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The Essence of Psychiatric Nursing

Redefining Nurses' Identity Through Moral Dialogue About Reducing the Use of Coercion and Restraint

Elleke G. M. Landeweer, MSc; Tineke A. Abma, PhD; Guy A. M. Widdershoven, PhD

In this article, we focus on core values of psychiatric nurses in relation to coercion and constraint. We analyze changes that took place in a project aiming at reducing coercion at a closed inpatient ward of a psychiatric hospital. Using the philosophy of Hans-Georg Gadamer and Margaret Urban Walker, we analyze both the process of moral changes through dialogue and the outcome in terms of new identities and moral responsibilities. We conclude that the project stimulated nurses to redefine their roles and develop a deeper intersubjective understanding of core values of their profession. **Key words:** *coercion*, *dialogical ethics*, *empirical ethics*, *intersubjectivity*, *moral responsibilities*, *moral dynamics*, *psychiatry*

COERCION and restraint are crucial and controversial issues in inpatient psychiatric settings. These methods aim at assuring safety of the patient or others and to prevent harm. In case a person with psychiatric disabilities admitted in a mental health hospital (in this article referred to as patients) becomes violent or aggressive, coercion and restraint are used to avert danger and harm. Yet, the (extensive) use of coercion and restraint has raised critique among patients, patient advocacy groups and others.[1-5] Issues for debate include the therapeutic effectiveness of coercive measures such as seclusion and the psychological harm and antipathy toward treatment and working relationship with nurses.[6] Coercion, whatever form it takes, produces traumas and fuels distrust among patients and nurses.[7-9] Coercive interventions can be seen as tragic interventions, surrounded with ambivalences: It is experienced as both necessary and wrong.[4,5,10,11] In the case of restraint, the patient still has some freedom to choose an alternative. Yet, restraint can be manipulative and hard to identify given its more subtle character.

The problematic character of coercion and restraint is especially relevant for nurses. In this article, we'll refer to nurses at random in he of she form, as both men and women work equally at the wards. On the one hand nurses are responsible for the safety of patients at the wards, on the other hand their profession requires them to provide care. Nurses are asked to evaluate unsafe situations, to protect patients from others or themselves. But these are not neutral and objective assessments. Personal and cultural value structures like distrust and control may bias judgments. This results in ambivalence when the values of ethics of care (trust, recognition, etc.) contradict with the need for safety and control within wards.

Author Affiliation: *Department of Medical Humanities and the EMGO+ Institute for Health and Care Research, VU University Medical Center, Amsterdam, the Netherlands.*

Correspondence: *Elleke G. M. Landeweer, MSc, VU University Medical Center, Department of Medical Humanities, Van der Boechorststraat 7, 1081 BT Amsterdam, the Netherlands (e.landeweer@vumc.nl).*

There are 58 mental health care hospitals in the Netherlands with an average total number of 50 000 admitted patients (total number of residents in the Netherlands are 16 300 000). Over time, the number of involuntary admissions has risen. In the last 20 years, the number of acute involuntary admissions has doubled.[12] Seclusion as intervention to avert danger during admissions in the psychiatric wards is more frequently used in the Netherlands compared to other European countries. Per 1000 admitted patients seclusion is used around 305 times.[13]

As a response to the problematic and ambivalent nature of coercion and restraint, a societal debate was raised 10 years ago in the Netherlands to reduce coercion in psychiatry. This resulted in funding by the government for projects in psychiatric institutions to foster changes in ward cultures toward reducing the amount of coercion in general and the amount of seclusions more specifically. Participants in psychiatric care aimed to develop alternatives to the use of seclusion and create prevention strategies.

We monitored and supported several of these projects aiming to reduce coercion and restraint at the wards. The goal of our research was to map the (cultural) changes that occurred during the projects and to develop recommendations to enable the projects to adjust their strategies during implementation. In this article, we will describe and analyze one of the projects in one mental health hospital to illustrate the transformative moral dynamics among nurses that were set in motion. The transformations are exemplary for other projects although the processes of change in various participating institutions all had their own pace.

