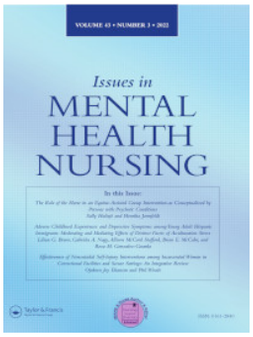

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"You Know Where the Boundary Is When You Cross It" - A Phenomenological Understanding of Vulnerability as Experienced by Carers in Forensic Inpatient Care

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ABSTRACT

In forensic nursing, carers must balance caring and limiting actions in encounters with patients. Interpreting suffering in others raises awareness of one's own vulnerability. Hence, the aim of this study was to describe the phenomenon of vulnerability as experienced by carers in forensic inpatient care. Nine participants were recruited at a major forensic hospital, and their narratives were analysed with a reflective lifeworld approach. The findings revealed that vulnerability was both a strength and a burden. Vulnerability comprised becoming aware of one's boundaries, being genuine and protecting oneself. Dealing with vulnerability enables carers to open up to patients.

Background

The aim of forensic psychiatry is to reduce the probability of criminal reoffending by getting patients involved in their treatments and the care given, thus improving their mental health and enabling them to take on societal responsibility (Olausson et al., 2019). Forensic psychiatric care is enabled by establishing an alliance and relationship with the patients (Rydenlund et al., 2019), and carers must deal with the duality of being both fostering and caring (Hörberg, 2008). In Sweden, forensic psychiatric care is primarily offered at regional clinics for patients suffering from severe mental illness (Strand et al., 2009). Under the law of forensic psychiatric care (LRV), patients are transmitted to care, often due to commission of a violent crime, rather than being imprisoned (LRV 1991:1128). Swedish forensic psychiatric clinics are divided into three security levels (very high, high and acceptable), if care is delivered at multiple wards, at the same premises, each ward must be classified on its own (SOSFS 2006:9). Being a carer in forensic psychiatry means facing and dealing with expressions of burdens while still being permissive in everyday encounters (Urheim et al., 2011). Forensic psychiatric nursing care presumes that carers maintain a compassionate approach, remaining fixed on the patients' needs (Sturzu et al., 2019). To do so, carers must deal with their own reactions and feelings. Emotions such as frustration, fear, humiliation and anger (Hammarström et al., 2019) that emerge from situations characterised by threats and violence constantly challenge carers to define their boundaries (Eivergård et al., 2020). Whilst balancing caring and limiting actions, carers must find a way to develop a person-centred and holistic approach in their encounters with patients (Nyman et al., 2020).

Defining the characteristics of an encounter can be difficult (Holopainen et al., 2019); nonetheless, the everyday encounters between patients and carers are a central aspect of psychiatry (Peplau, 1988). Gaining insight into how carers perceive encounters is achieved by developing an awareness of their mindset and predetermined ideas, which play a major role in the quality of the carer–patient relationship (De Leeuw et al., 2012). This insight may help carers avoid an imbalance of power within the carer–patient relationship (Delmar, 2012).

Being a carer is intertwined with experiencing vulnerability, a phenomenon that transgresses both personal and professional boundaries (Angel et al., 2020). Carers' vulnerability could be seen as both a resource and a burden, as it requires becoming morally aware, strengthening courage and developing sensitivity, but ultimately promotes an ethical attitude in the carer–patient encounter (Stenbock-Hult & Sarvimäki, 2011). To address their own vulnerability, carers must first realise that the phenomenon can be emotional, cognitive and physical (Boldt, 2019). This involves realising that dependency is not exclusive to patients; rather, it is something that is shared—a mutual dependency (Angel & Vatne, 2017). In health care, the concept of vulnerability is acknowledged and seen as a self-evident truth, but not often explained or described (Sellman, 2005). Thus, often, caring

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for patients means facing the vulnerabilities of others, but not regarding oneself as being in a vulnerable state and addressing this vulnerability (Gjengedal et al., 2013). Encounters with patients contain an ethical dimension of care related to the carer's ability to respond and pay attention to the patient; that is, his or her ethical sensibility (Weaver et al., 2008), a situation close to Lögstrup's ethical demand (Lögstrup, 1992). Reacting to others in harm means being at risk of facing one's own vulnerability; thus, in such situations, an objective phenomenon causes a subjective experience (Sellman, 2005). If not addressed, such experiences may lead to adopting a distanced approach to avoid being hurt (Angel et al., 2020).

