Society of Medical Education & Research

2025, Volume 5, Page No: 114-123
ISSN: 3108-4818

International Journal of Social and Psychological Aspects of Healthcare

Navigating Ethical Complexity: Nurses' Experiences in Forensic Inpatient Settings Interpreted via Løgstrup

Anna Al-Khotani[1], Mario Vianna Vettore[2]*

[1]Department of Health Sciences, Mid Sweden University, Sundsvall, Sweden.
[2]Faculty of Nursing and Health Sciences, Nord University, Namsos, Norway.

***E-mail** ✉ vettotemario@gmail.com

Abstract

This study investigates ethical dimensions of the nurse–patient relationship in forensic psychiatric care. Drawing on Løgstrup's philosophy, it explores how trust, moral responsibility, and relational challenges influence nurses' daily practice. A conceptual analysis was carried out using five qualitative studies on nurses' lived experiences in forensic inpatient settings. These studies, originally rooted in phenomenology and hermeneutics, were re-interpreted through reflective lifeworld research (RLR), a method emphasizing openness and careful reflection to understand lived experiences. The findings were further analyzed using Løgstrup's ethical framework. Analysis revealed five central tensions: *Trust versus Distrust*, *Compassion versus Indifference*, *Courage versus Fear*, *Authenticity versus Pretence*, and *Delicacy versus Forcefulness*. Together, these highlight the "in-between space" where nurses negotiate ethical dilemmas, institutional pressures, and patient interactions. Nursing in forensic psychiatric settings demands a careful balance between institutional requirements and compassionate care. Ethical understanding emerges through self-reflection and relational engagement. Encouraging structured reflection and dialogue can help nurses manage ethical challenges, support professional growth, and enhance patient-focused care.

Keywords: Forensic nursing, Ethical tensions, Lived experience, Reflective lifeworld research, Løgstrup

Introduction

This paper revisits earlier studies to examine the nurse–patient relationship in forensic psychiatric care (FPC) through a philosophical lens, highlighting the ethical challenges inherent in this field. Using a lifeworld perspective, it emphasizes how nurses' encounters with patients require continual self-reflection. Because FPC significantly limits patients' freedom and daily activities, it presents complex ethical dilemmas that need careful consideration [1].

Access this article online https://smerpub.com/

Received: 04 June 2025; **Accepted:** 18 September 2025

How to cite this article: Al-Khotani A, Vettore MV. Navigating Ethical Complexity: Nurses' Experiences in Forensic Inpatient Settings Interpreted via Løgstrup. Int J Soc Psychol Asp Healthc. 2025;5:114-23. https://doi.org/10.51847/xE07pOl98l

The Danish ethicist Knud Ejler Løgstrup (1905–1981) explored human connectedness from a phenomenological standpoint, emphasizing that every human interaction carries an implicit ethical responsibility [2]. He argued that encounters between people are not problems to be fixed but opportunities for reflection and moral attentiveness [3]. Løgstrup's idea of the ethical demand rests on the recognition that humans are interdependent; while it does not dictate specific actions, it calls for a sincere responsibility toward the other person. Acting in the best interest of the other is central to ethical engagement [2].

Working in FPC involves navigating ethical complexity, as nurses care for individuals with restricted autonomy. They must strike a balance between promoting patient well-being and maintaining safety for all involved, managing the inherent imbalance in these relationships [4, 5]. Patients often present with histories of violence, severe mental disorders, or legal limitations, creating a challenging care environment [6]. Despite these

conditions, trust remains crucial for effective therapeutic relationships [7].

Løgstrup [8] emphasizes personal boundaries, or "untouchable zones," which must be respected to facilitate meaningful encounters. Nurses need to be aware of what is shared in the relationship and maintain openness to foster trust [9]. This requires attentiveness to patients' expressions without judgment, allowing their experiences to shape the interaction [10, 11]. Genuine engagement depends on ethically perceiving these expressions rather than trying to control them [8].

While FPC is guided by legal and institutional frameworks, some aspects of human experience—such as trust, hope, mercy, and love—cannot be legislated. Løgstrup [2] refers to these as "sovereign expressions of life." Nurses who embrace these qualities can provide more meaningful, patient-centered care by seeing beyond behavior to the person's humanity. Active reflection and self-regulation are essential for responding ethically to patients' needs [2].

