the situation, the informant acknowledged that she "didn't have backing from management." Instead of being taken care of, she was "muzzled and told not to mention the situation again." That led to a feeling of powerlessness and being betrayed by management. In the discussion that continued in the focus group, another of the participants questioned whether it was too challenging to be a professional practitioner in mental health services without support and when management had no ideas. One participant revealed the following personal experience:

> I think I clearly gave my opinion to the management that the work conditions started to have an effect on me. The management might understood it differently. I know the culture where I work and I have seen the turnover. Several colleagues have said 'life is too short for this'. Management should take charge of the problem and have a conversation with them.

The possibility of debriefing was discussed as important for mental health professionals after experiencing a challenging, life-threatening situation. The informants claimed that this was the manager's responsibility.

5 | DISCUSSION

Our study's findings indicate that milieu-therapists viewed the workplace context as an antecedent to professional vulnerability. Experiences in both contexts exposed professionals to challenging, caring relationships, especially physically and mentally threatening situations, but also difficult ethical dilemmas. The professionals in community-based care did not have a security net for handling threatening situations, in contrast to specialized care contexts where professionals have the ability to call for support by sounding an alarm. In addition, they described a macho culture dominated by house rules that guided the professionals' actions. This macho culture hindered their ability to act according to their ideal of person-centred care, which in turn was a threat to their professionalism. In the community context, being alone over time with the patients made professionals feel overwhelmed when practising what they defined as person-centred care without professional limitations. We see a contrast in these findings and will discuss them more fully bellow.

5.1 | Vulnerability through the possibility of being physically harmed: protected and not protected

Our findings show that professionals from both health service levels were working with a new patient/service user group due to changes in mental health services in general combined with increased mental health- and drug-related problems. They experienced patient and service users as tougher, with more threats and acting-out behaviour. In her narrative, Kari described potentially dangerous situation that could result in mental distress or physical injury to her. The consequence of changed working conditions is in line with both international and national research. A review of Hamrin et al. (2009) refers to a Norwegian psychiatric hospital with a sample of 85 staff. One hundred per cent (62) of the nursing staff reported physical assault by patients. The most common types of abuse were verbal abuse, threats and physical assaults in inpatient psychiatric wards (Hamrin et al., 2009). A recent descriptive study by The Norwegian Labour Inspection Authority (2018) showed that 27% of Norwegian nurses were exposed to threats and violence, in contrast to 7% of other professions and 20% of health professionals in healthcare services. Working alone in a community-based setting is a concrete risk factor for assault in the work context (Norwegian Labour Inspection Authority, 2018).

In community-based mental health care, milieu-therapists have a long tradition of working alone, which is highlighted in the nursing literature as a "Libero-model" (Hummelvoll, 1996). Hummelvoll describes libero as an ideal for mental health nursing, comparing it to the hindmost defence player on a football field, who has the freedom to establish interplay and unorthodox alliances. In one of the findings of Hummelvoll`s study (1996), mental health nurses are expected to be socially involved with service users, a point also considered important from the patients' perspective (Topor, 2005). The recovery ideology underpins the need to cross frontiers in the relationship between service users and health professionals. We question whether this libero-function in line with Hummelvoll's descriptions (1996) is suitable when working conditions have become more physically threatening. The employer is additionally responsible for securing the employee's working conditions, for educating the staff in risk assessment and for continuously simulating possibly threatening situations to improve staff's knowledge and skills. The aim is to avoid situations where violence and threats might occur. It is also important to have guidelines for possibly threatening situations. This can contribute to the individual`s feeling of support and create a secure working environment for the health professionals.

