Carriers of pain: Vulnerable meetings between staff and clients with a dual diagnosis

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Abstract

Persons with complex problems challenge nursing. The interest of this study was to identify the tools staff have used to continue working with compassion, empathy and sensitivity amongst vulnerable clients with complex problems, mental ill health and substance use (so-called dual diagnosis). The data were collected in a focused ethnographic study at a low-threshold service for substance users, and were analysed using Leininger’s ethnographic and a phenomenological lifeworld method. The staff attitude was positive towards the clients, they approved of the client’s background. Vulnerability appeared as a common pain, which touched both the staff and clients, and needed to be negotiated. A staff tool was the capability of carrying the pain, not being overwhelmed by it. The implications for practice are to recognize openness, awareness, reflexivity and communion with other staff members, the need for balancing of personal and ethical roles with professional requirements.

Keywords

dual diagnosis, empathy, focused ethnography, low-threshold service, phenomenology, vulnerability

Accepted: 1 July 2019

Illicit drug use and mental health co-morbidities create complex vulnerabilities.1 These complex vulnerabilities are unlikely to be quickly resolved, since mental ill health and problems related to substance use are connected with physical illness, poor housing and problems with family and close relationships. Persons with co-occurring mental health and substance-use disorders are called dually diagnosed. The term dual diagnosis is used in this article to be consistent, in a wider perspective, including persons who have not been diagnosed, but suffer from simultaneous mental ill health and substance-use problems, and whose life-situations are complex. It is possible that the vulnerable background of clients creates barriers from the standpoint of the client, staff and service delivery system.2 These individuals may simply be overwhelmed, experience shame and guilt, and struggling in everyday life.1,3

Substance use is often considered to be self-inflicted, which may create poor regard or stigma towards clients and act as a treatment barrier as well as influencing the outcomes.4,5 Stigma acts so that individuals do not seek help, and the individuals are faced with being stereotyped when seeking help.

The staff meeting with the dually diagnosed are facing the dilemma of professional guidelines of compassion, empathy, acceptance, respect and caring, in contrast to emotions such as frustration and helplessness. Care implies a specific attitude, intention, readiness and concern are fine-tuned into a professional relationship.6 It requires a constant inner negotiation on different ethical aspects in care, and for staff to have an ability to handle their own feelings.7 Thus nurses are expected to maintain the desire and ability to understand the client, to be humane, demonstrate respect and maintain empathy in whatever situation.8 Additionally nurses are those who meet with the complex needs of clients, and they have to compromise in the midst of organizational constraints. In order to avoid ethical conflicts nurses have reported limiting their emotional involvement with clients and their families.9,10 As time goes on, emotional hardening can take place in order to be able to deal with a constantly stressful and demanding role.

There is missing research data concerning how staff have resolved the conflict arising from emotional burden and stigma, in contrast to compassion and approving each person as an ethical ideal. Staff working with vulnerable individuals are at risk of giving up on their values and basic ethics, due to workforce shortages and exhaustion.5,7,9 For staff being close to suffering as a human and being touched by the other may raise their own controversial reactions and feelings of powerlessness.7,10,11 Nurses’ life experiences may develop sore points that develop into blind spots, which make them unavailable to the clients.7 As a result clients may feel rejected when
they are not met with compassion, and those being accused of lacking compassion feel offended.

In a caring tradition within nursing science such as mental health nursing, practice ideals of client-centred and non-judging ways of working are the standard. Mental health nursing can ideally include an egalitarian, positive, health-oriented and collaborative approach. Mental health nursing involves the provision of conditions for the promotion of growth and development, so that the client’s unique personal experience receives attention. As the situations and expectations in care differ, a question is whether nurses can continue being humane or are their abilities delimited because the working conditions may seem too much to cope with on a personal level? The interest of this study is to identify the tools staff have used to continue working amongst vulnerable clients with many kinds of complex problems (so-called dual diagnosis).

Method

A focused ethnographic study was conducted at a low-threshold service for families with drug and mental health induced problems in life. Focused ethnography has been used to study experiences within subcultures, such as specific settings or the experiences of care. Data collection included interviews with clients and staff, observations, a reflexive diary, and the changing of position as a tool to be immersed in the culture of the setting. The approach included the search for phenomena within the culture of care, which may involve complicated constructions and subjectivity within the specific context. An approach of openness has been supported both in ethnography and phenomenological lifeworld research.