Gaining a greater understanding of the phenomenon and its very core may help reduce carers' vulnerability and enable them to participate in encounters that are perceived as harmful (Angel & Vatne, 2017), thereby allowing them to acquire insight into the patient's lifeworld (Hörberg, 2018). Taking care of patients with mental illness increases the risk of burnout and emotional exhaustion compared to providing care in a non-mental health setting (Johnson et al., 2018). Vulnerability itself could be a basis for change and creativity, sparking human capability (Ricoeur, 1995). Thus, the aim of this study was to describe the phenomenon of vulnerability as experienced by carers in forensic inpatient clinics.

Materials and methods

This study was guided by the reflective lifeworld research (RLR) approach described by Dahlberg et al. (2008). RLR originates from the phenomenological philosophy first described by Husserl and Merleau-Ponty in which a phenomenon is explored through the notion of the lifeworld. The philosophical concept of the lifeworld was explained by Merleau-Ponty (1995) as "being in the world"; that is, the lifeworld is a world of perception and comprises how humans interact and relate to their existence in this world. Understanding the lifeworld is a necessary condition for understanding a phenomenon.

This research approach is directed towards finding meaning and developing an understanding of a phenomenon by a movement from the whole to its parts and back to the whole again. During this movement, the research process, including data collection and analysis, focuses on the phenomenon being studied (Dahlberg et al., 2008). In the present study, the phenomenon is vulnerability as experienced by carers in forensic psychiatry inpatient care during carer–patient encounters.

According to Dahlberg et al. (2008), to comprehend a phenomenon, one must embrace a phenomenological attitude. This means acknowledging the phenomena in the world and illuminating the essence, general structure and very core of the studied phenomena. Each phenomenon is further described by meaning constituents, which emphasise variations of the essential meaning. Together, the meaning constituents and the essence of the phenomenon describe a meaning structure. A meaning structure can only be developed once the researcher has become aware of their natural attitude and what is perceived to be taken for granted, striving towards a phenomenological attitude. This is described as difficult (Husserl, 1970) because humans tend to view objects or events along with their meaning. Thus, being able to bridle (restraining one's pre-understandings via openness and flexibility and remaining reflective and critical towards oneself and how the phenomena present itself in the data) is essential (Dahlberg et al., 2008).

Participants and settings

Nine participants were recruited at a major forensic hospital (clinic) in Sweden. The clinic is one of Sweden's regional clinics and is one of the larger clinics with national admission, and was classified as a high-security clinic, with one department classified as very high security. The clinic was populated by approximately 180 employees and 100 inpatients at the time this study was conducted. Most patients were between 25 and 45 years of age and were transmitted to care due to violent crimes. The study participants consisted of four men and five women between 31 and 67 years of age (md 39 years). The amount of experience in forensic inpatient care differed between the participants and ranged from 3 to 33 years (md 13 years). Among the participants, there were three specialist nurses in psychiatric care, three registered nurses and three assistant nurses. In this study, all participants are referred to as carers in order to conceal their identities.

Data collection and analysis

Approval for the study was obtained from the head of the clinic. Participants were informed about the study and recruited through email and phone calls; all interviews were carried out with consent. Participants were recruited with a purposive sample, and the inclusion criterion was having experience in forensic inpatient care. Once participants decided to partake in the study by answering email or directly by phone, additional information and clarity regarding consent, procedure, data collection and study's purpose was further explained, on which a date and time was agreed upon for the interview. The first author who carried out the interviews was known to most of the participants as being known from the studied context, either as a former colleague, researcher or tutor. Due to the ongoing COVID-19 pandemic, all of the interviews were conducted by the first author digitally with video and audio recording via a video chat platform. The interviews were conducted with the aim of achieving high information power, as described by Malterud et al. (2016). The narrative interviews lasted between 40 and 60 minutes (md 42 min). The recorded interviews were later transcribed verbatim by the first author. The transcribed interviews were also validated by comparing text and recordings as any non-verbal information, such as laughter, silence or changes in tone, was added. The interviews comprised open-ended questions in line with Mishler (1986). The interviewees were initially asked to describe what it had been like to start working in the department and about how they thought they had developed as carers. In the rest of the interview, the main questions were: Can

you talk about one or more encounters that have been difficult to handle? What happened? How did you feel? How do you think you were perceived as a carer? How do you think others' perceptions of you as a carer have changed over time? How might the job affect you as a person? Follow-up questions were asked to encourage the participant to elaborate and share more.

