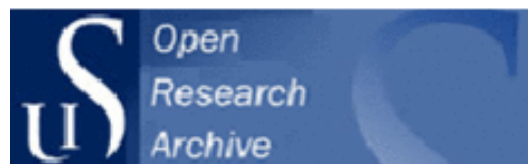




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Ellen Ramvi

THE RISK OF ENTERING RELATIONSHIPS: EXPERIENCES FROM A NORWEGIAN HOSPITAL

This article analyses how nursing students being trained in a Norwegian hospital interact and communicate with their patients – a task that seems to be one of the hardest of all for the students. Based on data from a fieldwork study, the article investigates the development of empathy among student nurses. In doing so, it addresses the concept of a social defence system developed by Isabel Menzies Lyth, who referred to a hypothetical construction describing certain features of a nursing hospital such as a high level of tension, distress and anxiety among the nurses. The findings point to the fact that the nursing students were constantly in danger of losing their focus on the relational aspect of their work; instead, they were being drawn towards an instrumental nursing style. This took place despite the conviction that ‘creating a relationship’ was one of the most important dimensions of being a competent nurse.

Keywords: learning from experience; empathy; nurses; student nurses; social defence

Introduction

This article is based on previously conducted fieldwork, and has the aim of studying the development of empathy among student nurses training in a hospital in Norway (Ramvi, 1996). Being there as a researcher in the field I had two main sources of data, my own experiences and the ones told to me by my informants. I saw and heard the students frustration and confusion in relation to all the activity in the hospital unit, and I had the same feelings myself of being there and trying to obtain the most salient data. One of the first observations I was struck by was the lack of naturalness in the behaviour of the nursing students, as it seemed as if the simplest rules for polite behaviour in making contact were put aside. The students were unsure whether it was correct to greet the patients or not, and they even thought it was difficult to talk to the patients at all. One student said: ‘Just to say something to the patients is artificial and stiff. Just to say their names when I distribute the medication and another nurse is listening is difficult. I am afraid to sound stupid and say something wrong.’

It was the interaction and communication with the patients that seemed to be one of the hardest tasks. One student reflected on this together with her teacher: ‘Someone died on my night shift. There was so much we didn’t know about him, what he wished for, if he wanted us to read from the Bible and so forth. We didn’t know anything about him. Then I thought, we should have asked more when we had the opportunity. I stood beside him when he died without any clue of his needs.’ However, another student nurse told

me she had felt a deeper contact with one patient. The reason for this contact was the time spent in his room. She said they 'got used to each other' and she started to feel 'trust'. But the student was not responsible for that room anymore because they had changed groups. To understand this, we have to know that the unit was divided into three groups according to the patients' room numbers, with eight patients in each group. The nurses were also divided in three groups, and every sixth week the group of nurses exchanged the groups of patients, which is an ordinary way of organizing care in a hospital unit. I asked how the student nurse felt about that and she replied: 'I can't attach myself to the patients. I have to follow the rules in the unit.'

As is briefly shown one of my final findings in the study was that the nursing students were constantly in danger of losing their focus on the relational aspect of their work, and instead were drawn towards an instrumental nursing style. This happened despite the conviction that 'creating a relationship' was one of the most important parts of being a competent nurse.

Menzies Lyth used the term social defence system (Jaques, 1955) in her classic article from 1959, referring to a hypothetical construction that described certain features of a nursing organization. In her investigation, attention was drawn to the high level of tension, distress and anxiety among the nurses in the hospital. She said in order to understand this, it was not just the fact that by the nature of her profession the nurse is at considerable risk of being flooded by intense and unmanageable anxiety, but that it was also necessary to direct attention to the techniques used in nursing to contain and modify anxiety.

In this article, I want to address the concept of the social defence system used by Menzies Lyth 50 years ago to see how this concept may still be applicable for nurses working and training in today's hospitals in Norway.

