

Problematizing Boundaries of Care Responsibility in Caring Relationships

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Abstract

Introduction: Nursing care takes place within nurse–patient relationships that can be demanding. In exceptional circumstances, the relationship may be destructive, and when this happens, significant onerous demands, appeals, or challenges can arise from patients and be placed upon nurses.

Aim: The aim is to explore what can be termed boundaries of care responsibility when relationships with patients place significant destructive demands on nurses.

Method: Based on a hermeneutical approach, this study introduces aspects of phenomenological philosophy as described by the Danish theologian and philosopher Knud E. Løgstrup and provides examples of nurses' experiences in everyday nursing practice drawn from a Norwegian empirical study focusing on remaining in everyday nursing practice. Data in that original study consisted of qualitative interviews and qualitative follow-up interviews with 13 nurses working in somatic and psychiatric health service.

Discussion: The exploration of empirical examples demonstrates that nurses consider confronting demands from patients which manifest themselves as onerous and that they have to set limits to safeguard themselves. When the nurses had to manage acting out or actions from patients by opposing what was said and done, they experienced the situation as more than very unpleasant or connected to a perversion. Significant destructive caring relationships cannot be without boundaries, and explicating boundaries are of relevance to protect nurses from onerous demands. Protecting them implies reducing a hazard, that is, that nurses carry on even when this may be unhealthy for them.

Conclusion: Consistently pinpointing boundaries between demands is assumed to be essential in caring relationships, as onerous or destructive demands are strongly connected to a content where boundlessness is involved. To protect both nurses and patients as valued human beings, thus raising and preserving the status of the nurse and the patient, the nature and possible detrimental effects of destructive caring relationships should be considered and examined.

Keywords

boundaries, destructive demands, caring relationship, responsibility

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Introduction

Patients can place significant and onerous demands upon nurses (Franz, Zeh, Schablon, Kuhnert, & Nienhaus, 2010; Kristoffersen, 2013; Kristoffersen & Friberg, 2017). Research has documented that these demands which can be understood as destructive demands, appeals, or challenges manifest in caring relationships worldwide (Spector, Zhou, & Che, 2014) and are most obvious or substantive when patients are very ill or cognitively impaired (Gjerberg, Hem, Førde, & Pedersen, 2013; Ünsal Atan et al., 2013). At such times, strong

emotions can sway, dominate, or steer their behavior (Hem, Nortvedt, & Heggen, 2008). Demands may further be heightened when patients who are dependent on nursing care react negatively against or resist what nurses suggest they should do or consider (Gacki-

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Smith et al., 2009; Gjerberg et al., 2013; Pich, Hazelton, Sundin, & Kable, 2010). In extreme situations, patients behaved aggressively and menacingly or direct abusive actions *outwards* at nurses (Blair, 1991; Carlsson, Dahlberg, & Drew, 2000; Finnema, Dassen, & Halfsens, 1994; Jackson, Hutchinson, Luck, & Wilkes, 2013; Lovell & Skellern, 2013) or *inwards* at themselves (Baker, Wright, & Hansen, 2013; Wilstrand, Lindgren, Gilje, & Olafsson, 2007). There is little agreement about what violence or aggression involves or includes and excludes in relation to nursing care (Child & Mentis, 2010; Luck, Jackson, & Usher, 2008). However, verbal abuse is proposed to be a common form of violence directed at nurses (Gacki-Smith et al., 2009; Stone, McMillan, Hazelton, & Clayton, 2011).