The culture at the specific low-threshold service is considered a psychological structure made up of the components by which individuals and groups of individuals allow their behaviour to be guided. The special interest was in the emic view of the participants in connecting between clients and staff, and the way staff described their stance, and linked subjective viewpoints with socially established structures of meaning of the specific service. The participants’ experiential viewpoint is intentional: according to phenomenologists, cultural situations inform values, assumptions, and norms, and consciousness is directed and oriented toward specific pieces of experience. The culture shapes everyday life experiences, and thus the ethnographic viewpoint is connected to a phenomenological lifeworld perspective. In Leininger’s method discovering complex care phenomena is approached with inductive open questions.

Entering the setting

The data were collected at a low-threshold service for drug-using or abstinent mothers, small children, and entire families in southern Finland. The site was chosen because of the research interest in dual diagnosis and client-centredness as a professional practical goal, which was of value at this site. The service is community based and funded by several municipalities in the area. It is a joint undertaking with a substitution clinic and a small family ward. There is also outreach in the community and networking with different agencies in the area. The field research was planned in advance by arranging several meetings with the centre’s management and staff.

The professional background of the ethnographic researcher (MS) as a trained psychiatric nurse facilitated access to the field. Questions about confidentiality and ethical questions related to professional ethics were known in advance, and a document of professional secrecy was signed. The professional background yielded knowledge on how to connect with the clients on a professional level. The ethnographic researcher is generally viewed as a co-participant and co-producer of data. The researcher intentionally changed between being an observer and participant; she participated intensely in the day programme, both through active presence and by running two weekly groups for clients. As to the research interest, a special effort was put into explication of the pre-understanding and awareness, so that the study would give the participants their voice.

Data

The data collection took place over five weeks on 23 separate days (a total of 149 hours). The data comprise 117 field note entries. The data include notes on participation and observation in specific situations or brief discussions with clients and staff, staff meetings, home visits, training, and descriptive data describing daily routines and the process of care. Furthermore, data describing the culture and context were included. Additionally, all of the 12 staff members were interviewed in open-ended yet thematic interviews, so that questions could be confirmed by several participants. Each interview lasted 30–90 minutes, the average being 62 minutes. The staff members were aged 34–57 years (median age 44 years), ten were counsellors with different training backgrounds in the health or social services.

Data analysis

Both description and interpretation were used during the course of analysis. The study boundaries and focus were deliberately chosen. The study started with an interest in how client-centredness is established in the low-threshold service culture. Observations, field notes and ideas formed the basis of understanding. The staff interviews were open-ended and changed with each interview by contesting with the notes and reflections from the field. All data were recorded verbatim. The QSR NVivo 11 Pro program was used to assist the handling of the data. During the analysis, transcribed notes and interviews were thematized and the preliminary themes arose inductively from fieldwork. In practice, after individual interview-see-level analysis, these data were compared, and contrasted to the field notes with observations and reflections, which is a form of validation.
had appeared as a key concept, a decision was made to study connecting and vulnerability in more detail, and go through the same rich data again. In this specific study the process started from a new pre-understanding, and by new thematization. As the context-bound meaning is central within focused ethnography and within a lifeworld phenomenological tradition, the last analysis phase included inductive interpretation, and the reporting stage added interpretation via discussion through previous literature.

**Ethical questions in the study**

The protocol for the research project was approved by the Ethics Committees in Finland: (1) Tampere city (Dno SOTE:/5407/403/2003) and (2) Tampere University Hospital (RO3125H). The study participants gave their informed consent.

**Findings**

**Meeting the client with a positive regard**

Human connections are a part of care encounters. The staff described a stance, when they consider the mothers first of all in the role of valuable and appreciated persons, as mothers, parents, as individuals, and only secondly as a dually diagnosed person with problems, or the vulnerable victim:

I think that I do this work with these values, because I experience it valuable and I can sort of fight for them a little bit, their values and sort of also for these clients. (Participant 1)

In our study staff wanted the clients to know that they are welcomed at the site. As workers they had needed to go through their own attitudes, it was not possible to work with false assumptions. Staff had negotiated their attitudes towards these clients into approval, for example in relation to potential child abuse. They felt they could not help unless they approved of them as persons. In fact the core value for staff was that they had a positive regard towards the clients:

Our clients are brilliant personalities, and I like them umm somehow. (Participant 1)

This appreciation towards the dignity of another human was specific, and they had to educate other staff members within the service network and to argue against negative thoughts and stigma about ‘addicts being spoilt’. They had taken the role of advocates for the mothers with a dual diagnosis.