Trust is fundamental in human relations, as Løgstrup [2] notes, and initial openness is the default stance unless there is reason to withdraw. In the hierarchical context of FPC, trust is especially vulnerable. When trust is compromised, coercive measures may replace relational care, which can harm both therapeutic relationships and the overall care environment [12].

Phenomenology highlights the constant tension between opposing forces in human experience. Husserl [13] describes the lifeworld as shaped by the interplay of contrasting elements, such as trust versus distrust, closeness versus distance, and authority versus vulnerability. In FPC, nurses must continuously adjust their ethical approach, balancing involvement with professional detachment. Dahlberg and Dahlberg [14] calls this delicate negotiation "the space in-between," a dynamic zone where ethical awareness and relational engagement intersect.

In forensic psychiatric care, nurses often navigate a complex mix of trust and caution toward their patients. Trust may develop through professional competence and empathy, while caution or suspicion can arise from patients' unpredictable behaviors or previous experiences [15]. Similarly, nurses must balance emotional closeness with professional distance—showing care while protecting their own safety and mental well-being in a high-risk setting. These dual experiences are not contradictions but reflect the nuanced relational dynamics that define forensic psychiatric nursing [14].

This article investigates nurse–patient interactions in forensic psychiatric care using both philosophical and empirical insights [15-19]. Building on the Reflective Lifeworld Research tradition and interpreted through Løgstrup's ethical philosophy, it examines how trust, ethical responsibility, and relational tensions shape caregiving in this specialized field. The aim is to provide a deeper understanding of the ethical and relational challenges nurses encounter in forensic psychiatric environments.

Materials and Methods

Following the methodological guidance of Hörberg and Dahlberg [20], the study applied a theoretical perspective to previous empirical findings. Five qualitative studies **(Table 1)**, all grounded in the lifeworld approach and utilizing phenomenological and hermeneutic methodologies, formed the foundation of this analysis. These studies focused on nurses' lived experiences with patients in forensic inpatient care, aiming to reveal the meaning and challenges of their daily encounters in this ethically and emotionally demanding setting.

Table 1. Overview of the five published studies that constitutes the empirical foundation

Paper	Objective	Participants	Data Collection Method	Analysis Approach
Hammarström *et al*. [16]	To explore the significance of nurses' lived experiences in interactions with patients with mental illnesses in forensic inpatient settings.	2 Registered Nurses (RNs), 3 Specialist Registered Nurses (SRNs), 8 Assistant Nurses (ASNs).	Narrative interviews	Phenomenological-hermeneutic method [21]
Hammarström *et al.* [15]	To examine and interpret nurses' experiences of compassion while	2 RNs, 3 SRNs, 8 ASNs.	Secondary analysis of 2019	Hermeneutic method [22]

	caring for patients with mental illness in forensic psychiatric inpatient care.		narrative interviews	
Hammarström *et al.* [19]	To uncover the core meanings of carers' experiences in managing themselves while caring for patients with mental illnesses in forensic inpatient care.	1 RN, 5 SRNs, 3 ASNs.	Narrative interviews	Phenomenological-hermeneutic method [21]
Hammarström *et al.* [18]	To describe carers' experiences of vulnerability in forensic inpatient care settings.	3 RNs, 3 SRNs, 3 ASNs.	Narrative interviews	Reflective lifeworld research [23]
Hammarström *et al*. [17]	To explore the phenomenon of "avoiding the situation" in patient interactions as described by carers in forensic inpatient care.	3 RNs, 3 SRNs, 3 ASNs.	Narrative interviews	Reflective lifeworld research [23]

Participants and data collection

All five studies were conducted at a major forensic psychiatric clinic in Sweden, which employed around 180 staff and accommodated approximately 100 patients across eight wards, each with 12 to 15 residents. The patient population mainly consisted of men aged 25–45 years who had committed violent offenses. About 60% of these patients were diagnosed with schizophrenia or other psychotic disorders and were admitted under the Forensic Mental Care Act [24], rather than being placed in the criminal justice system.