In the project under consideration, several interventions were implemented to make nurses aware of the need for reducing coercion and involve them in this endeavor. At the ward, an experienced nurse was assigned as an ambassador to enthuse others. She received extra hours to spend on the project. Nurses received a training course in techniques to reduce aggression. Also, nurses were asked to develop own ideas to prevent seclusion and restraint. Regular meetings were set up with nurses to evaluate what lessons could be learned if coercion had been used and how to prevent it next time. Episodes of coercion were systematically documented and registered, and analyzed looking for patterns and regularities. A project group comprising of the manager of the ward, 2 exclients, 2 nurses, the psychiatrist of the ward, and a family member, monthly discussed the development of the project. All these interventions started more or less at the same time. Our research aimed to look back and reflect on the results of these interventions, and to help the team to make changes more permanent and to improve the situation further.

Our qualitative research showed that during the project, the nurses developed a deeper understanding of how they saw their own identity, how they wanted to relate to patients and colleagues, and what they considered as core values working as a team of nurses in a psychiatric inpatient setting. Nurses experienced their responsibilities differently compared to the old days. In this article, we will elaborate on the process of change in the nursing team and the new views on the essentials of nursing practice, which came out of this process. We will describe 2 cases that illustrate these changes. The first case is an example of how moral changes were set in motion in a dialogue about involving ambulatory care workers in trying to reduce coercion on the ward. This was a new development because before ambulant care and inward care were separate compartments of the hospital. As soon as the patient was admitted at a closed ward, the ambulatory care worker was not involved anymore. The dialogue was organized, because the nurses, while looking back at results of prior actions, came to the conclusion that the connection with ambulatory care was a subject for improvement. The second case shows the changes in moral attitudes and professional identity the nurses experienced looking back on the results of prior interventions in the project. They realized they had

changed from guardians into coworkers with patients. The meaning endowed to the value of safety also shifted, and trust and recognition became more important values. The 2 cases are supported by other data, such as interviews with clients and family members. We selected these 2 cases as they exemplify the most remarkable changes according to the participants.

THEORETICAL FRAMEWORK

The study presented here is an example of empirical ethics, aiming to articulate and foster a process of changing value commitments and responsibilities among nurses in psychiatric hospitals toward coercion reduction and prevention. Empirical ethics as a research method tries to bridge the gap between ethical theory and social practice. Traditionally moral philosophers focused on semantics or epistemology of moral claims and moral reasoning, and showed little interests in socially and practically embodied moral concepts.[14] Such approaches are less productive in the context of moral uncertainty issues in health care practice. In health care settings, moral issues and concerns are emerging on an everyday basis and are in need to be discussed and interpreted by the people involved to develop shared intersubjective understandings and practice improvements. Nursing ethics should relate to how persons comprehend a specific morally laden situation, based on actual questions, doubts, disagreements, responses, and negotiations.[15] Morally laden situations are situations in which nurses are confronted with daily issues that demand normative evaluations. For example, how much freedom a psychiatric patient at the ward can handle, how much trust can be given to a patient, how much control is necessary at the ward, and whether or not to an exception on the ward rules. Answering to these daily moral issues is particularly an intersubjective search.[16] Empirical ethicists aim to observe the phenomenon of the moral habitat (moral attitudes, responsibilities, and expectations), and correspondingly to facilitate dialogue and reciprocal learning processes.[17,18] This requires bringing in observations and different stances in dialogue with relevant stakeholders.

To understand and reflect on the moral processes in practice and on our own role as facilitators, we adopted the model of hermeneutic dialogue developed in hermeneutic philosophy by Hans-Georg Gadamer.[19] To explain the changes in moral values experienced by nurses involved in the projects, we introduce the expressive-collaborative model of morality developed by Margaret Urban Walker in *Moral Understandings.*[20] Reflections on the empirical data aim at uncovering the intersubjective moral developments and transformations. They provide tools to develop a deeper understanding of the intersubjective experiences of core values of nurses.