In the data the expertise of professionals is not sufficient without a caring approach, where the human-to-human encounters receive adequate space. This is professionalism that includes staff members’ human characteristics, such as approving of others as they are, a capacity for astute listening and intuitive support for others in trouble. Staff at the low-threshold service regarded this as fundamental to helping mothers with simultaneous mental health and substance-related problems:

If I take really good care of them and treat them well with respect, like ordinary people, I think that they will likewise do the same with their children, so that it can somehow transfer: they receive care and good experiences in a human relationship, and then they manage to transmit this to their children and other relationships. (Participant 1)

Non-judgemental acts and empathy establish such relationships with clients, where therapists access peoples’ individual and everyday lives. The approving and sensitive approach may lead to a possibility of developing other relationships in the clients’ lifeworlds.

**Approving vulnerability**

Mothers with simultaneous mental ill health and substance issues may have such a harsh background within the drug community and struggles with mental health problems that this context makes everyday life routines remote or unapproachable:

If you lived in the drug community, the unpredictable, where nothing is planned in advance, then you find out that people do not remember or they do not want to remember, so it is sort of, when you just live there in that drug community, and when you get out of there, the grasping surface to life starts to grow and other things come into life … one goes through that it was a time period in my life when it was like this, so vulnerable stuff… saying that was my life, I was the person who lived that and then the human also gets rightfulness to those bad feelings. (Participant 2)

Ambivalence and instability were words appearing in the staff interviews when they described their clients. Taking drugs meant involvement in threat and fear. Many clients had experienced relapses in regard to trying to become abstinent, and previous failure in using different services. Many of the parents attending the low-threshold service were tired, and still tried to progress. Their lives were recognized as a struggle, including pain.

There are differences between mothers in regard to their early experiences. Some experiences can be heartfelt by the workers, who looked back in time:

If something has occurred very early, something traumatic, whereof they have no recollection, what it is about, so these examples, such as the memory of buns are such that raise a deep pain in myself and I have to think that these mothers absolutely need the therapy to overcome what happened in the early interaction. Then you see the attachment relationship, and if it is not sort of good, integrated, there is no inner wholeness, and when I see it, I feel deep sorrow and seriousness. (Participant 2)
As a phenomenon within the care culture, approval of the vulnerable background became a tool of acceptance and approval in the current moment. Individual staff members managed to approve vulnerability by looking back in time in as wide a viewpoint as possible. It was not a negative way of defining the other, but as a route to viewing their clients as part of a wider life agenda, with limited possibilities in the past, and yet striving for change and something better in the current situation involving suffering. The staff saw that previous attachment experiences influence processing one’s inner life and current relational experiences, and the way of viewing the world. Earlier interpersonal relationships may have had an impact on the current situation so that it seems impossible for the client that others can accept her as she is.

The mothers with a dual diagnosis are utterly vulnerable, and their background meant usually prolonged phases of using substances, addiction and mental ill health. The viewpoint in the specific cultural setting took the whole human with their life history into consideration. This is a much wider aspect than solely a diagnostic viewpoint of the individual or family situation.

Vulnerability touches both the client and nurse

Both clients with a dual diagnosis and staff become vulnerable when they share the question of relationship building and care in the everyday life situations at the low-threshold service. As the staff can see questions and needs in both the parents’ and children’s situations, there are many moments in practice where contradictory emotions may arise. As the worker may be a mother herself, ambivalent feelings may arise:

I am scared as the mother of a small child what life and the world bring along, and at a certain age the pals and relationships with friends have much more importance than heritage and the family, it has given me a lot of thoughts and how it impacts when we do work like this and its impact on my own parenthood. (Participant 3)

If the staff perceive, for example, the parents avoiding their own child, or see moments when the client past vulnerability appears as ambivalence and discord, the staff may be deeply impacted emotionally. Staff may be left with a feeling of wanting to enforce changes and they want to help the children in need by involving them deeply with the parents. In some situations clients shout and show outbursts of anger:

It is a manifestation of trust from the client, that she dares to throw the dung at me, because I still feel at this moment of yelling, that when the situation calms down, we are moving into discussing what occurred, what made you that furious. (Participant 1)

One belief is that good experiences of the client-nurse relationship can be transferred to other situations. In this way the situations raised in the collaboration become items for discussion. Genuine appreciation and a non-judgemental approach in relation to the meetings may enhance the opportunity of clients to carry on in care.