Research has further documented that nurses are aware of and acknowledge threats to their physical and psychological safety (Carlsson et al., 2000) and recognize that unpleasant and occasionally dangerous relationships with patients may be a part of nursing (Franz et al., 2010; Kristoffersen, 2013; Kristoffersen & Friberg, 2017; Kristoffersen, Friberg, & Brinchmann, 2016). Psychiatric nurses in particular work in and through relationally challenging situations, and violence or the threat of violence is frequently present (Yang, Stone, Petrini, & Morris, 2018). In response to violence or its threat, coercive behavior on the part of nurses is sometimes required and can be different kinds of restrictive measures, for example, physical restraints as belts (Hem, Gjerberg, Lossius Husum, & Pedersen, 2018; Sheehan & Burns, 2011). However, de-escalation and other alternatives to coercion are preferred (Gjerberg et al., 2013). This involves nurses purposefully seeking to build therapeutic relationships with patients through the use of strategically directed talk and touch (Baker et al., 2013; Finnema et al., 1994). Nurses also respond to patient needs in creative ways that allow or attempt to permit nurse–patient encounters that fully recognize the personality and humanity of patients (Carlsson et al., 2000; Solvoll & Lindseth, 2016; Wilstrand et al., 2007). In these encounters, it is often the *small things* that make the biggest difference (Skorpen, Rehnsfeldt, & Arstad Thorsen, 2015). *Small things* may include spending time with the patients or human finesses such as removing identification tags when patients and nurses are out of the hospital (Skorpen et al., 2015).

Research has nevertheless documented that nurses have persistent and real concerns about the burden that demanding relationship work places upon them (Baker et al., 2013; Ünsal Atan et al., 2013; Wilstrand et al., 2007). The capability of nurses to endure has been questioned, and when overwhelming loads are placed on nurses, they can fail to adequately care for themselves and also lose their principal focus on patient care (Kristoffersen & Friberg, 2017; Molin, Hällgren

Graneheim, Ringnér, & Lindgren, 2016). In such circumstances, it might be prudent for nurses experiencing moral distress (Jameton, 1984) to set aside intentions to fully care for patients (Varcoe, Pauly, Storch, Newton, & Makaroff, 2012). Demanding forms of relations may also be exacerbated when, from the patient's perspective, nurses deliberately confront or cross patient beliefs in a manner that undermines patient understandings of their personal worth (Hem, 2008).

To summarize, a considerable body of nursing research highlights the ways in which nursing practice can be experienced as unpleasant and dangerous. Nurses regularly expose themselves to relationships with patients who occasionally embody demands that may be perceived as destructive to the personal worth or integrity of the nurse. However, few studies have sought to explore the boundaries or limits of nurse–patient relations where those relations negatively and significantly impact upon nurses. This problem clearly raises difficult moral and professional issues. It is nonetheless important to discuss where boundaries are laying in nurse–patient relations.

Aim

The aim was to explore what can be termed boundaries of care responsibility when the caring relationship places significant destructive demands on nurses.

Background

A Demand

The Danish theologian and philosopher Knud E. Løgstrup (1997) describes a “demand” as an appeal or a challenge. A demand incorporates that we are *the object of an appeal or a challenge, an appeal from another person or a challenge implicit in the situation itself* (Løgstrup, 1997, p. 148). Although demands can be unspoken and cannot always be equated with a person's expressed wish or request, they are nonetheless connected to situations in which we are involved. We are *the object* because something is demanded of us. Demands arise from the fact that human beings are seen as intertwined. According to Løgstrup (1997), demands rest on relationality or the assumption that we are mutually dependent of one another and know what is in the other person's best interests and must thus take care of whatever in the other person's life depends upon us. This means that demands are radical and one sided. Løgstrup (1997) states that demands receive this radicality from the understanding that we can never *demand something in return for what we do* (p. 123). Løgstrup (1997) points out that demands can be described either as an ethical demand or a destructive demand.

Boundaries Between Demands

There is no absolute demarcation line between an ethical demand and a destructive demand. Løgstrup (1997) argues that boundaries between ethical and destructive demands are fluid because our ability to determine another person's fate as well as our inability to determine how that other person will react to his or her fate are unsolidified. It is nonetheless possible to indicate some boundaries by relating to the content of demands.