Student nurses' clinical training

In Norway, a nurse obtains her license to practice after three years of bachelor education in a university or university college. The mandatory National Curriculum Regulations for Nursing Programmes guides the training, which is intended to ensure a high national academic level so that the programmes are consistent and recognizable regardless of the institution. The curriculum regulations lay down the objectives and aims of the programmes, as well as their scope and content, and provide guidelines for organization, working methods and assessment agreement. The nursing programme gives 180 credits, of which 90 credits (50 weeks) are clinical training. There are different mandatory areas of clinical training such as hospitals, the municipal health service and mental healthcare.

This article is based on a project in which I studied student nurses in their second year of education over the course of their nine weeks of practical training in medical units in a hospital. For each period of specific practice, operational goals for relation competence (handlingskompetanse) are determined in accordance with the national regulations. The goals are also defined by the student's readiness and accessibility to learning situations. On

the evaluation form, we can read goals such as: 'Displays ability and desire for empathy toward the patient and relatives' and 'Communicates purposefully with patient and relatives.' One student wrote these personal goals in relation to the training: 'I have to develop my holistic view of humanity and empathy, recognize and accept the patient as he is and encounter the patient as a fellow human. Be more secure in my communication with the patient.'

The assessment of practice is continuous and compulsory for practical training, with the assessment and instruction connected to the goals for relational competence. Both a teacher from the nursing programme and a nurse from the hospital unit (a 'contact nurse') are responsible for evaluation and instruction. When the clinical training starts, the three of them meet to discuss the student's goals for the period. They meet again for an evaluation in the middle of the period and at the end of the practical training in the unit. Besides this, the contact nurse is responsible for the daily guidance and support of the student in face-to-face encounter/situations with patients. Additionally, the teacher from the programme meets with the student in the unit for instruction.

Conditions for the development of empathy

This organization of clinical training gives several basic conditions for the development of empathy. Before outlining these conditions, let me start by giving my account of the concept of empathy. In the framework of object relations theory, the early mother – child relationship is the model for achieving an understanding for the development of empathy. Bion's (1962 [1991]) metaphor of 'container-contained' symbolizes the experience of being taken care of and caring in the sense of emotions in the early mother – child relationship that help us understand the development of empathy. The mother (or other care giver) must have the ability to receive the child's projected ambivalent or intolerable feelings, and contain them. Then the mother returns these feelings in a 'digestible' form so that the child can gradually contain them him/herself. This way of 'thinking with feeling' (Williams, 1998) can be a description of empathy. In certain circumstances in life, we all need another person in order to be able to understand 'the truth' about ourselves.

Bion understood these early unconscious communicative processes between mother and child as a kind of normal projective identification. To understand the concept of projective identification, we need to understand the concept of splitting. Splitting is a primitive type of defence against anxiety, and refers to early life in which the infant is not able to contain difficult emotions, but instead resolves ambivalence by splitting contradictory feelings into 'good/bad'. In the process of projective identification, the child splits both good and bad objects and inserts these parts of the self into the mother to be able to experience or control these parts through the mother. Hinshelwood (1991) claims that normal projective identification allows us the possibility of understanding empathy. 'Putting oneself in someone else's shoes' is a description of empathy, but it is also a fantasy of the type of projective identification of 'inserting oneself into someone else's position'.

Winnicott's (1985) concept of 'the capacity for concern' is closely related to this understanding of empathy. To develop the capacity for concern, a child has to

experience that his/her feelings of hate and anger are accepted and can be forgiven by the person the feelings are directed towards. For the child, this leads to an experience of being a person that can let hatred be replaced by love. The child develops the capacity to recognize both negative and positive sides in his/her mother and through that also him/herself. However, it is a lifetime challenge faced by every human being to integrate both positive and negative feelings towards oneself and others. The greater the problem we have with such a two-sided view, the less our capacity to care and concern. According to Bion, the capacity to remain sensitive to both positive and negative feelings provides an opportunity to understand the complexity of relationships.