Participants for the studies were recruited from the same clinic using purposive sampling, with inclusion criteria focusing on prior experience in forensic psychiatric care. Both written and verbal informed consent was obtained from all participants. In Hammarström *et al*. [15, 16], 13 staff members (10 men, 3 women; aged 28–67 years, Md = 36) participated, including five registered nurses (three specialized in psychiatric care) and eight assistant nurses with psychiatric training. Hammarström *et al*. [19] involved nine participants (5 men, 4 women; aged 30–66 years, Md = 41.6), comprising five specialist nurses, one registered nurse, and three assistant nurses. Hammarström *et al.* [18] also included nine participants (4 men, 5 women; aged 31–67 years, Md = 39). Hammarström *et al*. [17] included nine participants (5 men, 4 women; aged 30–66 years, Md = 41.6). In total, the dataset consisted of interviews with 40 healthcare professionals.

Data were collected through narrative, semi-structured interviews aimed at capturing staff experiences and emotional responses in patient encounters. Questions were open-ended, and interviews were conducted either face-to-face or digitally depending on pandemic restrictions. All interviews were transcribed verbatim, with attention to non-verbal cues to ensure a complete representation of participants' experiences.

Ethical considerations

The study followed national legislation and was approved by the Swedish Ethical Review Authority (No. 2018/157–31). Ethical standards regarding information, consent, confidentiality, and data handling adhered to guidelines from the Swedish Research Council [25] and the Declaration of Helsinki [26]. As the research relied on previously collected data, ethical considerations primarily focused on maintaining participant anonymity and respecting their integrity. Data were stored securely, and participation in the original studies was voluntary, with informed consent obtained in writing and verbally. The phenomenological foundation of the study emphasized openness and ethical sensitivity during analysis, ensuring that participants' lived experiences were represented faithfully.

Results from the empirical studies

In forensic psychiatric settings, providing effective care involves recognizing the individual beyond their criminal history. Nurses must engage with patients authentically, demonstrating compassion, trust, and courage, while prioritizing the patients' best interests.

At the same time, nurses must balance patient-centered care with adherence to legal regulations and institutional rules, managing the tension between personal responsibility and societal safety. Working in FPC involves negotiating power dynamics, confronting fear

and discomfort, and maintaining authenticity without adopting roles that conflict with one's professional or personal values.

Encounters with patients involve navigating a duality, described as the "space in-between," where nurses balance these tensions. Within this space, opportunities arise for professional and personal growth, adopting a phenomenological approach, and genuinely engaging with the patient's lifeworld.

Developing an overall framework

This analysis relied on the published outcomes of the original studies; no new coding or transcription of raw data was conducted. Instead, essential meanings and thematic patterns were identified and summarized to support a theoretical interpretation. The combined findings from the five studies were examined anew using a phenomenological approach to reveal overarching structures. Reflective Lifeworld Research (RLR) principles [23] guided this synthesis, allowing for an integrative perspective that highlights common experiences across nurses in forensic psychiatric care (FPC). The focus was the phenomenon of nurse—patient encounters in FPC. Following RLR methodology, philosophical perspectives were introduced only after this empirical analysis, ensuring that interpretation did not overshadow the lived experiences [23].

Conducting the new analysis

To construct a general structure, the researchers first reviewed the essential meanings identified in the five empirical studies, asking: "What defines encounters in forensic psychiatric care?" and "How do these encounters reflect caring in practice?" The analysis involved moving back and forth between the individual studies and the overall dataset, a process described as examining "figure and background" [23]. Patterns from one study were compared with those from others, allowing recurring and contrasting themes to emerge. Throughout the process, the researchers maintained a reflective and open approach, carefully "bridling" their preconceptions to preserve sensitivity to the phenomenon [23]. This iterative approach resulted in a general structure highlighting the core meanings of nurse—patient encounters. In a subsequent phase, Løgstrup's ethical philosophy was applied to further interpret these meanings and illuminate the moral dimensions of caregiving in FPC.

Results and Discussion

The results are presented in two stages: first, the general structure emerging from the empirical studies, and second, the philosophical interpretation. The philosophical examination was organized around five relational dimensions: Trust versus Distrust, Compassion versus Indifference, Courage versus Fear, Authenticity versus Pretense, and Flexibility versus Rigidity (described metaphorically as Being a Ballerina or a Bulldozer).

General structure

The "Space In-Between" in forensic psychiatric care

Encounters with patients in FPC are complex, involving attention both to patients' needs and to broader safety and legal considerations [16]. Nurses often face circumstances that challenge their professional identity, requiring them to balance emotional responsiveness with controlled detachment. By allowing themselves to be affected by patients' expressions while maintaining a regulated emotional stance, nurses can engage meaningfully and alleviate suffering even in potentially threatening or stressful situations [15].