One basic boundary between ethical and destructive demands can be perceived as a content where caring responsibility for another person's life implies excluding all reciprocity. The most obvious reason for indicating this is Løgstrup's (1997) emphasis on the aspect of reciprocity. He connects reciprocity to relationality, which implies a reciprocal demand that we care for the other's life. The demand rests on reciprocity as we are delivered over to one other. This means that reciprocity regulates our mutual life and we cannot necessarily exclude reciprocity to the point where we are solely oriented to the other person. Løgstrup (1997) states that excluding a claim of reciprocity does not mean that care for the other's life consists *in words or deeds which prevent his or her discovering that he or she has received his or her life as a gift* (p. 117). The point is that the one placed under the demand should also receive from life. When we care for others, it is *not only that person's life which succeeds, but our own as well* (1997, p. 124). Løgstrup (1997) explicates that this is *implied in the demands own understanding, otherwise, there would be no difference between goodness and wickedness* (pp. 117–118).

Løgstrup (1997) clarifies that a demand is destructive when the other person is not able to live at all except by the sacrifice the person under the demand makes, and the care of the other person's life requires *my self-destruction and self-annihilation* (p. 137). For Løgstrup, such a radical one-sided content makes a demand destructive, as it requires the person placed under it to be willing to give up his or her life altogether. In the struggle between expectations of life and the care of the other person's life, this means that expectations must give way. It involves self-destruction and self-annihilation having been an independent goal. However, Løgstrup (1997) underlines that such an extreme situation may mean that my own life cannot succeed *through my having taken care of it and then the other person cannot belong to my own world as a vital part of it* (pp. 137–138).

Boundlessness

A more definite boundary between ethical and destructive demands relates to boundlessness. Løgstrup (1997) describes boundlessness as being robbed of independence, and he *forbids that we ever attempt, even for his*

or her own sake, to rob him or her of his or her independence. Responsibility for the other person never consists in our assuming the responsibility which is his or hers (p. 28).

By underlining that boundlessness involves assuming responsibility for what is beyond one's power to control, Løgstrup (1997) explicates that it includes taking responsibility to the point of having no limits and, in the worst case, leads to encroachment. The human being is then subject to exploitation by another person in an unlimited way. This means that when our taking care of the other person is not coupled with what Løgstrup (1997) describes as a willingness to let him or her remain sovereign in his or her own world, it excludes a wish that our life will be successful and fulfilled. Thus, the result instead is that we experience disappointed expectations of life.

More concretely, Løgstrup (1997) connects boundlessness to perversions which can occur related to what we say and what we do in human relationships, implying we are caught in a conflict between regard and disregard for the other person. He terms one such form of boundlessness as a passing mood. This form is characterized by indulgence, compliance, and flattering regard, where the final result is that the other person is not cared for. Løgstrup (1997) terms another form of boundlessness as our wanting to change the other. He characterizes this as an interest in our own outlook, which can turn into arrogance and possibly encroachment upon others.

Material and Method

Aspects of Løgstrup's (1997) work, the linking of destructive demands and their refutation, were used as analytical tools to explore empirical examples describing how nurses expressed their experiences of demands placed upon them by patients. The empirical examples and the philosophical texts were read several times, the analytical exploration being carried out using a back and forth reading approach with an open attitude to get an understanding of the examples in relation to the philosophy. A more in-depth understanding of the empirical examples emerged, resulting in the description of two themes. This implies that the study's exploration was based on a hermeneutical approach (Taylor, 1999).

The findings of a larger Norwegian study focusing on remaining in everyday nursing practice (Kristoffersen, 2013) inspired exploration of what can be termed boundaries of care responsibility, and the empirical examples used in this study were considered relevant in interpreting such boundaries. The participants were 13 nurses, aged from 26 to 62 years, with a minimum of 2 years' nursing experience in full or almost full-time work within primary and secondary somatic and psychiatric health-care services. Data included qualitative interviews and follow-up interviews (27 in total). Follow-up interviews

were used to deepen and broaden information regarding perceptions of everyday experience (Kvale & Brinkman, 2009; Silverman, 2006). The phenomenological hermeneutic analysis took the form of narrative reading, the composition of alternative thematic readings, and a comprehensive understanding (Lindseth & Norberg, 2004).

Ethical Considerations

The empirical examples are drawn from the larger empirical study which was approved by the Norwegian Center for Research Data (NSD; Kristoffersen, 2013). The participants were given written information about the study, and their consent was obtained before data collection occurred. Permission to proceed using anonymized data was given by NSD, so the participants were not contacted about this again.