The knowledge one acquires from empathy is global, intuitive and often happens unconsciously (Fog, 1994). Holm (1995) emphasizes the importance of 'seeing' the other in the process of empathy, as one has to take interest in the other as a unique human being. If empathy means being kind and friendly it is not necessary to 'see' or show interest in the patient. I do not apply an everyday understanding of empathy in this article. Here, the concept refers to a recognition and communication of emotions. In other words, a way of thinking about 'the other' that includes emotions.

So let us recognize how the hospital training gives the students the proper conditions for a development of empathy. First and foremost, the hospital gives the students rich access to various emotional experiences. To develop the ability for empathy, the student nurses have to be able to contain difficult emotions and tolerate uncertainty. It is therefore an important condition for the students' development of empathy that a stable relationship is set up between the student nurse and the contact nurse. Ideally, this relationship could have the characteristics of a 'container-contained' (correspondence to Bion, 1962). The student could use the relationship with his/her contact nurse to vent his/her frustration over difficult experiences with patients. The contact nurse could receive and 'digest' the difficult emotions experienced by the student and give them back to the student in such a way as to be able to contain his/her own feelings. The more the student is able to contain his/her own difficult feelings, the more he/she will be able to demonstrate an emphatic understanding of others.

Another important condition for development of empathy given in the clinical training is that the care function is highlighted, both in goals and as criteria for evaluation of the students. Student nurses are motivated to enter 'into relationships' with their patients in order to learn, and their teacher and contact nurse support this. For example, one student said in her first meeting with her teacher and contact nurse: "I have to enter into situations with patients, even if I think it is scary. I have a tendency to withdraw". The contact nurse replied that she wanted the student to "use" her, "Just ask me questions and give your reactions" she said. The teacher asked the student if she was able to: "be together with and follow-up on a terminal patient, can you do that? It is difficult, but is maybe a challenge you can force yourself into?" This illustrates how supportive and motivated everyone seems to be to dig into the hard process of learning from experience (Bion, 1962), thereby developing their capacity for empathy.

But what happens when the students meet with reality in the hospital? Through my fieldwork, I observed six students in two different medical units at a hospital. The student nurses were all women between the age of 22 and 37 years. In addition to these six key informants, I also included eight contact nurses and two teachers from the nursing programme. I observed the students in their daily routines at the units, as well as in their meetings with their teachers and contact nurses.

Parallel processes in relationships

My hypothesis, deduced from the theory of learning from experience, was that the students have to enter into relationships to develop their ability for empathy. Because of this, I focused on the student – patient and the student – contact nurse relationships.

Surprisingly, I found that the interplay between the contact nurse and the student nurse could be characterized in the same way as the relationship between the student nurse and the patients. Both ‘pairs’ of relationships could be described as superficial, with a lack of focus on the relationship and characterized by randomness in their contact. The communication was characterized by the concrete here-and-now situation. There was a lack of data collection about ‘the other’ and a lack of communication about feelings. The relationships were based on action (the performance of procedures). The following gives more detail about the relationships.

Student – patient relationships

The student – patient relationship should ideally be the ‘place’ where the student can develop her ability for empathy by encountering an emotional experience that lets herself be affected. Ideally, she recognizes and tries to contain the feelings of both herself and the patient. She should be able to distinguish between her own and the patient’s emotions in a given situation. She uses her cognition to try to understand the patient, and lets this understanding (acknowledged both by emotions and cognition) influence her contact with the patient. Unfortunately, reality is not always the same as the ideal.

The overall data suggested that there was little communication between the student nurses and the patients as far as either making contact or gathering data. Early in my fieldwork, I realized that even though the student was not in face-to-face contact with the patient for most of the day, her activities were patient-related: nearly everything she did was connected to patient care, but did not always take place in a face-to-face situation. It was only practical actions with the patient, such as assistance with eating, dressing and personal hygiene, which ‘forced’ the student nurse to have direct contact with the patient. The conversations in these situations were very specific and only about food or clothing.

