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Bored Together: The Friendship of "Filling Time" in Child and Youth Mental Health Nursing

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Abstract

In this article, I argue that, on locked child and youth mental health units, friendships can form between patients and nurses. This may occur due to the confined nature of such settings, which gives rise to feelings of boredom. Boredom can be thought of as a stimulus or meaning deficit. Phenomenologically, it may be experienced as a dragging of time, restlessness, and a desire to do something else. Nurses often feel responsible for relieving the boredom of patients by engaging them in conversation or recreational activities. However, this ignores the fact that nurses experience boredom as well. One understanding of friendship, in this context, could be that friendship starts with a mutual understanding of the boredom of the other. Friendship is conventionally frowned upon by nursing regulators. However, in this paper, I argue that their views are based on a particular kind of friendship derived from the Western tradition—that which has normative characteristics and is incompatible with hierarchy. Using both aspects of Western and Confucian thought, I challenge this perspective, arguing that aspects of friendship do indeed show up in nurse-patient relationships and that they are not necessarily problematic. Using examples from my own practice, I aim to show that nurses and patients may involve each other symbiotically in shared meaning-making, especially in confined spaces such as the mental health ward. Nurses and patients mutually participate in a filling of "empty time," demonstrating that even in confinement, there is the possibility of friendship.

Keywords

Boredom, friendship, hermeneutics, Gadamer, mental health nursing, child and youth, health humanities

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Can mental health nurses and patients be friends? For some nursing regulatory bodies, the answer is a resounding "no" (British Columbia College of Nurses & Midwives [BCCNM], 2025). In this paper, I will argue for a more nuanced view, acknowledging the existence of "professional friendship." This is to say that there are different degrees of friendship and that certain qualities of friendship may manifest within a professional context. Throughout this paper, I will use resources from both Western and Confucian notions of friendship to understand nurse-patient relationships differently. Using the context of the locked inpatient mental health unit, I aim to show that friendships *do* form between patients and nurses. One reason this may occur is due to the confined nature of such settings, creating a shared sense of boredom.

Boredom can be thought of as a stimulus or meaning deficit (Loukidou et al., 2009). Phenomenologically, it may be experienced as a dragging of time, restlessness, and a desire to do something else (Heidegger, 1983/1995). Nurses often feel responsible for relieving the boredom of patients by engaging them in conversation or recreational activities (Shattell et al., 2008). However, this ignores the fact that nurses experience boredom as well. As such, one understanding of friendship in this context could be that friendship is accentuated due to a shared affective experience. To cope with boredom, nurses and patients may involve each other in shared meaning-making through humour and play. Life on locked inpatient units can be experienced as monotonous (Shattell, 2007; Shattell et al., 2008) and I suggest that within such conditions, nurses and patients may join in mutual friendship to pass the time together.

Part One: Friendship

The Western View

Helm (2023) described friendship as "a distinctively personal relationship that is grounded in a concern on the part of each friend for the welfare of the other…" (Friendship section). This view of friendship was influenced by Aristotle and the Greek concept of *philia*, which loosely translates as "friendship" or "affection" (Helm, 2023). For Aristotle, while friendships can be pleasurable and utilitarian, they can also be virtuous (Helm, 2023). Many Western accounts of friendship rely on this last idea, tying it to the goodwill between two individuals (Gartner, 2022; Helm, 2023). In their survey of the Western tradition, Helm (2023) highlighted three major characteristics of friendships: mutual caring, intimacy, and shared activity. Caring for the other involves not just mutual action but also mutual feeling. To be a friend may involve an emotional connectedness where experiences such as sadness and joy are felt together. Additionally, Helm (2023) discussed that intimacy is frequently described as a necessary ingredient. This may mean sharing personal stories, interests, or our worldly values. Lastly, as friends, people join willingly in shared activities or goals (Helm, 2008).