Exploring Boundaries of Care Responsibility in Relation to Empirical Examples of Demands in Everyday Nursing Practice

The examples demonstrated that nurses consider confronting demands from patients which manifest themselves as more or less onerous and that they have to set limits.

Considering Confronting Onerous Demands

Boundaries between demands can go unheeded, meaning that a line is crossed between ethical demands and destructive demands. Demands from patients can then manifest themselves in everyday nursing practice as more or less onerous. One psychiatric nurse said:

A patient jumped up at a colleague and attacked her; he was in “full steam” and in that same second, I jumped up and restrained the patient.

The empirical example can be seen as an expression of how boundlessness occurred, as the nurse suddenly became the object of a demand from a patient who was in “full steam” and had jumped up at a colleague and attacked her, implying he was very upset and there were no guarantees that he could take responsibility or cooperate with the nurse. In this highly dangerous situation where the patient had turned to a kind of violence and stopping it might be difficult, the nurse was required to be involved to a more than unpleasant degree. She was presented with the challenge of opposing the patient’s action by acting against or even standing in their way,

thereby putting herself in a position where she was willing to give up her own life to help the colleague and thereby the patient.

Other empirical examples also demonstrated how boundaries between demands are crossed in situations related to what a patient says and does. A psychiatric nurse said:

A patient screamed, cried, berated us, threw a chair at the wall and broke this and that, and we worked with the patient for one and a half years before there was no more acting out.

The content in the demands from this patient can be understood as an expression of boundlessness because nurses had to handle acting out in order to attend to the patient’s best. The example demonstrates an extreme situation which was more than unpleasant or dangerous, as the patient screamed, cried, berated the nurses, threw a chair at the wall and broke this and that. This means that the demands from the patient were one sided and radical to a degree where they can be understood as an expression of a kind of perversion which not only intrudes disturbingly into the nurses’ own existence but also requires unselfishness for a rather long period of time. The nurses had to be solely oriented to the patient. Such kinds of boundlessness may in turn be an issue for discussion in everyday nursing care as the nurses worked with the patient to eliminate acting out. Another nurse working in a psychiatric ward explained:

Sometimes I confront patients with how they are when they behave as they do. Then I get a reaction, I often get an aggressive reaction.

The empirical example demonstrates how boundlessness can escalate within a short time despite the nurse’s willingness to relate to what can be understood as an unspoken appeal from patients: to be taken care of as a human being. This involves crossing boundaries between demands when a patient’s condition deteriorates and the nurse gets an aggressive reaction. Experiencing such disappointed expectations of life in relation to nursing care can contribute to a sense of standing still and going nowhere. One nurse working in a psychiatric ward stated:

I wear myself out having to face heavy or violent tasks and issues, so, sometimes “the air goes out of the balloon.”

Here, it is possible to see how the nurse reacts when having to face heavy or violent tasks and issues in relationships with patients, meaning the nurse had to

consider confronting demands to a degree where the situation was experienced as more than unpleasant or connected to a perversion intruding more than disturbingly into the nurse's own existence, thus making the nurse tired and vulnerable.

Having to Set Limits

Empirical examples demonstrated how nurses have to set limits when boundaries between ethical and destructive demands are crossed in everyday nursing care. One psychiatric nurse stated:

It has happened and in fact quite powerfully, that a patient turned around and was pretty mad at me. Then I reached my limit, because it can't be limitless.

Here, it is possible to see how the nurse articulated that being the object of the patient's pretty mad behavior required her to safeguard herself. The nurse reached her limit when the patient's expressions and actions were experienced as going beyond proper limits. Thus, stating that it cannot be limitless can be understood as an expression of how the nurse refuted the demand, meaning that she did not want to rob herself of independence in taking care of the patient. The nurse went on to say:

It can't be without boundaries, otherwise you will be tormented and destroy yourself as a human being. I have to have respect for the patient and he mustn't be destroyed but I can't destroy myself either.