The concept of the "space in-between" captures this delicate balance. It represents the relational dynamic where similarities and differences, trust and uncertainty, closeness and distance coexist [14]. In this space, nurses respond not only as professionals but also as fellow human beings, acknowledging the patient's experience. These dual aspects should not be viewed as opposing forces but as interdependent elements that define the encounter. Embracing the tensions inherent in this space fosters deeper understanding and strengthens the quality of care for both patient and nurse [27].

Developing trust and managing distrust

In forensic psychiatric care, nurses must balance cultivating trust with managing the intermittent feelings of distrust that can arise. Trust develops through consistent, attentive care and by fostering a predictable environment that allows patients to participate and relate more equally. Nurses must approach encounters without prejudice and remain open, a strategy that supports trust-building by setting aside personal biases and emotions that might interfere [2]. Forming trust is gradual, shaped by multiple interactions that can evoke both positive and negative responses, influencing the overall nurse—patient relationship [16].

Nurses recognize their duty to support and be accountable to patients, seeing trust as a gateway for patients to share their experiences and suffering. Achieving this requires reflection on one's own vulnerabilities and careful management of emotions to avoid undermining the relationship. Openness and truly perceiving the patient's needs are central to this process [16]. At the same time, the patient's criminal history and institutional rules may reinforce anxiety and distrust. By focusing on trust in the relationship rather than relying solely on rules for protection, nurses may reduce aggression and coercive measures while fostering genuine care [2, 15].

Balancing compassion and indifference

A critical aspect of nursing in this setting is responding empathetically to patients' expressions of suffering, which supports the development of compassion [16]. Yet interpreting these expressions—ranging from verbal aggression to apparent disengagement—can be challenging, sometimes leading to frustration and emotional withdrawal [19].

Even within a framework dominated by rules, nurses can act with genuine compassion, integrating care with regulatory compliance [16]. The duality of balancing compassionate care with institutional constraints complicates the distinction between following rules and maintaining empathy [15, 28]. Difficult encounters may evoke discouragement or shame, potentially leading to indifference. Reflection on personal responsibility, coupled with supportive environments that acknowledge nurses' own emotional needs, can mitigate this risk [19]. Developing self-compassion is therefore essential, enabling nurses to engage with patients' suffering without conflating it with their own emotions [19].

Navigating courage and fear

Caring for patients in FPC often entails confronting fear, particularly when patient behaviors present potential danger [16]. Nurses must negotiate the tension between attending to patients' needs and ensuring their own safety, managing internal conflicts that arise from uncertainty and risk [15, 28].

Exercising courage allows nurses to maintain presence and offer meaningful support, even under threatening circumstances. This requires openness, self-reflection, and confidence in one's ability to respond appropriately to complex patient behaviors [2, 15]. Fear can impede the normalization of patients, influencing whether they are included or excluded in the care process. Nurses often implement safety strategies to manage perceived risks linked to patients' past offenses [16, 18, 19].

Overcoming fear is a relational and reflective process, strengthened through dialogue with colleagues who share experiences and strategies for ethical care. Courage involves witnessing patients' vulnerability while trusting one's own capacities, acknowledging personal weaknesses, and fostering professional and personal growth [2, 16, 29]. It is through this integration of courage and self-awareness that nurses can provide ethical, compassionate, and resilient care in challenging forensic settings.

Being authentic or adopting a façade

Caring in forensic psychiatric settings is complex, requiring nurses to balance safety concerns with a therapeutic, patient-focused approach [17]. Nurses often navigate conflicting roles—providing care while maintaining control—which can dominate their interactions with patients, colleagues, and even themselves [18, 19]. One participant described how letting go of a "tough" persona and being more natural improved both patient relationships and personal confidence:

"Over time, I felt more secure with the job, the patients, and my colleagues. When I allowed myself to be genuine, the connection with patients improved, and my work felt easier."

Nurses manage a variety of situations by controlling their responses to project calm and reassurance [18, 19]. This often involves adopting a protective front, shaped by reliance on coworkers and the ever-shifting ward dynamics [16]. Authentic care requires a self-awareness grounded in trust, confidence, and acceptance, allowing nurses to interact meaningfully despite their own imperfections [18, 19]. Experience and time help nurses find their footing, understand themselves better, and act with authenticity. Belonging to a supportive team fosters trust and safety, even if this entails adapting to the ward's culture or expected roles [15].