At this site an instant tool is the aim of avoiding pressure and hurry, since pressure and haste can prevent the clients from opening up or solutions being found. In times of worries, the staff may call or visit a family more often and ask what happened, they want to deal with questions as soon as possible after they arise. In order to find solutions, they contact other workers with whom they can discuss and share their thoughts and feelings. As the staff work is personal, and each worker has their individual way of working, it is necessary that the staff as a whole can approve of any methods the individual worker uses. Some questions are dealt with within whole-staff meetings, and require stringency and intrinsiveness, whereas other questions require more sensitivity and intimacy.

The workers’ skill included the possibility to see and hear the full story of their clients, to have the time and resources to be exposed to the entire and full stories of their clients without being numbed, and continuing to approve of the human as such. In this way vulnerability served as a bridge of human co-understanding. The negotiated collaboration included staff tools so that clients would not need to go through sensations of rejection. The main aim was to increase their own sense of direction in life:

I would like to emphasize, that the human considers their position and they do it for themselves, not for us, not to show us what they do . . . . It has importance for herself and it is her life. We try to make it such from the client perspective that the client sees the usefulness. (Participant 6)

It may be possible that staff cannot help such a wide variety of clients involving deep goals for their futures, if they do not recognize the potential vulnerability of their clients in an appreciative and sensitive way. Expertise on mental ill health and substance issues are needed, must go together with a humane attitude towards the client, with the viewpoint of opportunities of life, or know-how such as flexibility and reflexivity. Approval included a stance of norms being personal, and also culturally bound to respect individual choices.

In this kind of low-threshold service we cannot change them, as they come we have to start with, how I can meet with them, I cannot say that you must not do like that or be like that . . . you have to consider those situations from the viewpoint of the client. (Participant 4)

The mothers themselves decide what the next steps are, and staff can only react and take action in relation to the clients’ decisions. Observing and witnessing such vulnerable histories may instil a fear in the staff of losing control.

Negotiating vulnerability

The clients’ needs may be in conflict with what the services can offer. For staff, they have the option of stepping out of
therapeutic client encounters into the staff realm, by closing the door in between the space of the low-threshold service, and the staff rooms. The staff used tools such as being practically precise and logic:

I put all those things I have to take care about in my small calendar, and then I can sort of move it away from bursting me, it will be taken care of, and something I have to talk about with the mother and finalize, makes me get myself as in a package and in order. (Participant 4)

In the midst of many unfinished and difficult questions staff needed to move systematically stepwise. On the other hand, part of the negotiations with clients included requirements of flexibility, because in order to help their clients and adapt to their needs, the staff had to change their own model of being with the person, they needed inner negotiations e.g. on whether to answer their professional mobile phone numbers at times outside the scheduled working hours. Being available was a form of informing the clients of appreciation and value:

Meeting the client has remained and we intend to meet the client, even though it is only for popping in to eat or coming here for a few phone calls, we aim at that personal meeting, so that the client feels that it is good to arrive here and you can speak out. (Participant 5)

The staff may go through moments of despair:

Frustration may appear after you have given a lot of input in a certain family, and then things go backwards. (Participant 3)

One suggested solution was gathering at a network meeting to openly discuss the changes and trying to establish and negotiate the boundaries for collaboration, within the possibilities of the service system. As the social workers in the service delivery system may require abstinence, and the drug screens need to be clean, staff are required to attend, talk and try to connect so that the mothers may see also the good sides in such controls:

Screens, when we take those is decided by the social worker, how many times, and here twice a week, we decide which days, the social worker decides how many times according to the recovery. (Participant 3)