This empirical example demonstrates how the nurse articulated that she was not willing to give up her own life altogether or sacrifice it in any sense of the word. Pointing out that neither the patient nor the nurse must be destroyed as a human being and that taking care of the patient cannot be without boundaries implies underlining that self-destruction or self-annihilation has nothing to do with a successful life as a nurse. This means that the example can also be seen as an expression of how the nurse articulated a wish for reciprocity in nurse-patient relations or a wish to receive her due when put under demands. However, this does not mean she was solely oriented toward herself. On the contrary, the nurse tried to prevent an escalation of demands beyond proper limits by respecting the patient.

One nurse working in a nursing home described how nurses have to set limits for themselves:

The times I have to push myself are when I know or experience that the patient is behaving unreasonably. At the same time, I know that they are in a situation which may allow them to be unreasonable, and I am

required to keep calm and know that I have to push myself to set aside my own needs, and instead focus on the situation: There will be a way out if I endure for one more minute. On the other hand, I have to know where to stop—that's enough now—and so I give up because we will not succeed.

Here, it is possible to see the nurse's reasoning that what she says and does could be crucial for the final result in a heavy-going and stressful situation. While caring for patients with an unreasonable destiny, who are unable to live without help, the nurse has to keep calm and at the same time push herself to avoid disregard for the patient cared for. This means that the empirical example can be seen as an expression of the importance of focusing on the hope that the situation will get better while trying to prevent an escalation of radical content in demands from the patient through one-sided unselfishness. The nurse had to set aside her own needs and reduce the influences of her own expectations of life in order to endure the situation. However, enduring does not mean being unaware of the significance of knowing where to stop, thus being open to refuting demands.

Discussion

Significant Destructive Caring Relationship Cannot be Without Boundaries

The empirical examples from everyday nursing practice have demonstrated how appeals from patients can be understood as significant and onerous demands. Something very definite was required of nursing care within a less definite time, even though nurses experienced the situation as unpleasant or even more than unpleasant or connected to a perversion intruding more than disturbingly into the nurse's own existence. Nurses had to manage acting out or actions from patients by opposing what was said and done. In doing so, the nurses also had to set limits to safeguard themselves when they confronted demands which can be understood as expressions of boundlessness—a finding in line with previous research (Carlsson et al., 2000; Jackson et al., 2013; Kristoffersen et al., 2016; Pich et al., 2010; Wilstrand et al., 2007). Therefore, everyday nursing practice cannot be without boundaries of care responsibility when destructive demands are placed on nurses in caring relationships.

Although previous research has documented how some nursing care can be morally unacceptable (Hem, 2008; Hem & Heggen, 2004), it is worth noting that in Løgstrup's (1997) view, nurses alone do not have the ability to determine the patient's sickness nor how the patient will react to his or her destiny. Placing significant

and onerous demands on nurses means that the content has been radical to a degree where the nurses had to set limits. The situation can be understood as more than very unpleasant because it intrudes more than disturbingly into the existence of the nurse under the demand. Løgstrup (1997) states that demands rest on relationality, which incorporates knowing what is best for the other. Radical one-sided responsibility to care for the other's best never consists of imposing expressions or actions upon the other because this will certainly not promote the person's worth by going beyond paternalism. The content has changed to a point where we are not to live our life as something that is given to us.

However, patients cannot always be expected to understand or realize what is best for the nurse. Any significant and onerous demands they make are often the result of the sickness trajectory and internal subconscious tensions (Gjerberg et al., 2013; Hem et al., 2008; Kristoffersen & Friberg, 2017; Ünsal Atan et al., 2013). Nevertheless, a patient's ignorance of what they are doing does not make boundlessness in their demands excusable or morally acceptable when viewed in Løgstrup's (1997) terms of relationality and reciprocity. In particular because this might mean the nurse and the patient are not perceived as intertwined human beings and in one another's power. The nurse cannot be absolutely indifferent to what the patient says or does (Baker et al., 2013; Ünsal Atan et al., 2013; Wilstrand et al., 2007). As a human being, the patient often can know what he or she does and why they did what they do. Taking what patients say and do to nurses less seriously than what nurses say and do to patients implies being somewhat dismissive of nurses and their experiences of boundlessness related to demands from patients. A nurse may also be the weaker part in a caring relationship. The patient's actions cannot always be excused solely because of sickness or destiny. In the view of Løgstrup (1997), when demands from patients are solely self-oriented, more or less becoming an encroachment on the nurse, the nurse may feel robbed of independence. The nurse may not receive his or her due because the patients did not receive or fulfil their care. When put under such demands, the nurses' endeavor to exercise nursing care cannot be realized as fully as they wished and their expectations of life must perhaps give way.