When searching for the essence of a phenomenon, a descriptive systematic analysis of the qualitative data is necessary. In order to illuminate and describe the meaning structure of the phenomenon of vulnerability as experienced by carers in forensic psychiatric inpatient care, an analysis according to the principles described by Dahlberg et al. (2008) was conducted. The initial analysis included becoming acquainted with the data, gaining an understanding of the whole by reading the transcribed interviews and comparing the text with the digital recordings. Once familiar with the text, the authors attempted to gain a more in-depth understanding of the data by dividing the text into smaller segments called meaning units. The meaning units were then used to find patterns by combining them into clusters of similar meaning units. These clusters were discussed and reflected upon by all authors, thereby elucidating the phenomenon's essential meanings and overall structure. During this part of the analysis, the importance of bridling one's pre-understanding and keeping an open mind, avoiding making definite what is indefinite, became even more apparent. Bridling one's pre-understanding means restraining one's pre-conceived notions and problematising one's natural attitude, allowing the phenomenon's multiplicity to show itself, as "it is more than meets the eye" (Dahlberg et al., 2008). Bridling could be seen as an individual process, but in this case, it was made possible by discussions among the authors. Eventually, when the data was perceived as thoroughly harvested and the meanings were tidily organised into clusters, the process of analysis moved on to the next step: returning the parts to a whole. This time, with a better understanding of the phenomenon studied, its true essence was described along with its meaning constituents. Together, the essence and meaning constituents describe the meaning structure of vulnerability as experienced by carers in forensic psychiatric inpatient care.

Ethics

The study was carried out with the approval of the Swedish Ethical Review Authority (No. 2018/157-31). Written information and a presentation about the study were presented to each participant. All interviews were conducted following collection of written informed consent that was retained by the first author. Participation was voluntary and confidentiality was assured. Participants could choose to withdraw from the interviews at any time. The interviews were carried out and directed according to the ethical guidelines from the Declaration of Helsinki (World Medical Association, 2008) and the Swedish Research Council (2016). In case the interviews stirred up unpleasant emotions, all participants were provided with contact information for all of the authors and a plan of action was established.

Findings

The following presentation of the meaning structure is written in present tense, as it is intended to describe how the phenomenon of vulnerability is experienced, rather than what the participants said about it. The meaning of vulnerability as experienced by carers in forensic psychiatric inpatient care is presented below, including its essence and variations in the form of the meaning constituents. To highlight the lived experiences of the carers, quotes are included throughout.

Carers describe vulnerability as something subjective, a concept with a relational and embodied nature. Vulnerability is described by carers as relational when it is caused by one's openness and exposure to others and highlights the inherent insecurity in the relationships. The essence of the phenomenon of vulnerability as experienced by carers working in inpatient forensic psychiatry is "not knowing where the boundary is until it has been exceeded".

The carers interviewed describe the essence of vulnerability as trying to understand oneself, to constantly look inward and reflect on one's own behaviour. This can be perceived as exhausting and hard work. Facing the suffering of others evokes emotions and thoughts about one's own vulnerability and what it means to be fragile. Being allowed to be human is considered a prerequisite for being able to treat patients based on understanding. One's own vulnerability is brought to light in the face of patients' and colleagues' vulnerability and suffering, as vulnerability is described in encounters with patients and meetings with colleagues, as well as in one's expectations of oneself as a carer. One's vulnerability develops through dealing with the tension of coming to terms with oneself, being in the midst of being close to a patient or avoiding controversies. Distinguishing one's individual assets can enable a fruitful relationship and an alliance with the patients. For the carers, managing this complexity means becoming aware of their own personal boundaries, which are closely intertwined with how the patients perceive the carers, as carers can be seen as either genuine or distant in the eyes of others. This reflection on oneself increases one's awareness of what it means to be fragile in a context that is perceived to be threatening and harmful. We find that the meaning of vulnerability is further described by its meaning constituents: "finding a balance between what is personal and private", "struggling with being authentic and true to oneself" and "protecting oneself and avoiding harm".