Suppressing vulnerability can conflict with personal authenticity, especially when strict adherence to FPC rules is required [16]. Control is central to the role, requiring emotional regulation and a professional demeanor when engaging with potentially threatening patients [18, 19]. Nevertheless, openness and a willingness to embrace the uniqueness of each patient facilitate trust, cooperation, and genuine connections [16,

18]. By balancing authenticity with strategic self-protection, nurses can navigate both their own vulnerabilities and those of the patients [18, 19], reinforcing the importance of being genuine as a foundation for trust and relational engagement [2].

The ballerina and bulldozer approaches

Participants in Hammarström *et al*. [17] used metaphors to describe different strategies in nurse—patient interactions. The "bulldozer approach" reflects a protective, assertive stance, where the nurse prioritizes safety for patients and staff. In contrast, the "ballerina approach" represents a delicate, responsive way of engaging with patients, emphasizing openness, presence, and emotional availability to foster trust and security.

These metaphors illustrate the challenges nurses face, including fear in response to threats, making critical decisions independently, and striving to maintain control while managing internal conflict between engagement and withdrawal [17]. Retreating from an encounter, or "fleeing," is sometimes necessary for reflection and self-preservation. Løgstrup [30] emphasizes that understanding our emotional responses requires conscious reflection and, at times, stepping back to gain perspective.

Routine encounters can unexpectedly escalate into threatening situations, creating tension between the potential for meaningful engagement and the perceived need for self-protection [17]. Difficult interactions can affect a nurse's professional identity, triggering shame, self-doubt, and concerns about maintaining control. In this context, strategic withdrawal allows nurses to regain balance, navigate the space between closeness and distance, and maintain both relational presence and personal composure [30].

Synthesis of the meaning of "The Space In-Between"

The five themes collectively illustrate how the "space in-between" operates as both a relational and ethical dimension in forensic psychiatric care. This space is not defined by fixed opposites—such as trust versus distrust, compassion versus indifference, or control versus closeness—but rather emerges through the dynamic interplay between these states. Nurses continuously adjust their presence and responses in relation to patients, navigating complex emotional, moral, and ethical demands.

What ties the themes together is a constant sense of tension and attentiveness. Nurses respond to patient suffering while simultaneously safeguarding their own well-being, and they strive for authenticity while conforming to institutional expectations. The "space in-between" becomes apparent in these ongoing shifts, revealing that caregiving is not about eliminating conflict but about maintaining presence amid it. Through this process, patients' expressions leave a mark on the nurse, and meaningful interactions can develop even within a context shaped by risk, coercion, rules, and hierarchical imbalance. Within this space, nurses create opportunities for mutual understanding and, at the same time, foster personal and professional growth, as illustrated in **Figure 1**.

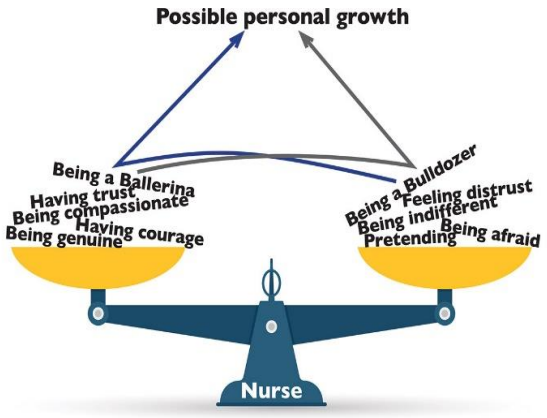

Figure 1. The encounter and the space in-between

The theoretical lens applied in this analysis is grounded in Løgstrup's concept of independent, direct, and contextually embedded access to the world (Danish: *Sansing*) [2]. This study highlights that encounters with patients in forensic psychiatric care are fundamentally communicative, with the nurse playing a central role in establishing a caring relationship by attempting to understand and share the patient's lifeworld [3]. The findings reveal that nurses must navigate the dualities inherent in FPC while operating within the "space in-between," shaped by the impressions left by patient interactions. A patient's expressions influence the nurse's perception, providing insight not only into how the nurse is affected but also into what emerges from the encounter itself. This approach emphasizes the existential dimensions of care, highlighting phenomena that are fundamental to human experience.