Gadamer emphasizes the role of dialogue in understanding. He distinguishes 3 ways of understanding the other/the world.[19,21-23] The first stance is objectivist. The other is seen as an object; the knower observes the other from a neutral, outside perspective, and explains the observations with the use of general and universal laws. The second stance is what Gadamer calls subjectivist. The knower tries to understand the other by placing himself in the footsteps of the other. Although this way of knowing is strongly embedded, it can also lead to relativism. According to Gadamer, both stances are problematic as they ignore what the outside world means for the knower and the knower's perspective and his or her place in the world. The knower does not relate to his own perspective in both these stances. The third position goes beyond objectivism and relativism.[23] It requires to be really open to what the other has to say, without abandoning own experiences. Being open means the person is willing to recognize the views of the other as valid. He is open and responsive to the interpretations of the other. He is ready to accept the other's issues as being relevant for him. According to Gadamer:

"...this simply means that we try to understand how what he is saying could be right."[19]

This is hermeneutic understanding. Perspectives merge and lead to what Gadamer calls a "fusion of horizons" through dialogue. The term "horizon" as a philosophical notion refers to frameworks of meaning. New situations are interpreted within such larger existing frameworks. These frameworks are formed by tradition and culture. Because interpretations are based on frameworks, they have implicit presuppositions. According to Gadamer, such presuppositions have the form of prejudices. Prejudices cannot be averted. They can, however, be challenged when one is confronted with other perspectives, which entail different presuppositions. In a dialogue, participants change and adapt their interpretations and understandings toward shared meanings. Shared meanings are the result of dialogue when views are changed and merged.

Walker regards morality as "a socially-embedded medium of mutual understanding and negotiation between people over their responsibility for things open to human care and response."[20(p.9)] Moral issues constantly will come up and demand new constructions of responsibilities and expectations. In daily practice, moral issues are presented by using stories or narratives. Walker distinguishes 3 kinds of narratives in which responsibilities are expressed and developed. The first presents the narrative of identities (roles and related expectations). The second, closely related narrative concerns relations (mutual needs and interest, development of trust). The third narrative is that of values. Although we analyze these narratives separately, they are fundamentally connected: *"Our identities, moral and otherwise, are produced by and in histories of specific relationships, and those connections to others that invite and bind us are themselves the expression of some things we value."*[20(p119)]

Both theories claim that intersubjective processes and dialogues contribute to evolvement and improvement of moral stances as a constant search between people. The responsive methodology we used in our qualitative research subscribes our theoretical propositions.

METHODOLOGY

The study presented here is part of a comprehensive empirical ethical research program, which started in 1999, to develop and implement criteria of quality for coercion within Dutch psychiatry.[8,17,24] In the implementation phase of this project, we conducted evaluation studies of coercion reduction projects within 5 psychiatric hospitals in the south of the Netherlands.[25] The central aim was to map the implementation process of the coercion reduction projects and to provide recommendations to adjust the projects and to further improve the quality of care. The ward we present in this article is a closed inpatient ward of a psychiatric hospital. The ward houses a maximum of 15 patients. During daytime 3 to 4 nurses are working at the ward. At night, 2 nurses are present. Patients at the ward are both involuntary and voluntary admitted. All patients experience serious acute psychiatric disturbances, like psychosis, suicidal thoughts, or manic episodes. The acuteness of their psychiatric disturbances and the related risk of harm are the main reasons for (involuntary) admission.

The evaluation studies followed a responsive design.[24,26,27] Responsive evaluation aims to foster quality improvement of practices through reflections and dialogues among program participants and external stakeholders.[22] It does not stand outside or above practice, but is embedded within practice, and an inspiration for dialogical and interactive approaches to empirical ethics.[17,28] Responsive evaluation does not aim at evaluating projects after interventions are implemented based on preordained program goals, but focuses on the process of implementation itself. In line with hermeneutic understanding, responsive methodology aims to articulate different issues and organize a

dialogical process with program participants and external stakeholders to exchange perspectives and develop mutually shared perspectives. The evaluator participates in dialogues as a facilitator. He has to acknowledge his own perspectives to be able to understand and relate to the multiple perspectives. Transparency toward own normative stances contributes to trustworthiness of the research as it openly reveals how knowledge is constructed and influenced by the evaluation team.[29] For example, the normative stance of the research and public debate was that the use of coercion is morally wrong. The aim of the projects was to reduce coercion. It did not aim to determine justifiable ways of coercion.