Consequently, by not declining care responsibility when significant destructive demands are placed on nurses, we allow a peril to exist in everyday nursing practice: It risks reducing the nurses' personal worth and their wish to help the patient. The peril may intensify because knowing where the ethical demand ends and the destructive demand begins can be difficult when sickness or destiny is used as an explanation of the patient's expressions and actions.

The Relevance of Explicating Boundaries of Care Responsibility

It is relevant to propose that to protect themselves from significant and onerous demands, nurses may in some instances decline care responsibility, even when doing so could negatively impact on patients. Although we do not have the space here to consider such potential negatives, we can maintain it is morally acceptable for nurses to protect themselves, largely because explicating boundaries of care responsibility in significant destructive caring relationships can be understood as in line with how nursing is described as established, maintained, and enhanced. One identified position is that of the American theorist Joyce Travelbee (1971), who argues that both the patient and the nurse are human beings with personal worth and seen as utterly unique; the relationship between them is established as therapeutic when they relate as human being to human being. Another position is person-centeredness, as elaborated by the Swedish theorists Inger Ekman and Astrid Norberg (2013). They describe the human being as a person with an identity and autonomy, and as capable of being a co-creator of meaning, implying that the person will express themselves in the role as patient. These positions incorporate an increased power and responsibility for the patient, who is regarded as an equally and actively involved partner in nursing care. Considering the patient as a rational human being with a capacity to take informed and voluntary choices not only implies that the patient's biography should be apparent, it also implies that expressions and actions from patients must be regarded as related to a human being with a capacity to reflect, understand, and evaluate what is said and done in caring relationships (Ekman & Norberg, 2013; McCance, Slater, & McCormack, 2009; Risjord, 2013). This involves expectations of the patient as a human being to respect the nurse simply because the nurse deserves it as a human being. Placing significant and onerous demands on the nurse can then be understood as an expression of not respecting.

Explicating Boundaries of Care Responsibility Reduces a Hazard

Explicating boundaries of care responsibility implies reducing a hazard, that is, that nurses carry on without making boundaries perceptible even when this may be more or less unhealthy for them (Kristoffersen, 2013; Kristoffersen & Friberg, 2017). Such kind of hazards can of course be provoked and reinforced by several factors (Ekman & Norberg, 2013; Travelbee, 1971). One difficulty might nonetheless be related to the most explicit moral of the nursing profession, which is to help the patient (Haynes & Woodard Leners, 2004; Hem &

Heggen, 2004; Kristoffersen & Friberg, 2016; Peter, Simmonds, & Liaschenko, 2016). The ICN Code of Ethics for Nurses requires nurses to provide care that is *not compromised* (International Council of Nurses [ICN], 2014, p. 3). Not compromising care can be perceived as having a sensitivity to needs, values, and choices without exploitation of the patient (Solvoll & Lindseth, 2016) and such sensitivity might also involve the nurses' own vulnerability as a constructive element in caring relationships (Hem et al., 2008). The professional moral is thus based on an innate intention and capability to maximize the patient's personal worth (Ekman & Norberg, 2013; Peter et al., 2016; Travelbee, 1971) and accordingly, at least in Norway, the political and society-based nursing mandate is to consistently help the patient (Grimen, 2008). The empirical examples have demonstrated the nurses' awareness of nursing care as crucial for the final result when confronting significant and onerous demands in caring relationships, and how they have tried to prevent the escalation of such content, implying they take responsibility to promote high-quality care—a finding in line with previous research (Carlsson et al., 2000; Finnema et al., 1994; Gjerberg et al., 2013; Beyene, Severinsson, Hansson & Rørtveit, 2018).