Working with enforced screens requires inner personal negotiations from the staff perspective, since opposing coercion on a personal level may be in conflict with the professional role. In this way the staff become executors of policy, they need to find the means to an end, e.g. placing screens instead of coercion into a frame with the goal of abstinence and as a tool of giving the client another possibility of choice. If the guidelines within the services are not acceptable from the staff viewpoint, or if the client has lied about substance use, the staff can find themselves with an ethical dilemma. The staff may be hurt on a human level if they feel that the client has betrayed them. They have to negotiate in order to build the caring relationship and avoid losing trust. However, this may complicate professional care, since in the midst of the many choices and negotiations, it is the staff who have to make the bigger efforts to solve and negotiate the conflict situations. The ways of discussing and negotiating the difficult aspects are indications of negotiating vulnerability, which may impact the trust in between the client and the nurse.

The caring relationship is not totally equal, because the nurse uses professional power. Any action on the part of the staff requires professional reasoning. In times of relapses negotiations do not suffice, because the choices and actions are ultimately made by the clients themselves. Staff described falling into the ‘mother’s role’, and since they want to aid the client they continued working with them even in these situations. The daily situations raised issues of interpretation and making conclusions, e.g. when a child acted aggressively towards the other children, in times of relapses, if the client is late for appointments and group discussions. For workers, daily situations required becoming aware of what had happened and why.

The negotiations involved ethical reasoning. The worker needed to make decisions and endure constant inner discussions and aimed to find solutions on a both the ethical and practical levels:

We have lately discussed a lot these boundaries among staff, where we are moving and what is right and what is wrong. (Participant 3)

They also had to compromise and try to find solutions, which could be approved by several workers. They needed to adjust between the child and parent perspectives. The goals of work were to be talked about and to be checked. The staff needed to decide on general rules and the possibility to vary a rule individually. The staff needed to negotiate their own feelings of insecurity. Thus the boundaries of deeds became a constant issue of negotiation. The staff met to try to openly discuss their understanding with other staff members and clients, since their own knowledge and observations may have been limited. Even though the staff could use the approval of past vulnerabilities as an approach in their work, they did not have to approve situations of current neglect, since they were also authorities within the child protection services at the same time.

When misinterpretation or information breaks appeared, these also needed action and time, so that solutions could be negotiated together with clients, with colleagues or with other workers in the networks. Staff are bound by professional ethics into building trusting and hopeful relationships, and at the same time becoming involved in a complexity of client choices, possibly filled with hopelessness and despair. Staff are bound strongly to the client’s own will and choices, since change cannot be imposed from the outside, but from within the human. Client choices are linked with the safety of their children, and professional ethical considerations are required as an univocal part of everyday work. Negotiations are needed to direct care, to focus, and to create consistency.
Carriers of pain

The staff needed be deeply involved in the client’s world, and use humaneness and understanding, but on the other hand, they needed knowledge in order to distance themselves. Thorup et al noticed that nurses saw distancing themselves from their own needs as a duty, irrespective of their painful experiences. The staff in the study used everyday life events and daily routines, such as having meals together therapeutically, in constant moments of connecting:

We could meet them and embrace their pain, whatever they want at that specific moment. We could help and carry the bad experiences, we could help and modify the content according to our own knowledge and skills and experience.

To carry the grief, in the same way as if we would have a child, we would carry her, they could carry the child, and we carry them both. (Participant 2)

In order to embrace the client’s pain, they had been required an inner personal process to endure emotions such as jealousy, being abandoned, or feelings of inferiority. Constantly, the everyday situations raised emotional reminding. Staff felt they were co-experiencing the emotions of the mothers and in order to make progress in this complex context, the staff described they had to stop the routines many times during the day, to keep their thoughts together. The clients may remind the staff of issues they themselves never had the possibility to grieve. Staff want to transfer the emotion of being cared for, so that the clients can care:

As workers we sort of give, feed, tolerate the anger and pain and that they leave their food untouched on the plate, and many times we say that you could take the plate, but we cannot insist requiring that the client behaves as an adult at once, but she would also be allowed to be insecure here. (Participant 5)

Staff need to create a boundary between the vulnerability within themselves and the therapeutic context. As the staff need to be available, present and believe in the chances of a human being, they need to create inner boundaries in order to protect themselves. The staff had to come close, and at the same time distance themselves, and to be fully aware and sensitive and at the same time to cope with the worries of the client. They had to be attentive and open to any event occurring, so that they could use this as a discussion topic in negotiating vulnerability. The responsibility of the worker and client differed so that the client was ultimately responsible for their lives and the workers were assistants, with a professional responsibility of dignity, reflexivity and the role of searching for solutions in the meetings of sharing and doing together. This led not to co-suffering the client’s pain, but to carrying the pain. As a carrier of pain, a person sharing the vulnerability can feel like a translator who tells the client what happened in a network meeting, and on the other hand, opening the person’s life events, what is actually happening now, to others in the support network.