The first step in the data collection was to identify the issues of the participants. In this evaluation, participants included practitioners (nurses, psychiatrists, managers, and ambulatory care workers), patients, and their families. The evaluation team (first and third author) used open interviews for interviewing the respondents individually at the mental health care hospital. A selective set of topics were leading in the interviews, including expectations and experiences of the project to reduce coercion, ideas on how to reduce coercion, foreseen barriers, and pitfalls of the projects and how to overcome them. The next step was to organize homogeneous (converging interests) focus groups in which the issues from the interviews were further discussed. Focus groups resemble group interviews, but differ in that respondents are encouraged to interact and respond to each other. Participants do not have to agree with each other, and can be inspired by other visions. Focus groups are also referred to as focussed dialogue meetings. The ideal focus group exists of 10 to 12 participants and will take 2 to 3 hours. Then heterogeneous (diverging interests) focus groups and interactions were fostered between the various participants to exchange different perspectives. These steps were repeated several times (beginning, middle and end phase of the project) to collect data at different moments during the implementation of the project (see the Table for an overview of the phases and activities). The 3 phases were connected in a cyclic way; data from the interviews were used as input for focus groups to further explore issues and their relation, and the issues from the focus groups formed the input for the dialogue groups. Data collection and data analysis interchange in an iterative, interpretative process.

All the interviews and focus groups were audio taped and entirely transcribed. We checked the first analysis with the

Table 1. Scheme of Data Collection

Case	Period of Data Collection	Interviews	Focus Groups
Phase 1 Beginning	June 2007-September 2007	13	1 homogenous group (nurses)
Phase 2 Middle	May 2008-September 2008	7	1 homogenous group (nurses) 1 heterogeneous group (2 nurses, 1 psychiatrist, 2 patients, 1 manager, 1 family member)
Phase 3 End	September 2008-November 2008	3	1 homogenous group (ambulant nurses) 1 heterogeneous group (ambulant nurses, inward nurses and patients)
Total	June 2007-November 2008	23	7

respondents in so-called "member checks"[26] by mailing them a resume of the transcriptions and asking them if they recognized our description and interpretation. Analyses of the interviews were also regularly discussed within the evaluation team to prevent bias. The second author functioned as a peer debriefer during the study; she critically followed the emerging design and asked for justification of methodological decisions such as whether saturation was reached, and whether or not negative cases were taken into account. To meet standards of rigor preliminary analysis were checked with the respondents. As the issues and themes raised in the interviews and focus groups were discussed over and over among all participants (hermeneutic dialectic process) a one-sided picture of the process could be prevented.[27]

CASE 1: PREVENTING COERCION BY INCLUDING AMBULATORY CARE WORKERS

This case is an example of how moral changes were facilitated by organizing dialogues. In the interviews and homogeneous focus groups, participants were asked for their ideas to reduce coercion. The majority of the participants reckoned coercion could be further reduced if nurses of the closed ward would collaborate more intensely with ambulant care workers. Our next step was to organize a heterogeneous dialogue with various parties to jointly explore how their collaboration could be developed. A dialogue which aimed to stimulate nurses to search for new ways of preventing coercion by bringing together nurses from the ward and nurses from an ambulatory team: broadening their horizons.

Ambulatory care in psychiatry is the mental health care performed on an outpatient basis. In case of ambulatory care, the psychiatric care can be managed without an admission in the hospital. Most persons suffering from chronic mental illness receive ambulatory care, although in some periods they are in need of hospital admission.