The quality of these encounters is influenced by the "tone" of the interaction. Heidegger [31] describes tone as a force that opens one to the world, fostering harmony

and attunement. In the context of nursing, this suggests that a nurse's experience cannot be separated from the social and environmental context of the clinic, as the tone arises from the broader environment rather than from the individual alone. Therefore, nurses are affected not only by the duality of their role in FPC but also by the culture and dynamics of the ward and institution.

Impressions left by patients are pivotal in shaping nurses' feelings of vulnerability. Relationships can either amplify or diminish these feelings, making the encounter a profoundly relational phenomenon. When a nurse engages with a patient, they are influenced by the content of the patient's expression, reflecting Løgstrup's [30] notion of the ethical significance of impressions. Initial reactions may include resistance, as nurses may instinctively attempt to interpret or reshape the encounter based on their own assumptions [8]. Achieving understanding requires creating a reflective distance—not by withdrawing from the interaction but by suspending habitual intentions and judgments, allowing for emotional presence and receptivity to the patient's expression [30].

Løgstrup [8] also emphasizes that all individuals protect certain "untouchable zones," resisting intrusion or violation. Genuine encounters are hindered without recognition and respect for these personal boundaries. Nurses can foster authentic connections when they interpret the patient's expressions while maintaining self-awareness, lowering their own defenses, and revealing their authentic selves [9]. True openness in the encounter involves attentively listening to the patient's voice and allowing their story to emerge, rather than reacting solely from one's own perspective [10]. According to Løgstrup [8], impressions are phenomena that can guide understanding but are never fully controllable, emphasizing the ethical and relational nature of human encounters.

According to Løgstrup [2], trust is a cornerstone of human existence, shaping our ethical obligations toward one another. We regularly place aspects of our lives in the care of others, relying on their responsibility and integrity. Ethical encounters also require trust in oneself, where self-reflection and authenticity are essential for acting ethically [30]. Trust extends to the surrounding environment as well, where belief in supportive conditions enables ethical behavior. When trust is nurtured, it promotes mutual understanding and responsibility; when broken, it can affect both personal self-concept and relational dynamics [2]. These insights have implications for nursing education and institutional ethics, emphasizing the importance of reflective training and organizational support to help nurses navigate ethically complex situations [15-19].

Yet trust alone is insufficient. Ethical responsibility also demands courage. As Thorup *et al*. [32] note, courage is vital in care ethics, allowing caregivers to remain present during moments of suffering and vulnerability. Caring ethically often requires stepping into uncertain, emotionally demanding situations and confronting one's own limitations. Without courage, ethical responsibilities may lead to avoidance rather than engagement, undermining trust in the process. Courage and trust are therefore complementary: courage reinforces trust, enabling ethical action to persist even under challenging circumstances [32].

In FPC, trust is continually tested. Institutional structures and legislation create both constraints and opportunities, influencing care practices. However, as Martinsen [3] points out, certain aspects of care—such as vulnerability, human interdependence, and life's finite nature—exist prior to social construction. Løgstrup [2] refers to these inherent qualities as "sovereign life expressions" (trust, mercy, hope, joy, and love), which can be either nurtured or suppressed. Restrictive structures risk fostering alienation and hopelessness, demonstrating how organizational and institutional contexts shape fundamental human experiences [29].

Power dynamics are a constant ethical consideration in nursing. As Kristensson Uggla [33] explains, power is embedded in patient–caregiver relationships, often placing patients at a disadvantage institutionally, existentially, and cognitively. This dynamic is fluid: nurses hold responsibility for the patient's well-being, functioning as a form of "proxy" for care [34]. Løgstrup [2] stresses that human encounters inherently involve trust and vulnerability, meaning those in positions of power must respond ethically to the responsibility conferred upon them. Misusing this trust can damage the relationship, so nurses must act to protect it. Patient resistance should not be viewed as defiance but rather as an assertion of dignity and agency; nurses' responses should promote understanding and care, not control [35]. Drawing on empirical data from Hammarström *et al.* [15-19], reflecting on emotions allows nurses to better understand their own experiences and encourages patient participation. This reciprocal openness empowers patients and strengthens the therapeutic relationship. For nurses, expressing and processing emotionally

challenging experiences fosters personal growth and a deeper appreciation of the patient's perspective. Structured reflection is essential, helping nurses recognize their vulnerabilities and regulate emotional responses in demanding situations. This practice is particularly important in navigating the "space in-between," where ethical tensions, emotional pressures, and professional responsibilities intersect. By challenging assumptions and deepening self-awareness, nurses can enhance their well-being while delivering care grounded in authenticity, responsiveness, and trust.