Finding a balance between what is personal and private

This aspect of vulnerability comprises the struggle to find one's own personal boundary that defines how genuine and personal they can be. Carers describe becoming aware of their own vulnerability and sensitivity in situations

and encounters in which the aim is to create an alliance and relationship with the patient. When trying to create a relationship, carers try to be genuine. The sore point in such situations is described as not knowing where the boundary goes; that is, not knowing how personal or genuine they can be without sharing too much. This is a boundary they become aware of once it is crossed. The carers indicated that this sore point is a constant companion in their relationships with all patients and described it as something that all carers will become aware of sooner or later.

In relationships with patients, carers express feelings such as sympathy and empathy; thus, the relationships develop into something more than a carer–patient relationship: "we became more like friends than carer and patient". Carers are affected by the patients' suffering and the boundary defining what is considered private is blurred. Finding your own boundary is expressed as a constant internal dialogue that affects everyday encounters with patients. The feeling of being too personal makes it difficult to meet with the patient, as the carers end up in a situation that they cannot get out of without damaging the relationship.

> We got too close to each other, it went too far. I had too much empathy. But the thing is, that feeling when it gets too private. That feeling is a little harder to back away from. Getting out of it is much harder, I think. I cannot just say that now you must take two steps back because I feel it´s too private. Then you risk sabotaging the whole relationship that you have built up.

In contrast to being private, carers can choose to distance themselves from the patient on an emotional level to avoid exposing themselves and to protect their own vulnerability, thereby dealing with the tension at hand. This is described as a simpler approach that provides a sense of security when encountering patients.

> Either way, I risk becoming too private and absorbed by the patient in this attempt to create an alliance. Or, due to security reasons, you do not want to let anyone come too close, then you risk becoming that guard that just says 'no' all the time, which is easier but not the one I want to be.

One carer described being in tension as a movement between two extremes. Finding a balance between acting as a guard and one's private life becomes easier over time, as does assessing one's vulnerability. This meaning of vulnerability accentuates the importance of being able to turn the gaze inwards and gradually opening oneself to the patient's suffering.

> It was just this, where does my own limit go … If there is one thing I have learned over the years, it is that I always make myself a bad guy to begin with. Then I can approach from there and gradually show who I am, one step at a time and then it is easier to stop before it goes too far.

Becoming aware of this aspect of one's own vulnerability means being willing to avoid "taking the easy way out". Finding the balance of being personal, yet not private, and dealing with one's own vulnerability can thus be beneficial for the carer–patient encounter.

Struggling with being authentic and true to oneself

This meaning constituent refers to struggling to become authentic and not playing a role, emphasising self-understanding and becoming aware of one's role, as carers expressed sometimes feeling pressured to conform. Vulnerability is characterised by the tension between knowledge and competence and ignorance and feeling incompetent, which is connected to insecurity in one's professional role. Carers' vulnerability and fragility affects their ability to manage carer–patient encounters. The experience of vulnerability is an existential emotion that makes the carer struggle to avoid ending up in a situation that they perceive to be unmanageable.

The following quote illustrates that carers find that being able to handle their own vulnerability and thereby encounters with patients is intertwined with becoming more authentic in the eyes of others and towards oneself: "In order to fulfil my mission, I want to become more authentic over time, then I am also perceived as more authentic by others."

Being inexperienced means an increased risk of becoming overwhelmed by the patients' suffering, as inexperienced carers are also in the midst of finding their professional role. Entering the role of a carer is not just about dealing with the complex task of caring for the patient and protecting society at the same time; it is also about finding a sense of belonging and "fitting in", which can create a feeling of security that allows the carers to do their job. The carers may choose to be "someone else" rather than their true self in order to deal with their own insecurities, fears and anxieties related to their new role and new expectations of themselves and others. Carers feel forced to live up to an ideal and the role of "prison guard", an ideal and façade that are perceived as foreign.

> Back then you may have felt that you had to play a role … The patients were more accustomed to it, and you also wanted to fit in. And if everyone else behaves in a way, you adapt to that … Maybe that it was more like that before. Maybe it was more that you should be tough or live up to some ideal you thought was omnipresent. Which, of course, it was not. I found it difficult to relate to that role.