The moral of the nursing profession also requires nurses to maintain a standard of personal health such that the ability to provide care is not compromised (ICN, 2014, p. 3). Maintaining such a standard of personal health (which involves drawing attention to one's own worth, autonomy, and uniqueness) while not compromising care of the patient is rather tricky. This is particularly true when boundaries between demands emerge as imperceptible or blurry in caring relationships, making it difficult to know where they have been crossed at the same time as the content of the demands having changed to boundlessness. The point here is that while striving to help the patient or developing strategies for care, nurses may ignore significant and onerous demands placed on them. Even when onerous demands are significant, ignoring them is possible, particularly when there is undertheorization of where boundaries between ethical and destructive demands lie.

Implications

When nurses experience boundlessness in caring relationships, they need philosophical resources in order to problematize boundaries of care responsibility and reevaluate the premises of the nursing profession (Lindberg, Österberg, & Hörberg, 2016; Risjord, 2010). At least in the Nordic countries, Løgstrup's (1997) writings are used by nurses as a philosophical resource (Alvsvåg, 2014; Hem et al., 2008; Kristoffersen, 2013; Kristoffersen & Friberg, 2017; Martinsen, 1996, 2012). Grimen (2008)

claims that the moral of the profession rests on the political and society-based mandate, clearly implying that nursing cannot rest on philosophical resources such as Løgstrup's (1997) phenomenological philosophy. However, this claim does not exclude that a philosophy such as Løgstrup's (1997) can generally serve to guide nurses' judgment in managing demands, as the philosophy helps deepen theorization of human processes along a continuum of knowing what is the other's best to robbing them of independence (Faust, 2002; Hem et al., 2008; Karlsson, Nyström, & Bergbom, 2012; Martinsen, 1996, 2012). More specifically, it can serve to guide nurses' reflections on where boundaries between an ethical demand and a destructive demand lie in caring relationships. Destructive caring relationships manifest in somatic and psychiatric nursing care (Kristoffersen & Friberg, 2017; Pich et al., 2010; Roche, Diers, Duffield, & Catling-Paull, 2010). Even though such relationships are universal (Spector et al., 2014), there are differences in rates and sources. Predictors have been found to be, for example, schizophrenia, drug misuse, and a history of violence and hostile-dominant interpersonal styles (D'Ettorre & Pellicani, 2017). Thus, in a psychiatric setting, nursing care can be regarded as different in regard to boundaries between demands, particularly because use of formal or perceived coercion restricts the patient's sovereignty and at the same time, often increases the nurse's professional authority (Hem et al., 2008). Considering confronting onerous demands and setting limits should therefore be tailored to the particular setting (Spector et al., 2014). Translating boundaries of care responsibility to prescribed or sufficiently useful "bedside" nursing care is a comprehensive task: Although human beings are intertwined, it is required of us to let the other person remain sovereign in his or her life (Løgstrup, 1997). When examined closely, this type of problematizing will essentially work to highlight the ambiguity in not compromising nursing (Hem & Heggen, 2004). It might represent one prerequisite to maintain a standard of personal health while considerations favor the patient, thus strengthening the nurses' competence or individual judgment (Rognstad & Nåden, 2011) and the nursing profession's morals and dignity (Sabatino et al., 2014).

Conclusion

Consistently pin-pointing boundaries between ethical and destructive demands are assumed to be of importance in caring relationships. This involves focusing on whether and on what grounds nurses can decline responsibility in significantly destructive caring relationships. When onerous or destructive demands are placed on nurses and they must decline care responsibility, the situation clearly raises difficult professional issues. Without

wanting to play down the complexities of the issue, we see that everyday nursing practice involves crossed boundaries, even by patients. Although boundaries are fluid, they are strongly connected to boundlessness. Significant and onerous demands from patients cannot be seen as less serious, excused in themselves or morally acceptable. It is therefore necessary to further examine how to protect both nurses and patients from the detrimental effects of such demands, thus raising and preserving the status of the nurse and the patient in the caring relationship.

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