As most of the patients receive ambulatory care before they are (involuntary) admitted, nurses at the ward wanted to explore how to strengthen the cooperation with professionals working outside the closed wards with the same patients. The idea was that as ambulatory caregivers know the patient in other, better periods of their illness, they might give useful information about the patient and assist in supporting and making contact with the patient. By collaborating with each other, nurses hoped to be able to place care in a long-term perspective. This idea was further explored in a dialogical meeting (heterogeneous focus group) with ward nurses, ambulatory care workers, patients and management of the hospital.

We will discuss some ideas that were developed on how ambulatory care workers could support their patients before, during, and after an (involuntary) admission.

Ambulatory care workers proposed they could give relevant information to the ward about suitable ways to treat a specific patient before or at the start of the admission: *"The ambulatory care worker can make an estimation about the amount of freedom a patient will be able to handle despite the level of paranoia of the patient." (Ambulatory worker)*

Patients additionally pointed at the importance of passing on "basic personal information" like the religion of the patient, special diets, allergies, etc to be able to attend better to the needs of a patient. All participants emphasized the necessity to share treatment strategies that are developed with the patient before he or she is (involuntary) admitted. The following quotation is an example of how prior information can be of help: *"For example, there are people who really feel threatened by being approached by a woman when psychotic, and will become aggressive. If we know that in front, we can anticipate to it."* (Nurse working on the close ward)

Furthermore, participants agreed that ambulatory nurses can supply information to the

patient in case an admission is about to happen. This information should include telling what the patient could expect at the ward, what has been changed since the last admission, etc. Ambulatory workers can also support the patient during the admission. For instance, when a patient asks for some personal things, the nurse may ask the ambulatory worker for help to get them. Since the ambulatory care worker has a long-term relationship with the patient, he may also be able to put the patient at ease. This support might reduce agitation and frustration of the patient and the need for coercion. The ambulatory care worker can also assist in bringing the patient and the staff at the ward closer to each other. In addition, patients report that at admission they sometimes feel abandoned by ambulatory caregivers, which is frustrating: *"It is not a good thing if a patient feels like, 'I am admitted at this ward, but my ambulatory psychiatrist does not visit me in here. He apparently has better things to do.'" (Patient)*

Finally, the ambulatory professional can evaluate the admission with the patient and help to find strategies how to prevent an admission next time. Together with the patient, he can advise on improvements of the ward.

In the dialogue meetings, the participants found several ways to collaborate and support in care and prevention of coercion. Ambulatory care workers listened to the difficulties the ward nurses were confronted with and considered how they could support the nurses to reduce coercion and improve the care for their patients. Thus, the meeting illustrated hermeneutic understanding. Participants recognized different interests, but also acknowledged mutual goals and were willing to be open and responsive to the issues that were put on the agenda. The process resulted in better mutual understanding, and in concrete suggestions for improving care through collaboration. This not only means that participants adapt their behavior to one another; they also come to see their own practice in a new way. Ambulatory nurses no longer see their work as ending at the door of the institution. They take a role and responsibility during and after admission. Ward nurses no longer regard their work as intensive care is completely different from the care in the community. They emphasize the common ground between care inside and outside the hospital. The process of exchange of perspectives on care and cooperation in the end implies a new view on the essentials of psychiatric nursing in general and dealing with coercion in particular. Nurses are open to share responsibilities to improve care for the patient and reduce the use of coercion. Constructions of moral responsibilities are changing and consequently also identities and core values. The second case shows more in depth that this results in new definitions of nursing practice and nurses' identity.

CASE 2: FROM GUARDIANS TO COWORKERS

The first case illustrated how nurses were enabled to develop new views on prevention through processes of dialogue, including new ways of cooperation with ambulatory colleagues. The nurses at the ward no longer considered themselves as the sole experts and "problem solvers," but recognized the value of close working relations with other colleagues to meet the needs of the patient. This also implies a new view on the role of nursing in dealing with situations of risk. In this case, we will focus on how nurses describe their new role, their identity and their relationship with patients. This case is different from the first one, in which the focus is on reflection on change, not on fostering further change. Yet, the difference is gradual, reflection and facilitation are not opposed, but actually presuppose one another.