My observations also indicated that the interactions with the patients were characterized by anxiety. It was not necessarily that the patients were in deep pain or other very emotional situations that provoked these emotions. Just to be alone in a room together with a patient enhanced the anxiety among the student nurses. Let me give a brief example from my field notes:

The student is nursing alone in a room with an elderly man in bed. She is nearly finished helping him with his morning toilet use, and prepares to shave him and brush his teeth. However, the patient seems to have fallen asleep during the care, and the student can’t wake him even though she shakes his shoulder. He snores with an open mouth. This is the only sound in the room, and it makes me very aware of his breath and I feel uncomfortable. It is my impression that the student also feels uncomfortable, in addition to being nervous and uncertain of what to do.

She looks at me, but I have nothing to say. She shuffles around, and then she talks in a low voice and says she thinks she wants to wait with the teeth and not disturb him. I got the feeling that she tried to calm herself by giving herself a voice. Then again, the only sound in the room is the snoring from the old man's open mouth. Sometimes he stops breathing for what seems like several seconds. Nothing is said. Then the student opens the door to the corridor for no obvious reason. There is noise and laughter. I think both of us felt relieved. There is a life out there! The patient suddenly wakes up, looks around and seems confused. The student then brushes his teeth. The door is still open, and the atmosphere in the room is easy and back to 'normal'. Before she leaves the room, she asks if he wants something to drink. He accepts, and in the corridor the student nurse turned to me and said: 'It is terrible to give him something to drink, because I am so afraid he is going to choke.'

This episode describes what it is like to be a student nurse in a hospital. Every little experience is hard to contain, and it is easy to feel uncertain and afraid. The student nurse never talks to anyone about experiences like this. In addition, the situation appears to be in huge contrast to expectations from the students themselves and others in terms of what type of situations the student nurses will have to enter during their training, e.g. being able to communicate with terminal patients and their relatives.

The relationship between the patient and the student nurse is regulated by both conscious and unconscious feelings. An illustration of how the students unconsciously defend themselves against anxiety and unbearable feelings could be the example of the student nurse who did not talk to the patient about how he felt by being diagnosed with cancer, because as she said, she understood him as 'calm and confident'. Consequently, she just concentrated on the practical/technical aspects of caring for him. My interpretation, however, was that the unacknowledged anxiety of death held by the student nurse was unconsciously recognized by the patient who then has had his own feelings exaggerated. On an unconscious level, the patient may appear to be calm and confident to 'rescue' both himself and the student nurse from unbearable feelings.

When a student nurse and patient share the same unbearable feelings, I could also recognize that the student nurse tries to 'help' the patient and herself by attempting to escape from the unpleasant feelings, e.g. by talking with a cheeky tone such as 'don't worry, everything will turn out well'. Or the student nurse projects her feelings onto the patient by saying: 'I don't think the patient wants to talk about it ...'. At the same time, the student nurses often pointed to an ethical principle of showing respect for the patients' integrity as a reason for not entering into a relationship or asking too many questions.

In other words, the student nurses struggle to distinguish their own needs from the needs of the patients. Unconsciously, they tend to view the situation in light of what satisfies their own psychological needs instead of those of their patients. The student nurses were often not able to contain the feelings awoken inside of them by the patients and defended themselves against those feelings, with the consequence being that they would reject the patients.

The students choose 'safe' tasks. Conversations and closeness to patients are not a 'safe' area for students. I have explained how the students wish to avoid relationships for 'inner' reasons. However, it is easy to understand that they want to withdraw the

interpersonal, patient-centred nursing role for other 'external' reasons as well. The role is not just psychically straining, but has little status, little reward and is invisible. On the other hand, the performance of technical care seems complicated, and mastering the technique makes one feel proud and professional. In the hospital, the nurses are qualified and rewarded for a practice deduced from the ethical principles of natural medical science.

Student–contact nurse relationships

Data have revealed that the relationship between the contact nurse and the student nurse was also not ideal. Their relationship did not represent a 'space' in which the student nurses could process the feelings that emerged from their encounters with patients (as in container-contained, Bion, 1962).