Discussion

Working with complex psychosocial needs create a relational power between staff and the clients. Thus creating a true reflective stance and positive regard, and being open to the power of relationships in care may enhance keeping the relationship on a non-judgemental basis. Non-acceptance of this power relation may distance the client and become a source of controlling from the staff perspective. Lakeman described the importance of humans experiencing being met, and warned of connections with humans becoming instrumental or mechanistic, if diagnoses are followed solely by medication and if the person and unique psychosocial context are ignored.

An understanding of the client’s lifeworld and acceptance stems from the view of vulnerability in time and being touched by vulnerability in such a form that the pain is not overwhelming. The approval of the other allows for compassion, empathy and sensitivity to flourish. The staff were required to act in situations of cultural sensitivity. Vulnerability can be considered a common human condition and tells about a shared human frailty. If vulnerability is seen as a subjective risky experience threatening well-being, nurses act to change the external environment to reduce the risks and control the client. This argumentation is in line with Lakeman, who noted that focusing on problems and diagnosis solely may lead to a situation where staff prejudice in advance the situation of the client. In contrast to the argumentation by Sellman, vulnerability did not appear as a paternalistic, protective and harmful feature in this study, but as a way of approving and seeing the full person with life struggles, with an open-minded viewpoint. Openness was described by Lakeman as unknowing, which requires sensitivity and understanding of a person’s experiences in their world. The empathetic and compassionate way of meeting the other gives the client their say and responsibility in their life context.

Hearing the unpredictable in severe life histories may raise questions of insecurity from the staff perspective. These moments may become overwhelming for staff, and staff may want to protect themselves from such feelings, including by avoiding such situations in advance. Vatne noticed that staff may feel powerless in the collaboration if they recognize moments of manipulation from the client viewpoint. The staff in Vatne's study felt humiliation, guilt and shame, if interventions were non-successful. Distancing as relational power protects the nurse, but may push the client into becoming an object.

Meeting clients with simultaneous mental health and substance-related problems includes meeting or confronting difficult interpersonal relationships. Mothers may lack the support from their social network, and from the service viewpoint need help with repairing broken relationships. Earlier experiences of powerlessness in relationships may involve mistrust, guilt, a feeling of exclusion, fear of being left alone and abandoned. This is why
the staff needed to reach out for the clients in order to establish a relationship, which can help the client on several levels. The caring relationship is a result of interplay between client and nurse, which results in contact and commitment on both parts. If the negotiations are not successful enough or satisfying, both the client and staff member could be involved in creating barriers in care. Either can create barriers, which would cause non-understanding. Obstacles or misunderstanding may occur if clients do not have the words to express their needs and problems, whereas staff may look at verbal expressions as a prerequisite to facilitate participation with in-depth discussions and exploration of their worldviews.

Both the client and staff have control over factors that will increase or decrease the rate and level of involvement on both parts. It is the staff’s task to look for solutions in favour of their clients. Staff have to strive to build relationships, and simultaneously they have to endure and co-experience emotional pain and suffering. In this setting the opportunities for change are co-created, and the main goal is that the client becomes more and more intertwined with her own life opportunities. In practice the cultural phenomenon at this site was approval towards the clients.

When looking at the findings from the perspective of Chinn and Kramer, nursing’s knowledge pathways, the findings focus on personal, ethical and aesthetic levels. The meaning of professional knowledge within substances and mental illness, dual diagnosis can be learnt, but the meaning stems from personal reflection of the theories. It is also about how aware the person as a worker can be in the specific situation. In their theory, the actions within specific situations are called aesthetic knowing, and these may involve transformative aspects. The ethical level is about which choices are possible and why, and provides direction-taking. One might ask what has occurred if not all the different aspects of nursing’s knowledge pathways are implemented at the practical level, since some clients do not seem to fit into the systems of care.