In evaluating the project, we talked with nurses in interviews and (homogenous and heterogeneous) focus groups about what had changed. Looking back at how they used to work, they signified major changes in their responsibilities toward patients and in the way they relate to patients. Before the project

started, nurses used to regard and describe themselves as cowboys or guardians. This perspective influenced how nurses viewed their responsibilities and effected normative expectations of others. The identification of nurses as guardians effected how responsibilities were understood. At the mental health institution, the nurses of the closed admission ward had to solve problems of aggressive behavior. If a patient was staying in another part of the institution and became aggressive, he was brought to the closed facilities. Not surprisingly in this context, safety was considered the main responsibility of the nurses. They worked at the ward that dealt with the most difficult and dangerous patients. From that perspective the use of coercion was considered normal practice. To protect safety on the ward they tried to control the situation as much as possible. For example, they used specific ward rules for eating and sleeping. If, despite control, an outburst happened, they reacted by using coercion and restraint: "*The use of our seclusion room was part of our normal daily practice. If a patient became aggressive, for instance by throwing a glass against the wall, the patient would be put in the seclusion room. Without asking any questions about why the patient got so agitated." (Nurse)*

Gradually, as discussions about the necessity of the use of coercion started, nurses became aware of the need for reducing coercion and restraint and began to look for alternative and experimental approaches. Deliberating on prevention of coercion, care for the well-being of patients became more prominent. Empowerment, stimulation, and giving more control to patients became more important new values.

Due to the project, nurses were motivated to look for new ways to deal with patients. For a patient arriving at the ward, it was no longer considered self-evident he should be put immediately into the seclusion room to ensure safety. The nurses of the ward started judging the need for seclusion and welcomed new patients in a normal room (with colleagues visually nearby, to guard safety). Looking back, they regard this approach as a good way to reduce aggression, because patients feel less threatened: "*Sometimes a patient may have been really aggressive toward a police officer. But if two nurses approach this person in a friendly manner and offer a talk and a cup of coffee, the agitation often diminishes." (Nurse)*

Another example of a change is the reduction of daily rules on the ward. It is, for example, no longer considered necessary to close the kitchen during the day. Patients are allowed to make use of the kitchen whenever they want to get a sandwich or make a cup of tea. This results in fewer irritations among patients, as they feel no longer controlled by others. It creates more space and enhances control by patients themselves. It also leads to a more flexible and patient-centered attitude of nurses. Nurses reflect on the purpose of rules and weigh the relevance of the rule in specific situations (group interests versus individual interests) instead of following blindly on general ward agreements.

The staff also decided to abandon strict rules for deseclusion processes. It used to be common to let the patient out for a short-time period, to see if the patient could handle the stress of being among other patients at the ward. After this try-out, the patient would go back into seclusion room. This had adverse effects. Even if the patient appeared to be able to handle the stress well, he was brought back to the seclusion room. This often led to a negative reaction of the patient; he behaved well, but still needed to go back to the seclusion room. On the other hand, if a patient would become stressed, the staff would not take immediate action, because it was agreed that the patient would only go back to the seclusion room after the set time period. Nurses did not approach the agitated patient earlier on to avoid confrontations, but this reactive attitude often induced escalations. Abandoning these rules enables nurses to anticipate tensions and crisis situations better. It compels them to look seriously at safety issues in an earlier stage of the process. Nurses are forced to make contact with the patient and to talk

about safety, and be clear about boundaries concerning safety and intolerable behavior.