My data showed that the students were often alone in a setting with the patients. And when the contact nurse was together with the student and the patient, having polite, informative communication with the patient was stressed, in addition to the practical/technical care aspect. For instance, the contact nurse explained what was important to observe, and showed the student how to do a new procedure such as dressing a wound or inserting a catheter, but did not focus on the emotional aspects of the encounter between the student nurse and the patient. As far as I could observe, the contact nurses did not let the students listen when they communicated with an anxious or terminal patient, or when talking with patients they wanted to learn more about.

My observations indicated that there was a lack of depth in what the students learned and reflected upon. One of the students said to her visiting teacher: 'What needs more than a quick answer is no use asking the nurses on the unit.' She they were only allowed to ask questions such as: 'How do you do that?' or: 'Is this the right way to do it?'

My data demonstrated that the student nurses absorbed the practices of the other nurses, including their way of distancing themselves from the patients. Thus, the interplay between the contact nurse and the student nurse was characterized more by mutual defence mechanisms than by empathic processes. An example of this is an assessment conversation in which the contact nurse and the student put a lid on the problems together. The contact nurse, the teacher and the student nurse were gathered to evaluate the student in the middle of her practice period:

Contact nurse: The student is clever and attentive in protecting the patient. Everything is going very well, and she is easy to collaborate with.

Student nurse: I think it is difficult to know if I or the other students should enter into situations when the next of kin are sent for, or the patient is very ill.

Contact nurse: The student thinks about her limitations. This is as important as the opposite – to risk everything. You see your limitations. It is very good to think the way you do.

Why in this situation is the contact nurse so eager to support the student in not interfering with relatives and very ill patients? Earlier I observed the student withdraw

from these situations, and in my view her reaction was a defence. She used an argument about the patient's integrity, while at the same time protecting herself from the emotional experience of interacting with the patient and his relatives. I later asked the contact nurse about our different interpretations of the student, and the contact nurse told me that she herself thought it was difficult to know how to talk to patients and their next of kin. She had learned by 'eavesdropping' on other nurses when they talked to patients. "One has to be prepared for emotional outbursts," she said. She had herself experienced a wave of sobbing on a night shift when a young man died and her task was to call his wife. "We have no conversation group or anything, and I have thought about that sometimes. I don't feel I need it, but there are so many newcomers, and it has struck me many times that we may need something like that (a conversation group)." The nurse said she did not "recognize" that she protected herself against emotions at work. However, it is exactly the feelings that she is not able to recognize that can become a social defence.

Social defence system

Bion's theory of learning from experience (1962) includes the fact that we do not always want to know. He says that we unconsciously avoid or resist knowledge, and that a failure to learn from experience is linked to a fear of thinking. According to Bion, to learn from experience we need to put in some hard mental work – we must be able to recognize and think about our own emotions.

On the basis of my study, it may look as if student nurses (and nurses) struggle to endure the pain and frustration associated with their relationships with the patients. Feelings are separated from experience (as in splitting), and therefore they cannot become thoughts according to Bion. The work of a nurse is of such a nature that it can lead to mental pain, thereby potentially giving rise to what Bion (1961 [1996]) calls basic assumptions, which has much in common with Jaques' concept (1955) of social defence systems. Menzies Lyth (1959 [1988]) applied this concept in her studies of nurses at a hospital. A social defence system has an individually inner origin, which one envisages as projected and given an independent existence in the social structure and culture of the organization according to Menzies-Lyth. Social defence occurs when a group of people unconsciously collude to protect themselves against anxiety and tension at their workplace, often at the expense of carrying out their main tasks. In other words, the social defence system is all about how organizations can protect against mental pain. Menzies-Lyth, however, made it clear that she did not think of the (nursing) organization as an institution that carried out this defence, since defence can only be carried out by individuals. She said that behaviour is the connection between the individual's mental defence and the institution. The psychoanalyst John Steiner (1985) describes a function which he calls turning a blind eye. The social defence system can be about turning a blind eye to difficult emotions, topics or relationships. The result is an undermining of necessary activities and genuine emotions.