Compared with community-based care, working conditions in specialized services have other consequences. Liss denied feeling fear and described her physical reactions as readiness. However, Liss is protected by her colleagues and has a secure working environment. Kari and Liss`s descriptions illustrate a contrasting context,

with contradictory environmental support and differing personal experiences of vulnerability. Rogers (1997) theory of situational vulnerability might shed light on this contrast. Rogers claims that vulnerability is situational, linked to both personal resources and environmental support. In home-based care, Kari experienced not having control of the situation, no colleagues to lean on and no support system. Her subjective assessment of the situation led to a feeling of discomfort when she had to encounter the service user after her incident. In contrast, Liss assessed her bodily reactions as a state of readiness to handle a situation that might escalate. She maintained control of the situation because she had several support systems, such as close proximity to her colleagues, alarms and house rules. Kari and Liss`s different experiences of vulnerability are in line with Spiers (2000) and are supported by the work of Angel and Vatne (2017), who describe the phenomenon of vulnerability as the result of interaction between external influences (the context) and a person's inner life.

5.2 | Vulnerability due to being hindered from acting professionally

The informants in this study experienced the impact of context as hindering their ability to act professionally. In the home care context, milieu-therapists mainly work alone in long-lasting relationships. Anne described herself as the patients' "corner stone." She wanted to "give something of herself," which she sometimes experienced as being too difficult. It seems that a lack of professional boundaries makes Anne to go beyond what is reasonable in a professional relationship to protect herself. Heaslip and Board (2012) support this finding. They found that the working environment, such as one that involves working alone in a close relationship between practitioner and patient, had profound implications for professionals' vulnerability. According to Topor (2005), such a relationship can result in emotional attachment to the service user, which he claims is positive and desirable. In contrast, Carel (2009) claims that witnessing suffering on a regular basis can make health professionals more vulnerable than people who do not encounter patients. On the one hand, a close relationship can be experienced as positive; on the other hand, it might lead to professional emotional exhaustion and burnout. In our opinion, a personal engagement in caring relationships is desirable, but one should be vigilant when person-centred care is an altruistic ideal. To avoid potential emotional exhaustion and burnout, it is important that care for service users is not privatized, but instead belongs to the healthcare services as a system. This requires respectful communication within the team, supervision and competence building to empower the professional. This can also be seen in the light of the concept of mature care (Pettersen & Hem, 2011), which places specific demands on the career. A mature carer must be able to conduct a situational review and judge where to set the limits in caring relationships. As a result, the mature carer must be capable of delivering care after careful consideration and focus on reciprocity, limits and contextually adjusted care, as shown in the work of Pettersen and Hem (2011).

Management of municipality healthcare services has a responsibility in cooperation with health professionals to regularly evaluate whether the organizational and structural healthcare system is suitable and meets the patients' needs. Additionally, Heaslip and Board (2012) illuminate that the dynamics of the team in which you work and the working environment may make a difference. Working in a community-based setting with low support (Rogers, 1997) could lead to extended vulnerability and emotional exhaustion. Orvik and Axelsson (2012) show that the main objective of a health organization, for example, mental health services, is to care not only for the patients but also for the health professionals. In relation to this view, health service management should pay attention to mental health professionals, who experience overwhelming caring demands and a lack of professional limitations in their relationships with service users, as shown by our findings and supported by Kristiansen et al. (2010). Here, we especially question the nurses' comprehension of person-centred care, which Camilla practised. In this situation, she witnessed a service user's suffering and met his need for help even though it was not her responsibility that day. The nurse took personal responsibility and acted a libero, going beyond what was reasonable in an unpredictable situation. These findings call into question the education of the professionals, the lack of professional boundaries in the nurse–patient relationship and leadership's responsibility for the mental health community service.