Together, all these adjustments stimulate nurses to take more initiative and anticipate possible tensions by relating to the patient. "*Nowadays we act much sooner. We say, for example, 'we heard you received some bad news, you have to stay longer at this ward despite your wishes. I would feel really bad if I were in your shoes. How about you?' So you anticipate those kinds of situations." (Nurse)*

The process of transition was not easy. At first, nurses rigorously tried not to use coercion and to ignore dangerous behavior. The effect was, paradoxically, an increase of coercion; the nurses waited too long and things would get out of hand and difficult to repair. This created moral distress: "*People in our team became really tense and felt like they were not allowed to use any form of restriction anymore. Because of that, we actually created more unsafe situations. Reducing seclusions is really important, but sometimes you just cannot prevent to intervene." (Nurse)*

Eventually, nurses regained control, not by using more coercion, but by approaching patients, confronting them with their behavior and involving patients in maintaining safety on the ward. They developed a shared understanding of responsibilities together with patients. Patients were no longer seen as dangerous people who had to be controlled. They were considered as human beings who could participate in developing good practices and could be considered as moral subjects.

An example of the involvement of patients in securing safety is the development of treatment strategies, which entails the views of the patient concerning how nurses should act in case of agitation and how to avoid using the seclusion room. In case it is not possible to prevent seclusion the event is evaluated with the patient afterwards, to learn to avoid this next time. In describing these new procedures, the manager of the ward says: "*We refer much more to the patient as a person, to his healthy behaviour instead of his illness. In this way we experience a reduction of aggression and resistance." (Manager of the ward)*

To summarize, nurses experienced major changes in treating patients. Several adjustments were made in rules and procedures, which contributed to different ways of dealing with patients attending more to the person behind the illness and anticipating on possible tensions. Moreover, nurses became aware that staying in control of safety is not realized by being repressive and using coercion and restraint, but by getting into contact with patients (relational safety) and involving them in preventing coercion and promoting safety. The examples show moral transitions in the 3 kinds of narratives Walker distinguishes. There are changes in how the team of nurses experienced their own responsibilities and assignments and what they expect of other (patients, ambulatory care workers). Parallel, there are changes in the relationship between the team of nurses and patients, as well as in relations between nurses (narratives of relations). Eventually, also shared values have changed (narratives of values). Coercion is no longer considered normal practice, but seen as an intervention that should be avoided as much as possible by averting dangerous situations by building a relationship with the patient.

In terms of identity, the professional changed from a guardian into a "coworker," working together with both the patients and other nurses. Before the project started, the professional-patient relationship was based on mutual distrust. Nurses distrusted patients because of the psychiatric illness that caused danger. Patients did not trust nurses because of the use of coercion and restraint. Both parties felt their safety being under threat. Slowly, patients were regarded as potential partners (moral subjects) in developing a shared understanding of responsibilities. These altered identities mean that the relationship between patient and professional is altered toward a more trusting relationship. By developing a more equal relationship, patients get offered a partnership, trust, and mutual responsibility in developing a recovery process.

In the new situation, relationships are less strategic. Nurses realize that getting into contact with patients is a better way to secure and foster safety. Knowing the patient makes it easier to estimate risks and anticipate on possible dangerous situations. Consequently, nurses actively try to understand the background stories of the (dangerous) behavior of the patient by understanding the person behind it. When a patient becomes aggressive, nurses want to know why. They wonder what causes the aggression and what can be done about it. The ambulatory care worker can assist in estimating the needs and interests of the patient and support the relationship between the patient and the nurses of the ward. They have a longer relationship, built on trust. They know each other also in periods without crisis.

DISCUSSION

An important finding of our research was that nurses reported themselves that their roles had changed. In retrospect they connected this role change to the emergence of reflection, openness, and dialogue. During the project, a dialogical process came forth within the mental health institution to engage nurses to think about their practice in general and coercion more in particular. As a result, illustrated in the 2 cases, the relationship between patients and nurses and among professionals (nurses and ambulatory workers) fundamentally changed. The focus now is toward mutual understanding, collaboration, contact, and trust. The first case showed that the number of people involved in estimating risks and dealing with danger has expanded. Before, dealing with risks was only a concern of the nurses at the ward. Gradually, ambulatory care workers were seen as possible partners, who can help to develop a better, mutually shared perspective on safety issues. The second case made explicit that patients are approached and involved as partners in care. Whereas formerly the practice of nursing was organized around the value of safety and guarding control over the ward, now the essence of nursing is defined in terms of sharing responsibilities with others. Nurses see their identity as being a coworker.