Le: The Confucian View

While friendship in Greek and Confucian thought share many similarities, there are some differences. For example, friendship as a shared activity has been emphasized even further in the Confucian tradition. Lambert (2022) stated that in Confucian texts, friendship could be interpreted as an "event-based" (p. 19) concept as opposed to a character-based one. This contrasts with

many Western views of friendship, which attempt to typify friendships into different categories or relate them to moral virtues (Gartner, 2022; Helm, 2023). As an "event," friendship was thought to manifest through everyday encounters, which generate aesthetic goods (Lambert, 2022). An example of this could be eating a meal together with a colleague and sharing a moment of banter. Thus, this type of friendship (*le*) was less about intimacy or selflessness and more about the ways that we co-construct a harmonious experience:

> In the friendship… imagination and personal interpretation play a greater role in discovering and blending the particulars – words, actions, gestures – that generate the aesthetic goods. Practical judgment and cultivated habit are also needed to bring together the elements of an interaction in such a way that interactions are transformed into events. (Lambert, 2022, p. 20)

There is something deeply hermeneutic about this description of friendship. The language used here parallels important Gadamerian concepts such as tact, the play of conversation, and *phronesis*. It seems that *le* is not a normative kind of friendship, but rather, an interpretive one. It is our tactfulness in each social encounter that brings about friendship through the production of pleasure and meaning. The production of such goods is not dependent on whether a relationship qualifies as a friendship, but rather how the two individuals act in a particular moment. Thus, the phenomenological products of friendship attest to its existence.

Friendship: Tying Views Together

While the Aristotelean and Confucian views are not exhaustive, these ideas are fruitful preunderstandings that will influence how I will discuss friendship. In this paper, I will assume there are varying degrees of friendship (Helm, 2023). In conventional speech, this is indicated by terminology such as "best friends," "acquaintances," or "professional relationships" (Caroline, 1993). Instead of taking a hard stance on whether a particular mode of relation actually constitutes a friendship, I argue that there are likely aspects of friendship in each type of configuration. Brink (2022) believed that the Greek concept of *philia* (love) applied to many different types of relationships including family, acquaintances, and colleagues. They suggested that *philia* could even apply to non-human concepts such as an important cause or a cherished hobby. I will also take inspiration from the Confucian notion of friendship (*le*), suggesting that the proof of friendship is in its aesthetic productivity (Lambert, 2022). This framework of friendship will be used in the first half of this paper to acknowledge that aspects of friendship exist between nurse and patient and that these aspects are not necessarily problematic.

Friendship Within a Nursing Context

Friendship is a complex matter for nurses in clinical practice. Many nursing regulators in Canada are wary of the possibility of friendship between nurses and patients and use strong language to discourage them. The British Columbia College of Nurses and Midwives (BCCNM) stated quite plainly that, "Nurses do not enter into a friendship…with clients" (BCCNM, 2025). While this seems quite clear, there remains room for ambiguity. The question of what constitutes a friendship is not expanded on in this document, but what I can surmise from their language is that

friendship is a stable, enduring "arrangement" that we choose to enter, closer to the Western view.

On one hand, the BCCNM's (2025) ambiguity may not be so important. Its overarching purpose is to prevent the abuse of patients, not to define what friendship is. The bottom line for the College is that nurses should never use a professional relationship for significant personal gain. At its foundation, this is based on the idea that the nurse has more power in the relationship than the patient. This is evident in nurses' privileged access and influence over patient information, treatments, and plans of care. While this makes sense, the ambiguity around the term, "friendship" and the directive to never enter into them puts nurses in an uncomfortable position.

This is especially challenging because nursing care involves personal closeness. The BCCNM wrote that nurse-patient relationships are "based on trust, respect, and professional intimacy" (BCCNM, 2025). Intimacy is a characteristic that is common to many definitions of friendship (Helm, 2023). However, the BCCNM (2025) added the modifier "professional" to intimacy to indicate the "[physical], psychological, spiritual, and social elements that are identified in the plan of care" (BCCNM, 2025). They recognize that some intimacy is intrinsic to nursing work. Physical closeness is unavoidable for many nurses and emotional closeness is also common. The "professional" qualifier to intimacy seems to suggest that the nurse's closeness is always used to benefit the patient in a clinical setting.