The findings for the specialized services highlighted other challenges. Our findings show that house rules had a strong impact on how to interact with patients. The informants experienced ethical dilemmas between their own professional norms and values and the organizational culture expressed by the house rules. Although the goal of house rules is safeguarding to reduce potential harm (Ward & Gwinner, 2015), it might challenge professional integrity in a negative way. According to Bang (2013), the organizational culture defines a set of shared values, norms and attitudes that has an impact on how the staff interact with each other and the environment. The informants in this study described the working environment as a macho culture; this caused ethical dilemmas between loyalty to house rules and meeting patients' need in line with person-centred care. According to Heaslip and Board (2012) unreflected practice, such as following house rules, can increase the vulnerability while increasing the nurses' vulnerability to sanctions from their colleagues, when, for example they break house rules by individualizing care. House rules are made to safeguard health professionals, but one can question whether they are much too close to demanding undignified care when professionals are hindered from acting in accordance with their professional values. According to our findings, it seems that less experienced nurses are "taken harder" than experienced staff members, which may be part of a socializing process. Thus, such nurses more vulnerable to unpredictable comments from their colleagues. The pressure of following house rules challenges individuals' professional integrity and personal resources (Spiers, 2000). This puts the mental health professional in a contradictory situation between the expectations of the caring culture norm and the ethical values that

underpin the profession as described of Stacey, Johnston, Stickley, and Diamond (2011).

In person-centred care (Gabrielsson, Savenstedt, & Zingmark, 2015), the primary focus is to explore the patient's perspective by using one's professional skills and knowledge, thus preventing humiliating situations. Our findings illuminate a macho culture in specialized care. This demands individual courage to act in accordance with their professional assessment in regard to breaking house rules. In this context, personal factors will influence the professional's vulnerability regardless of whether they have the strength to face criticism from their colleagues. Strengthening the professional's confidence requires a culture of respect for the individual's arguments for their choice of caring actions.

How can oppressive working cultures be challenged to improve person-centred care? Hamrin et al. (2009) point to the impact of creating environments that foster the ability to build therapeutic relationships. In this context, meeting the patient's need instead of following the house rules requires a continuous focus and critical reflection on one's own caring practice, as supported in the work of Espinosa et al. (2015), Gabrielsson et al. (2016) and Looi Rpn et al. (2014). In our opinion, professionals should discuss the structural conditions of their professional practice in the mental healthcare context and participate in reorganize their services in line with changes in external conditions to create a secure working environment.

5.3 | Methodological considerations

This study gives new knowledge, especially about milieu-therapists' vulnerability in the mental healthcare context, but its findings must be viewed in the light of the limited group of health professionals surveyed and the fact that they are from a limited geographical area in Norway.

6 | CONCLUSION

In the background of this research, we find that professional vulnerability is of multidisciplinary interest and is relevant to knowledge development in higher education. Extended knowledge and understanding about the working environment in the field of mental health services and its influence on professional vulnerability is both important and of clinical relevance. Milieu-therapists in both mental healthcare contexts experienced vulnerability at different levels interpreted as a contradictory relationship between the healthcare system where they work and their own ideals of what professional practice ought to be. It is important for the management of health services to organize those services to facilitate protective factors for professionals, as leadership and organizational culture underpin quality improvement, including shared values and norms in line with dignified care in the professions. It is important to improve knowledge and skills through education and supervision. It is also important to see the relevance of a safe working environment as a protective factor for the health professionals' experience of vulnerability. This issue is particularly related to the organization of municipal mental health care, where professionals mainly work alone. Further research on this topic needs to be considered to illuminate working environment impacts on professional vulnerability of nurses and health professionals.

7 | RELEVANCE TO CLINICAL PRACTICE

This study contributes to extended knowledge and understanding about the influence of the working environment on professional vulnerability of nurses and milieu-therapists` in mental health services. The impact of contextual conditions on health professionals' working conditions have multi-professional relevance for milieu-therapists and managers of mental health services and it is an important topic in health and social higher education.

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CONFLICT OF INTEREST

The authors declare there is no conflict of interest.

AUTHOR CONTRIBUTIONS

LB, RM and SV: Study design. LB and RM: data collection. LB, RM and SV: analysis and manuscript preparation. All authors have agreed on the final version and meet the following criteria (recommended by the International Committee of Medical Journal Editors [http://www.icmje.org/recommendations/]):

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

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