If the sensitive and approving approach is an ability, perhaps the solution lies within the individual workers? As understanding is a complex process within situations of care, a reflexive and open stance appeared so that the working conditions are not too much to cope with on a personal level. Perhaps working with the most vulnerable clients is not suitable for all workers within the services, and thus the working method has also limitations. Limitations appear within the negotiations, when the client and staff viewpoints may collide. In these moments the staff needed to use professionalism, to use the knowledge base stemming from their training. The workers are mediating between the care context and broader social, cultural and economic factors. Thus the services need to support the staff so that they are allowed to work with a stance where facing complex vulnerabilities is possible. It is up to the staff within mental health nursing to aim to grasp the deeper meaning of the client by reflexivity. Reflection is a central tool in order to process self-awareness, understanding of own prejudices, or dealing with the uneven power distribution. The viewpoint may have implications also for combatting stigma.

**Method and limitations of the study**

The data collection in the field and previous study phases were informed by a phenomenological tradition within ethnography and a lifeworld approach. The search for meaning from within the context connected the two approaches. The context was complicated, and thus the methodology had to account for the complicated constructions and processes of subjectivity in cautious and systematic ways, thus the focus was on the detailed intentions explicated by the workers and observations within the care setting structure. The difference to an ethnographic viewpoint was in the level of interest. Both methods use pre-understanding as a tool in the research process to give the participants their voice.

The Consolidated Criteria for Reporting (COREQ) checklist was used to evaluate the study. A limitation may be seen in that the study is based on staff interviews and observations of staff in a single clinical setting, the citations represent half of the interviewed staff members. However, the findings were discussed via previous research, and the results are an interpretation. A limitation is the single data coder, and participant feedback was not used at the reporting stage.

**Conclusions**

The interest and area of exploration of the study were the tools staff have used to continue working amongst vulnerable clients with many kinds of complex problems (so-called dual diagnosis). The tools used were described – professionals need to approve of their clients, and their vulnerable backgrounds in order to increase understanding, and to continue maintaining empathy. Empathy and therapeutic availability are ethical professional imperatives, which may not be maintained without a personal inner and humane interest. As professional ethics is intended to protect the rights of clients, there is a big need to discuss how professional ethics could and should protect staff so that nurses can continue being humane. One tool for redirection was recognizing vulnerability, since suffering became understandable in negotiations, with the possibility for growth and a descriptor of complexity. Vulnerability could include a common humane trait and kinship between the client and the worker, as a bridge of common human understanding and approval. The staff had recognized and developed tools to keep compassion, empathy and sensitivity as active tools. The staff attitude was positive towards the clients, they approved of the client’s background by looking back in time and searching for understanding. Vulnerability appeared as a common pain, which touched both the staff and clients, and needed to be negotiated. A staff tool was the capability of carrying the pain, not being overwhelmed by it.

The study highlighted that approval of the clients as individual persons is a way to increase positive regard
toward clients with a dual diagnosis. This may be challenging if staff members do not have training within mental health and substances. In this study the approving approach was gained via looking back in time and a merged comprehension, and involved a perspective of the human within a longer life struggle. A strength in the approach described is the supposition that creating positive relationships may help the client in reconciling with past histories of non-connectedness and vulnerable relationships. The supposition was that the created relationships would transfer into the use of the clients so that they would learn tools to relate in a new way towards their children.

**Implications for practice**

The nursing staff need to further develop skills in connecting and negotiating with clients with complex problems. The work tool is an attitude requiring openness, awareness, reflexivity, as well as communion with other staff members. The themes explored in this study warrant further research in order to continue working with compassion, empathy and sensitivity especially with the most vulnerable clients. Using their own personality as a tool in order to be able to connect with and meet with vulnerable clients is a challenge for training of nurses, as well as nurses practicing care. There is a need for balancing of personal and ethical roles with professional requirements.

**Acknowledgments**

I would like to thank Professor Päivi Astedt-Kurki for her support during this project, and the clients and service providers who participated in this study.

**Funding**

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

**Declaration of conflicting interests**

The author declares that there is no conflict of interest.

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