In line with "professional" intimacy, the "professional" qualifier could also be useful for legitimizing the friendships that occur between nurse and patient. This is one framing that has been present in the nursing literature already (Trygstad, 1986). Speaking to this, Webber (2024) wrote that while "professional" and "friend" seem to be at odds, it is perhaps this tension that holds the concept together. In the case of a professional friend, it is the professional environment that facilitates the friendship and without it, it would not exist. At my own workplace, in the mental health program at a major children's hospital, it is not uncommon for a young child to ask us, "Are you my friend?" One go-to response for many coworkers is "I'm a *friendly* professional." While this is very similar to "professional friend," there is a difference. Turning the noun "friend," into an adjective that describes the "professional" changes the meaning. As a "professional," the nurse manifests in a superior position while still maintaining the ability to be "friend-like." This suggests that the nurse is, in fact, not a friend but rather a mere imitation of one. This linguistic maneuver may be useful from the clinician's point of view as it is congruent with practice standards and sets firm boundaries. However, I wonder if this is overly restrictive and reductive. To say that nurses simply imitate friendships may not be the entire picture. Either way, both "professional friend" and "friendly professional" seem to attest that there are elements of friendship (or "friendliness" if we are being more careful) in such relationships.

Deconstructing Hierarchy

Due to nursing regulatory bodies and concerns around power differentials, there may be a tentativeness or a flat-out refusal to acknowledge friendships that exist within nurse-patient relationships (Geanellos, 2002). Since nurses have power over their patients, they cannot befriend them. This line of thinking seems to have the best interests of the patient at heart, and this is a legitimate concern I will discuss later. However, Papastavrou Brooks et al. (2025) criticized

this by stating that when nurses maintain an emotional distance from their patients, they may also be reinforcing the power differential. They described how vulnerability (a characteristic of close friendships) is discouraged in staff to legitimize the appearance of an all-knowing, infallible professional. From a critical lens, maintaining distance is protective for the nurse. If nurses value their position and status, they may see friendships as a threat to their license, leading to overly strict boundaries. Such a move is alienating for both nurse and patient as their characteristics become reduced to the membership of a particular group. Emotional vulnerability equalizes the relationship (Papastavrou Brooks et al., 2025), acknowledging that both patient and nurse are human beings with unique needs, feelings, and perspectives. Contrary to the conventional narrative, friendship could be understood as way to increase mutual understanding and deconstruct power relations.

The Confucian tradition also provides a useful way of thinking about power in unequal friendships. Confucian thought acknowledged the importance of hierarchy for one's development in life (Lambert, 2022). Lambert wrote that some inequalities are inherent in life (e.g., life experience, expertise, occupation), and a sort of mentorship can occur. As such, some friendships can involve ongoing learning alongside mutual affection. Some of this relates closely to how Gadamer viewed authority, where one pays respects (and gains) from the cultivated wisdom of the other (Gadamer, 1960/2013). In the power relations between nurse and patient, one might believe that it is patients who learn from nurses based on their clinical knowledge. This may be true some of the time, but what is less frequently talked about is how nurses also learn from their patients. Trygstad (1986) noticed that some nurses purposely assume a position of inferiority in relation to their patient. One nurse in Trygstad's study described asking their elder patients for life advice and how such encounters provided meaning for those who were dying. This brings up a salient point that while the nurse-patient situation entails a level of professional inequality, there are likely aspects of the relationship in which the nurse is in the "lesser" position. There may be differences in age, experience, and education that favour the patient. This has even been true in my work with youth. I have learned so many things about the world through the wisdom of young people such as what it is like to ride in horse races, the ins and outs of foster care, and even how one goes about acquiring street drugs. O'Donnell (2012) wrote similarly in his autobiographical memoir, *The Locked Ward: Memoirs of a Psychiatric Orderly:*

> I learned as much from the patients I met in just over seven years as I have in the rest of a (so far) reasonably long life – from teachers, university lecturers, pundits or gurus of any kind. I hope I helped some of the patients a little. I know they furthered my education in many things. The greatest lesson I learned from them was the indomitability of the human spirit. I'd read much about it in fiction and seen it filleted in the movies. But I saw the real thing, and lived beside it, week by week and month by month, in the ward. (p. 340)

Evidently, there are things left untaught in nursing education that nurses may pick up through professional friendship.

One might critique this view by saying that a nurse can simply come to know this from the viewpoint of a professional. We do not need to be friends to acquire this information. My concern would be that, without significant rapport, our patients would close themselves off to us.