Interpreting good care involves activities of all parties. Patients and ambulatory care workers have a role in finding out what good care means in situations. Gadamer's hermeneutics can help to understand what nurses need to reflect on their core values and develop their identity. First and foremost openness is required. This was at first lacking at the closed wards. Nurses did not talk about the routine of coercion. In the dialogues, nurses learned to share their experiences and perspectives and to listen and open up to other perspectives. Through the dialogical processes the nurses were actively invited to think about their roles and responsibilities in relation to coercion. In the dialogues, the nurses encountered different views on what it means to be a nurse and what it means to take care for psychiatric patients in crisis.

Whereas Gadamer's hermeneutics helps to understand the process of change, Walker's philosophy enables us to look more closely at the outcome that is the resulting views on core values and identity of psychiatric nursing. Walker invites us to look at the nurses' stories about values, relationships, and identity. Nurses no longer regard control and safety as fundamental values; instead they emphasize notions like care, trust, and responsibility. Relationships have become more equal, aiming at mutual understanding and involving patients and colleagues in searching for ways to prevent escalation and address the needs of all participants. The nurses' identity is defined in terms of being coworkers.

The new situation also creates new challenges. Routines and prejudices are no longer implicit, but open for discussion. This could create insecurity. The work of nurses requires more subtlety and demands different capabilities because of new responsibilities. Nurses experience that it is not easy to build mutual trust in case a patient is admitted against his will. To meet the needs and interests of patients, nurses have to stimulate and convince

them to participate, which is not an easy process as it is not always clear to what extent the patient himself is capable or willing to take on responsibilities and become involved.

A further issue for concern regards which partners to include in the process of assigning responsibilities. The cases expressed that patients are seen more and more as fullfledged partners in developing good care practices and ambulatory nurses have also become involved. Yet, other partners may play a role too. In the Netherlands, currently the involvement of family is an issue of debate. Family members may help to prevent or stop coercive measures. Some institutions have started working with ex-patients to understand the patients at the wards in a better way. Finally, there is a debate whether or not policemen or commercial guardians should be asked for help in case of criminal behavior.

Gadamer and Walker emphasize the role of dialogue and reflection. By making moral expectations and prejudices transparent, participants in practice are able to critically reflect on moral issues. Contradictions and incoherencies become explicit, which may provide a basis for new and better understandings. Yet, moral understandings are constantly under construction, and new perspectives and partners will emerge. Thus, developing good practices is an iterative process, in which normative conclusions will always be temporal. In our project, nurses have become aware of this, since they acknowledge that it is not easy to structure their work in line with their newly developed identity and the mutual relationships with patients and colleagues that come along with this. Yet, they are convinced that this is more fruitful in the end, as patients are less oppressed and more involved in developing good care.

Other mental health care institutions could learn from these developments that facilitating dialogues about roles and responsibilities will contribute to awareness how to reduce coercion at the closed wards. It brings nurses and other practitioners closer to their essence and core identities related to psychiatric care.

CONCLUSION

The essence of psychiatric nursing is to deliver good care in critical situations. The 2 cases in our project show that through dialogue, nurses are able to find ways to reduce coercion by changing the distribution of responsibilities. Nurses at the ward recognized that, in taking responsibility for safety at the ward, they need not take the role of guardians. Sharing responsibilities with patients and with ambulatory nurses provides new opportunities to reduce coercion and foster good care. The project stimulated nurses to redefine their roles and develop a deeper intersubjective understanding of core values of their profession. The process of searching for the essentials of nursing is never finished, because new ways of dealing with morally complicated topics such as coercion tend to raise new questions and challenges, requiring further communication in which new viewpoints and new parties will emerge. This requires being open for change and having confidence that moral reflection with all parties involved will result in a better understanding of nursing values and a further development of nursing practice. Future research could monitor these processes further by attending to experienced pitfalls and possible solutions. To sensitize and educate nurses into moral issues moral case deliberations could be used.[30] Moral case deliberations provide a practical tool to systematically organize moral reflections among nurses on the work floor.

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