Over time, the tension shifts, and as the carers gain experience, a feeling of security evolves as they find themselves and their role: "I can willingly admit that I'm not that type. But then it was kind of weird when I walked around and played tough, a role I did not want to play." This sense of security enables the carers to be none other than themselves: instead of playing a role, they can be more authentic and genuine. This enables more fruitful and genuine relationships with patients and other carers. Being genuine also means leaving the role of "prison guard" and instead entering the role of a "carer", in which they open up to the patients' suffering and their own vulnerability. Being genuine towards oneself allows one to be in a more authentic relationship with the patient, a relationship that is perceived to be stronger and more genuine. As the carer and patient gain more knowledge about each other, a stronger bond is created. Moreover, becoming aware of and dealing with vulnerability means responding to one's own

emotions and thus becoming more attentive and genuine, allowing the carers to take part in the patients' interests. One carer said:

> It was kind of weird when you walked around and played tough. Over time you felt more secure with the job, with the patients and also with your co-workers, it felt more right and was usually better if you let your shoulders down a little and was more natural … I also notice that my job becomes easier, and it goes better with the patients when they notice that I am genuine … we connect in a better way.

Caring in a forensic setting means experiencing fragility, an overwhelming sensation that is not exclusive to the work sphere, as it becomes intertwined with their personal life: "It was hard to find my role, I thought about it all the time". The sense of not being true to oneself produces vulnerability, forcing carers into an everlasting process of self-reflection, as being vulnerable means becoming aware of one's authentic self. As time progresses and with more experience, carers' sense of vulnerability diminishes as a sense of security arises from being affirmed that one's "real self" is good enough. This affirmation comes from being accepted by other carers and genuine relationships with patients: "before I might have had the potential, that I had good prerequisites. Which comes from interest and ambition; I was always driven to do something good. Due to time and security and being myself, it allowed me to do so."

Protecting oneself and avoiding harm

This aspect of vulnerability means dealing with the fear of threats and violence by shielding oneself and evading hurt. Caring in a forensic setting means facing expressions of suffering in the form of threats and violence, which can be difficult to interpret. Dealing with these expressions of suffering means coming to terms with one's own vulnerability, which manifests itself as fear, and one's ability to manage the situation at hand. One carer said:

> There are many times I have gone to work and had a stomach-ache. You have had the feeling that you don´t know what will happen today. If I'm totally honest it´s about being afraid … The ones I have the hardest time with are the ones who are physically competent and aggressive, the ones who simply scare me … To be completely honest, I think this is the first time in all the years I have worked here, when I talk about my own fears.

Being afraid means wanting to flee from the situation at hand. Being threatened or exposed to violent acts starts an inner dialogue and awareness within the carer, who must decide whether to stay present or escape. This awareness is intertwined with the will to stay involved and near versus becoming detached and distant. As the sense of fear becomes overwhelming, it can even display itself through physical traits, as illustrated by the following quote:

> I had a pulse and then I had hand sweat, something I usually never have. I was terrified, I was just thinking, where have I ended up somewhere. Then you saw the patients sitting in the corridor. My god, what a sight, I got scared and then I stayed two days inside the office and was terrified.

Being frightened and finding oneself in a situation ruled by fear has meaning for carers, as there is tension between shielding oneself and having the courage to stay in the moment and face the situation "here and now". Being able to deal with this tension is closely related to understanding the patients' expressions of suffering and the situation at hand and being able to predict what might happen.

> I was scared. He had beaten down a couple of other carers. Of course, you feel that way, otherwise it would be strange, I think. He is quite terrifying … People like him I find most difficult to limit and respond to. Patients like him who are a little scarier and more unpredictable in their mood.

Becoming aware of one's own vulnerability facilitates participation in and gaining access to the patients' lifeworld. Finding a balance when dealing with fear and staying present and overcoming distress through self-reflection instead of fleeing or abandoning the patient allows carers to take part in and understand the patients' expressions of suffering in a heated moment. The carers can then interpret threats and intimidation with compassion. One carer described:

> It was a patient who was to be secluded. He was very scared, angry, and upset. When we're going into the separation room, he turns around. And I'm closest to him. He says nothing, he just stares right into my eyes. Then I thought, now I'm getting punched … It was not many seconds we looked at each other, but in my memory, it felt like a very drawn-out moment. Then I felt it, the fear. Then suddenly, he starts crying, like a child. It all became very different. Then I felt how scared he was. How small he was. Then I felt very sorry for him.