As evident in the material, the students are confronted with the social defence system at the hospital through their contact nurses. The contact nurses focused on and were a role model for the student in terms of being a polite nurse, giving information and good technical care to the patients. This is the social defence system in practice. The emotional aspect of the work was made invisible and the connection between the nurse and the patient was turned into something practical with regard to everything other than emotions.

The basic mutual conflict for everyone working in a hospital is that the relationship to the patient calls forth feelings that are hard to contain. The shadow of death is everywhere in their daily work. The nurses receive little help in regulating their emotions towards their patients. They may have difficult experiences from their own practice as student nurses in which the effort to come close to the patients became a difficult and lonely experience. It is easy to understand that it is hard for the contact nurse to 'hold' (Winnicott, 1985) or contain the student when she is not 'held' or contained herself. One of the contact nurses said: "It is always something that torments our conscience, whether it is the students, the patients or the next of kin."

It is my interpretation that the nurses unconsciously build a common social defence to manage guilt and other unbearable emotions. Through projective identification, the nurses are colluding about keeping a distance with difficult feelings, and this often means relationships with the patients, the next of kin and the student nurses. Everyone avoids engaging in emotional topics.

In my view, the nurses in the hospital externalize their feelings of helplessness and inadequacy to the nursing school and the teachers. One nurse said: "There is nothing wrong with my relationship with the patients. It is the demands from the nursing school that fail. In the school, they don't understand us here in practice. They are over focusing on care to the patients." The nurses then identify with the school's inadequacy and are able to direct their anger and frustration connected to their own feelings to that inadequacy. This enables an immediate, but short reduction of tension. Nevertheless, the nurses' own pain and anxiety will not be counterbalanced, but intensified in the long run.

When the student nurses are training at the hospital, the social defence system comes under pressure. The students enter the hospital with a 'mandate' to focus on their relationship with the patients. The students and their teachers pick at the nurses' 'bad conscience'. Both the students' and teachers' questions are challenging the 'agreement' among the nurses to keep their emotions at a distance.

It is as difficult for the student to contain the emotional experience of helplessness and inadequacy as it is for the nurses. One interpretation is that the student nurses are split between the concept of good and bad, in which the nurses receive the idealized projection (the good) and the nursing school becomes the bad. In conversations with me the students said such things as 'the school is over focusing on relationships', whereas others talked about the 'gap' between theory (the school) and practice (in the hospital) and some even claimed that the ideals in the school were "incompatible with the real world". The need to split between good and bad has to be seen as an immature way of responding to a stressful situation.

An unconscious defence intertwined with a system of efficiency

Norwegian research suggests that the most salient motivating factors among student nurses going into nursing are the helping aspects and a desire to have a positive contact with people (Jensen & Tveit, 2005; Rognstad, 2002; Abrahamsen, 2007). However, Rognstad & Aasland (2007) find that after three years of experience, nurses place less emphasis on 'other'-oriented values (for example, the desire to establish positive

person contact). Similar to the findings in my study, research shows that students (Tveit, 2008) and graduated nurses (Alvsvaåg & Førlad, 2007) seem to ask for a more concrete, tangible and definite knowledge in their nursing education, particularly in relation to medical subjects.

There is a concern articulated in some Norwegian research about the decreasing interest for the contact aspect of the nursing role, as well as the health sector appearing cold and distanced (Rognstad, 2007). This situation could be understood as a result of the contemporary external pressure of efficiency and change. In Norway (and every European country), there have recently been added inducements to increase efficiency in hospitals. An all-embracing hospital reform took place in 2002, which requires a system that imposes quite a bit of procedural work, leaving the nurses with little time and space to exercise their clinical judgement and empathic knowledge (see also Rognstad, 2007).