This perspective resonates with Patel and Metersky's [36] analysis, which emphasizes that structured reflective practices enable nurses to identify and work through emotional, ethical, and professional challenges as they arise. Their study highlights the significance of both reflection-in-action and reflection-for-action as practical approaches to navigate the "space in-between," supporting patient engagement while also fostering professional development.

Conclusion

In conclusion, the dual nature of FPC and the "space in-between" experienced during encounters confront nurses with existential aspects of their own lifeworld. These experiences bring attention to personal vulnerability, which can either become a burden if avoided or serve as an opportunity for transformation when approached authentically [2]. For nurses, this highlights the challenge of balancing the structured rules and norms of FPC with the lived realities of patients, colleagues, and themselves. By actively engaging in the "space in-between" and reflecting on openness, nurses navigate the continuum between opposing forces. This space can serve as a setting where nurses explore their own lifeworld while simultaneously experiencing personal growth. According to Løgstrup [2], cultivating openness and awareness of the impressions left by encounters through reflective self-examination is vital for conveying meaning. Importantly, such reflection is relational rather than purely internal; understanding the patient's world and one's own identity emerges within interactions, where shared dialogue and verbalized reflection are essential. This underscores the value of structured reflection and team-based discussion in professional practice to address the ethical demands inherent in caregiving [2].

While legal and organizational systems vary internationally, the ethical and relational essence of patient interactions remains consistent. The findings highlight the importance of integrating structured reflective approaches in FPC, including ethical case discussions and collaborative team dialogues, to help nurses navigate complex relational and ethical situations. When nurses engage with patients through openness and responsiveness, encounters can become spaces that support personal growth, nurture the fundamental expressions of life, and deepen understanding. Ultimately, this approach strengthens nursing practice by enhancing nurses' insight into both their own experiences and patients' expressions of suffering, thereby enabling truly person-centred care grounded in the patient's lifeworld [18, 19].

Acknowledgments: None

Conflict of Interest: None

Financial Support: None

Ethics Statement: None

References

1. Vincze M, Fredriksson L, Wiklund Gustin L. To do good might hurt bad: exploring nurses' understanding and approach to suffering in forensic psychiatric settings. Int J Ment Health Nurs. 2015;24(2):149–57.
2. Løgstrup KE. The ethical demand. Notre Dame (IN): Univ Notre Dame Press; 1997.
3. Martinsen K. Lögstrup og sykepleien. Akribe; 2012.
4. Jacob JD. The rhetoric of therapy in forensic psychiatric nursing. J Forensic Nurs. 2012;8(4):178–87.
5. Hörberg U. Att vårdas eller fostras. Det rättspsykiatriska vårdandet och traditionens grepp. Acta Wexionensia No 133/2008. Växjö: Växjö Universitet; 2008. ISBN: 978-91-7636-590-8.
6. Laiho T, Hottinen A, Lindberg N, Sailas E. Staff attitudes towards seclusion and restraint in forensic settings. In: Völlm B, Nedopil N, eds. The use of coercive measures in forensic psychiatric care: legal, ethical and practical challenges. Cham: Springer; 2016. p. 231–40.
7. Gildberg FA, Bradley SK, Fristed P, Hounsgaard L. Reconstructing normality: characteristics of staff