This aspect of vulnerability is characterised by fear becoming embodied and evident through physical traits. Situations that are unpredictable and difficult to unravel lead to a sense of insecurity, stirring up emotions that are arduous and demanding to manage. Carers may struggle to balance between these extremes and at the same time process the will to be close and the desire to do good. Collectively, this creates a state of fragility that impacts the carer's ability to stay present in the situation and overcome fear, letting their expressions make an impression and thus gaining access to the patient's lifeworld.

Discussion

The aim of this study was to describe the phenomenon of vulnerability as experienced by carers in forensic inpatient care. The findings illuminate the characteristics of vulnerability in carers who are forced to turn the gaze inwards, discovering their own personal limitations through self-reflection. Being vulnerable is the condition of being subject to harm. It does not mean just physical fragility; rather, it also includes our moral and emotional experience of being vulnerable (Harris, 1997). This study suggests that encountering patients in a forensic setting means interpreting expressions of suffering that make personal boundaries evident when surpassed, thus placing the carers in a fragile state.

Carers' experiences elucidate that vulnerability is about finding a balance in a dichotomous relationship between two extremes. Navigating this balance requires an inner negotiation with oneself to be genuine towards the patient and find ways to create an alliance instead of adopting a role that is perceived to be foreign (i.e. that of a prison guard) to protect oneself from harm. By having the courage to open up to others, one can stay true to oneself. Caring for patients in forensic psychiatry means establishing relationships between carers and patients, as such positive relationships could potentially minimise coercive elements in the care given (Jalil et al., 2020). Entering the carer–patient relationship requires the carer to be willing to run the risk of rejection. In other words, it takes courage to dare to accept the possibility of rejection (Delmar, 2004).

Becoming aware of one's own vulnerability suggests a sense of affective anticipation of possible failures that may compromise our very existence (Harris, 1997). Caring as a forensic carer means developing trust that is derived from and guided by the courage and fortitude to be open and let the patient get close (Rydenlund et al., 2019). Our findings suggest that this is made possible by being authentic and genuine; however, this also means that carers struggle with revealing themselves and determining how personal or private they can be, as described in the meaning constituent "finding a balance between what is personal and private". Finding a balance in the asymmetry allows carers to base their care on compassion despite their own shortcomings (Fredriksson, 1999). Being vulnerable means having feelings and being open and exposed to others, not only expressing emotions but also receiving them in order to become close to others; thus, being vulnerable means giving and opening ourselves up as human beings (Stenbock-Hult & Sarvimäki, 2011). Forensic psychiatry contains an ethical principle of respecting aspects of one's "personhood", such as personal needs and emotions, drawing out these characteristics when necessary (Buchanan, 2015). Carers' vulnerability is a latent feeling that is displayed through bodily reactions and includes being overwhelmed by one's emotions and struggling to avoid being hurt. Vulnerability has an impact on the carer–patient relationship and stirs up feelings that pierce the private sphere. Nonetheless, being open and sensitive to patients and their needs means that carers must inevitably deal with their own vulnerability (Angel et al., 2020) and thus risk becoming emotionally fatigued (Johnson et al., 2018). This study elucidates that carers find themselves in a vulnerable state when they become too empathetic and get too close to the patients. It becomes difficult to find a way out of this fragile, unsustainable state without damaging the relationship. In an environment permeated by control and security (Maroney, 2005), carers risk turning to rules and legislations to feel in control and not expose own vulnerabilities (Kettles & Woods, 2006) when dealing with the duality of their caring task (Hörberg, 2008). Respecting what is perceived to be personal and private protects vulnerability, as vulnerability itself could further arise when a loss of control occurs (Buchanan, 2015). Opening up to others could be seen as a gamble, as it can also mean risking harm (Rytterström et al., 2021). Confronting one's own vulnerability and admitting to one's own limitations means having the courage to view fragility as both a weakness and a resource. Notably, concealing or dissociating oneself from others' and one's own emotions is one method to protect oneself from difficult feelings, and a potential consequence of failing to do so is vulnerability, which can lead to suffocation of one's emotions, thereby affecting connections with others (Stenbock-Hult & Sarvimäki, 2011).