Another approach for understanding the more instrumental and emotionally distant role of nursing is to use this phenomenon of individualization and self-orientation. These are key concepts in attempting to describe a postmodern society (e.g. Sennet, 1998; Ziehe, 2000), and Norwegian researchers have found that self-orientation is one of the characteristics of contemporary student nurses (Rognstad, 2007; Jensen & Tveit, 2005). This self-orientation '... can be at the expense of other-orientated values such as altruism and the desire to help' (my translation, Rognstad, 2007, p. 57).

To understand the condition for the development of empathy among nurses in a hospital, it is necessary and important to recognize the influence of 'external' factors such as the pressure on increased efficiency in hospitals and the possible consequences of a more individualized society. Even so, consideration for the meaning of the nurses' 'inner world' (Klein, 1959) is missing from the Norwegian research discourse, which is what I am highlighting in this article. For the student nurses, many conditions exist for creating relationships with their patients, as is evident in my study, but they did not use these opportunities. To risk entering into a relationship, a nurse needs something more than just the possibility of doing so. The inner resistance is intertwined with the external demands of efficiency, with the result that the resistance against entering into relationships is obscured.

To be able to understand conditions for a more emotionally responsive health sector with a closer contact between nurses and patients, or to put it another way: be able to turn the instrumental rationality to an ethic of care, we have to understand the nurses' needs for protection by an unconscious social defence. In my interpretation of the data, I suggest that the student nurses' development of empathy is blocked as a result of a social defence system within the nursing organization.

The role of a student nurse's training in a hospital represents a dissonance between what the student nurse has anticipated the work to be and what the hospital, the nursing organization or the inner world of the student nurse allows him/her to do. From the inner world of the student nurse there is a need for protection from mental pain, while from the outside world there is a need for efficiency. The same actions, a distance and an instrumental nursing role serve both purposes. It is also possible that contemporary external factors reinforce the social defence system that originates from the inner world. The worrisome reality may be a system that is resistant to change and prohibits the nurses from performing their 'primary task', namely "to accept and care for ill people who cannot be cared for in their own homes" (Menzies-Lyth, 1959m p. 46).

Many of the actions (or lack thereof) I found in my material should not be seen as evidence of incompetence, but rather of the (student) nurses' need to distance themselves from intense emotions. The nurses and the hospital play down or turn a blind eye to the experiencing of anxiety and vulnerability in their relationships. They feel it urgent to avoid feelings of guilt and personal responsibility in relation to their patients. They have developed strategies to keep strong emotions at a distance. Margaret Rustin (2005) also emphasizes professionals' need to avoid guilt, and says that the best way of achieving this is to stop thinking about and avoid giving meaning to these experiences. Rustin (2005, p. 12) clearly expresses this by stating that "Thinking involves the attribution of meaning to our experience. Without a sense of meaning, it is difficult to imagine what personal responsibility for actions would amount to."

As a result of my study among student nurses training in a hospital, I find it significant that the nursing school continues to push the social defence system in the hospital by maintaining a focus on relationships, even if nurses and student nurses call it a 'gap' between theory and practice. By this, the educational system has an important task in contributing to a change of the reality at the hospital.

Besides, the hospital culture must create an understanding of how demanding it is to live in the dilemma between closeness and distance in a relationship. According to my interpretations, there is a need for conversation groups among nurses in which they recognize and engage with the vulnerability in both the (student) nurse and the patient. Such a group could represent the 'holding' environment the (student) nurses need to endure the risk of entering a relationship with the patient. An important condition for a development of empathy is to enable the (student) nurse to see him/herself as a contributor in a relationship of mutual dependency with the patient. The nursing school also has a great responsibility to introduce and help young nurses to start using a way of thinking about nursing that includes vulnerability.

To develop their ability for empathy, the students need knowledge about themselves and their emotions. This type of basic knowledge can probably result in fewer questions about a concrete, tangible and definite knowledge. The knowledge needed for a development of empathy is to be found in a container-contained relationship. The social defence system gives the student nurse protection from a vulnerable relationship with the patient, but does not contain her anxiety as far as allowing her the possibility to learn from experience (see also Ramvi, 2010). A social defence system is rigid and gives no rise to a development of empathy.

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