interactions with forensic mental health inpatients. Int J Ment Health Nurs. 2012;21(2):103–13.
8. Løgstrup KE. System og symbol. København: Gyldendal; 1983.
9. Devik SA, Enmarker I, Hellzen O. When expressions make impressions—nurses' narratives about meeting severely ill patients in home nursing care: a phenomenological-hermeneutic approach to understanding. Int J Qual Stud Health Well-being. 2013;8:21880.
10. Barker P, Buchanan-Barker P. The tidal model: a guide for mental health professionals. Brunner-Routledge; 2005.
11. Brookes N. Tidal model of mental health recovery. In: Tomey AM, Alligood MR, eds. Nursing theorists and their work. 6th ed. St. Louis: Mosby; 2005. p. 696–725.
12. Berry S, Robertson N. Burnout within forensic psychiatric nursing: its relationship with ward environment and effective clinical supervision? J Psychiatr Ment Health Nurs. 2019;26(7–8):212–11.
13. Husserl E. The crisis of European sciences and transcendental phenomenology. Evanston (IL): Northwestern Univ Press; 1970.
14. Dahlberg H, Dahlberg K. The question of meaning: a momentous issue for qualitative research. Int J Qual Stud Health Well-being. 2019;14(1):1598723.
15. Hammarström L, Devik SA, Hellzén O, Häggström M. The path of compassion in forensic psychiatry. Arch Psychiatr Nurs. 2020;34(6):435–41.
16. Hammarström L, Häggström M, Devik SA, Hellzén O. Controlling emotions: nurses' lived experience caring for patients in forensic psychiatry. Int J Qual Stud Health Well-being. 2019;14(1):1682911.
17. Hammarström L, Hellzén O, Devik SA. 'Fleeing' as a strategy for navigating resistance in patient encounters within forensic care. Healthcare (Basel). 2023;11(21):2890.
18. Hammarström L, Devik SA, Häggström M, Hellzén O. Meanings of carers lived experience of "regulating oneself" in forensic psychiatry: a phenomenological-hermeneutic understanding. Int J Qual Stud Health Well-being. 2022;17(1):1682911.
19. Hammarström L, Devik SA, Hellzén O, Häggström M. "You know where the boundary is when you cross it": a phenomenological understanding of vulnerability as experienced by carers in forensic inpatient care. Issues Ment Health Nurs. 2022;43(8):712–20.
20. Hörberg U, Dahlberg K. Caring potentials in the shadows of power, correction, and discipline—forensic psychiatric care in the light of the work of Michel Foucault. Int J Qual Stud Health Well-being. 2015;10:28703.
21. Lindseth A, Norberg A. A phenomenological hermeneutical method for researching lived experience. Scand J Caring Sci. 2004;18(2):145–53.
22. Fleming V, Gaidys U, Robb Y. Hermeneutic research in nursing: developing a Gadamerian-based research method. Nurs Inq. 2003;10(2):113–20.
23. Dahlberg K, Dahlberg H, Nyström M. Reflective lifeworld research. 2nd ed. Lund: Studentlitteratur; 2008.
24. LRV Lag om rättspsykiatrisk vård; 1991: 1129.
25. Swedish Research Council. Etikriktlinjer [ethical guidelines]. 2017. Available from: https://www.vr.se/analys/rapporter/vara-rapporter/2017-08-29-god-forskningssed.html
26. World Medical Association. Ethical principles for medical research involving human subjects: Declaration of Helsinki. 2013. Available from: https://www.wma.net/policies-post/wma-declaration-of-helsinki/
27. Holopainen G, Kasén A, Nyström LM. Caring elements in the short encounter. Int J Hum Caring. 2015;19(4):50–5.
28. Løgstrup KE. Solidaritet og kärlighed. København: Gyldendal; 1987.
29. Martinsen K. Care and vulnerability. Oslo: Akribe; 2006.
30. Løgstrup KE. Art and realization: art philosophical considerations. København: Gyldendal; 1983.
31. Heidegger M. Being and time. Albany (NY): State Univ New York Press; 2010. (Original work published 1927).
32. Thorup CB, Rundqvist E, Roberts C, Delmar C. Care as a matter of courage: vulnerability, suffering and ethical formation in nursing care. Scand J Caring Sci. 2012;26(3):427–35.
33. Kristensson Uggla B. What makes us human? Exploring the significance of Ricoeur's ethical configuration of personhood between naturalism and phenomenology in health care. Nurs Philos. 2022;23(3):e12385.
34. Rundqvist E. Makt som fullmakt: Ett vårdvetenskapligt perspektiv. Doktorsavhandling. Åbo Akademi; 2004.

35. Skjervheim H. Deltakar og tilskodar og andre essays. Rev. ed. Oslo: Aschehoug; 1996.
36. Patel KM, Metersky K. Reflective practice in nursing: a concept analysis. Int J Nurs Knowl. 2022;33(3):180–7.