Vulnerability also showed itself through the carers' experiences and narratives as they "struggled with being authentic and true to oneself". Dealing with the duality present when caring for patients in a forensic setting could be seen as a burden that requires specific techniques when encountering patients; however, it seems more important to be transparent to establish a therapeutic alliance (Merkt et al., 2021). Our study shows that this aspect of the phenomenon of vulnerability is characterised by the tension that occurs when carers are struggling with the balance between being genuine and performing their professional role. Being inexperienced meant wanting to "fit in" and become accepted by colleagues and patients, which meant playing a role in which they distanced themselves personally from others. As vulnerability can be a source of imbalance and confused with a lack of potential and capability (Angel & Vatne, 2017), keeping one's distance is one way to manage the struggle of maintaining one's emotions when emotionally affected. This approach can have negative consequences, as carers who take this approach can be perceived as unsympathetic (Angel et al., 2020). Thus, providing care for patients in a forensic setting can be perceived as more focussed on fostering behaviour than providing care (Hörberg, 2008). The beginning of the carer–patient relationship is commonly permeated with the sense of feeling uncomfortable, a feeling that diminishes over time (Marshall & Adams, 2018). To avoid alienating and isolating oneself and instead gaining access to the patient's lifeworld, carers must become humanly sensitive (Dahlberg, 2011). Being approachable, opening up to patients and sharing details about oneself based upon genuine goodness allows carers to find a common ground with which to break through the initial barrier (Marshall & Adams, 2018). Maturing and turning vulnerability from a weakness into a strength requires allowing oneself to be sensitive and open, to have feelings and be human, giving a bit of oneself and consequently becoming closer to others (Stenbock-Hult & Sarvimäki, 2011). Carers shared that being genuine and being themselves promoted their relationships with others (both patients and colleagues) and elicited the sense of being accepted. Opening up to others is about showing them your vulnerability, a risk carers were at willing to take once they realised that their vulnerability could be a resource and not a burden. Instead of turning to paternalistic behaviour, they realised that vulnerability is something shared; though purely subjective, it is mutual and a part of the human condition (Sellman, 2005). The inner world, openness, and

authenticity that come with coming to terms with one's own vulnerability may further enhance "good" nursing (Angel & Vatne, 2017).

Vulnerability was also elucidated through the carers' experiences with "protecting oneself and avoiding harm". Being exposed to expressions of suffering in the form of threats and violence requires becoming aware of and dealing with one's fear. For the carers interviewed, being afraid meant experiencing the full embodiment of vulnerability, an overwhelming sensation that had meaning for the carer–patient encounter. Unravelling this embodied moment determines the course of action and how close or distant carers will be as they strive to avoid becoming frightened by their own emotions and instead embrace them (Carlsson et al., 2000). Vulnerability is an existential emotion that is evident when carers face situations in which they are trying to avoid harm, a feeling from which it is challenging to dissociate (Angel et al., 2020). Realising one's frailty and determining the risk of harm enables one to manage vulnerability, and assessing risk and one's capacity for self-protection could mean turning to others to seek refuge (Sellman, 2005). Withdrawing from the situation due to being frightened is a possible reaction to recognising one's own vulnerability (Gjengedal et al., 2013). However, if treated productively, vulnerability could be an asset in the caring relationship with patients (Hem & Heggen, 2003). As unpredictable behaviour in a psychiatric inpatient setting can be a source of insecurity and non-caring behaviour, vulnerability is to be perceived as a demand for openness, and in some encounters, vulnerability is required for individuals to understand each other (Gjengedal et al., 2013). While previous research has described vulnerability as a resource to a minor degree, our study indicates that vulnerability could help carers in a forensic inpatient setting stay present in the moment and not abandon the patient despite being exposed to threats and humiliation when embracing one's own fragility (Weaver et al., 2008). For vulnerability to become a resource, one must have the courage to acknowledge their own limitations, thus turning vulnerability from a weakness into a strength (Malone, 2000).

According to the Danish philosopher K.E. Lögstrup (1984), encounters with other people are always preceded by trust, and in conversations between two individuals, there is an unspoken demand not to betray the other's trust and create emotional suffering. According to the participants narratives, "crossing the boundary" means becoming aware of own vulnerability and a possibility to change. Vulnerability manifests itself in the patient's frailty and suffering, the expression of which lets the light into the encounter, and the carer may become emotionally touched as a result (Martinsen, 2021). Lögstrup (1984) wrote that vulnerability contains a withdrawal that is outside our power, which itself comes from our courage to face the foreign and thereby provides space to receive the foreign. If we deny our vulnerability, it will be replaced by mistrust and the encounter will be characterised by a desire to hide our own shortcomings, which is in line with the carer's descriptions in this study.

Methodological considerations

Gaining access to and approaching another's lifeworld requires problematising one's own natural attitude. Revealing others' perceptions, experiences and intentions requires embracing the concept of bridling, as well as confronting and provoking one's pre-understandings to maintain objectivity and validity, thus staying open to the studied phenomenon (Dahlberg et al., 2008). Although the first author conducted the interviews, transcribed them verbatim and performed the initial analysis, all of the authors contributed to this study. The first author's familiarity with and pre-understanding of the studied context could be seen as both an asset and a burden. This familiarity was an asset in the sense that the participants could speak freely and honestly because the first author was known to some of the participants. On the other hand, it made problematising one's natural attitude challenging. Thus, this process was facilitated by the co-authors, as being unfamiliar with the studied context was revealed to be an advantage in the process of analysis through numerous discussions, as ponderings ultimately resulted in a shared understanding. Regarding data collection, it should be taken into account that due to the ongoing pandemic, all of the interviews were carried out with the help of digital aids. Although face-to-face encounters would have been preferable as some may have felt uncomfortable using digital aids. Interviewing in person is also preferrable when interpreting body language, however the use of video recordings made it possible to interpret facial expressions and understand the participants' feelings and reactions.

Among the purposive sample of nine participants, there were four men and five women: three specialist nurses in psychiatric care, three registered nurses and three assistant nurses of various ages and with different amounts of experience. Altogether, this was considered a heterogenous group, which, according to (Dahlberg & Dahlberg, 2019), is preferable, as in phenomenological studies, heterogeneity promotes the acquisition of as rich and nuanced a description of the phenomenon as possible. This also makes it easier for the author to reflect upon and adopt the phenomenological attitude to which the method is connected.

As RLR studies a phenomenon based on people's lived experiences, the phenomenological philosophy must be integrated to provide an increased understanding. Philosophy can be perceived as difficult to access and demanding to unravel; consequently, a good introduction to the philosophical texts is needed (Dahlberg & Dahlberg, 2019). In this case, the co-authors' previous knowledge and prior experience in similar studies were seen as an asset when problematising the natural attitude and gaining an understanding of phenomenological assumptions.

The essential meaning and the meaning constituents together comprise a general structure that describes the phenomenon, thus creating an overall understanding rather than an unconditional truth to be generalised (Dahlberg et al., 2008). The findings of this study should thus be viewed as an insight into the meaning of vulnerability as experienced by carers in forensic inpatient care. This is a

scientific contribution that may inspire a further understanding that is unique to the Swedish context, as the laws and regulations that govern forensic inpatient care differ nationwide.

Conclusion

Vulnerability can be both a strength and a burden for carers. A burden that is exhausting and inevitable. It is a strength in that it can help the carers creatively approach the caring role. Vulnerability inevitably emerges as something to manage as encounters with patients force carers to undergo self-reflection. Getting close to the patients and creating alliances means becoming aware of the boundary defining how personal and private they can be. Vulnerability allows one to be genuine in the eyes of others and oneself instead of having to play a role. Dealing with one's own vulnerability enables carers to open up and get close to patients without increasing the risk of coming into harm.

Clinical implications for mental health nursing

This study contributes to research that illuminates the phenomenon of vulnerability in forensic inpatient care. This study suggests that becoming aware of one's own vulnerability is of the essence when establishing a carer–patient relationship and is essential for carers to be able to fulfil their professional mission. Facing their vulnerability may also have a profound effect on carers' well-being, reducing the risk of burnout or emotional exhaustion, both of which may negatively influence patient outcomes and quality of care. Hence, it seems important for carers to discuss not only the patients' well-being, but also their own; moreover, there is room for reflection about their experiences in carer–patient encounters.

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