Martin Buber (1923/1970) discussed the difference between treating the other as an "It" rather than a "Thou." In the "I-It" relationship, Buber stated we treat the other instrumentally, such that we see the other only superficially and in relation to our needs. On the other hand, the "I-Thou" relation is characterized by a transcendence of our narrow expectations. While this all seems quite aspirational, there is something here to be taken away by nurses. If we simply interact with patients instrumentally, they may respond in kind. Conversely, if we connect with patients beyond the narrow label of "patient," they too might connect with us in a more genuine way. Genuine connection (or conversation in Gadamerian terms) has a solid basis in nursing literature (Barker, 1990; Peplau, 1988) and research has shown that these connections are therapeutic for both patient (Geanellos, 2005) and nurse (Trygstad, 1986).

Friendships: When Caution is Warranted

So far, I have discussed how qualities typical of friendship are beneficial in nurse-patient relationships, despite the presence of a hierarchy. In addition, using a Confucian lens, I showed how hierarchy can facilitate friendship and how the nurse-patient hierarchy is not as clear cut as it appears. While this is supportive of the idea that nurses and patients can be professional friends, I do want to acknowledge that the reason this is frowned upon is the potential for exploitation or boundary crossing (BCCNM, 2025). This is different from saying that any semblance of friendship entails exploitation and should be avoided at all costs. Nevertheless, it is a possibility. While there are clear cases of this, such as financial exploitation, other scenarios may not be as cut and dried.

Earlier, I mentioned that nurses may benefit from nurse-patient relationships through their own growth and learning. Another way that nurses may benefit is through emotional means. Sometimes, the connection is such that the nurse may be helped by the patient. In his book, *The Gift of Therapy*, Irvin Yalom (2017), the existential psychiatrist, described the peculiar phenomenon of a therapist being helped by their patient:

> Even though the patient is not there to treat the therapist, times may arise when the therapist is burdened with sorrows that are difficult to conceal. Bereavement is perhaps the most common sorrow, and many a patient has sought to bolster the spirits of the bereaved therapist… (p. 108)

While this may indeed occur in isolated instances, nurses may need to reflect on whether an ongoing dynamic like this is therapeutic for the patient, given their own difficulties. Nurses and patients may provide each other with emotional support, but the professional context of the relationship necessitates that vast bulk of this is directed at the patient.

Sometimes this is complicated by the fact that patients may feel pressured to give back. Aristotle pointed out that in unequal relationships, the "inferior" party may feel obligated to equalize the relationship through excessive admiration (Pangle, 2002). While this feeling may be valid based on personal and historical ideas of friendship, I do not believe this to be appropriate for a professional one. It cannot be *expected* that nurses will receive back in the form of material goods or immaterial benefits such as learning or emotional connection despite many cases of this happening. Because of this, nurses need to be careful.

Fumerton (2022) stated that friendships may form and be maintained out of self-interest. When taken too far, I wonder if this may lead to unfair dynamics such as patient favouritism. When nurses are charmed by a particular patient based on their demeanor, interests, or established rapport, they may need to consider if they are closing themselves off to the possibility of friendship with others. While it is certainly not a requirement for nurses and patients to be friends, friendliness may affect the quality of care given (Geanellos, 2005). Thus, ignoring certain patients while attending to others out of friendship could be viewed as ethically questionable.

Part Two: Boredom, Confinement, and Friendship

Boredom in patients on locked in-patient wards is a well-documented phenomenon (Binnema, 2004; Shattell, 2007; Shattell et al., 2008; Steele et al., 2013). In this section, I will discuss how boredom related to the inpatient environment might help us understand friendships differently, particularly in the context of the nurse-patient relationship. As no data was collected for this paper, I arrived at many of my understandings hermeneutically, through a review of literature, personal experiences, and interpretations of relevant media.

Describing the Inpatient Ward

As a nurse in an inpatient child and youth mental health program, I have primarily worked on two adjacent wards: a short stay crisis stabilization unit and a longer stay treatment ward. Both wards are locked and while patients may progress to therapeutic leaves off the unit, many patients spend their first days to weeks in the confines of the unit. While days are structured around group activities and a couple hours of school, much of the day is left unstructured. Physically, the environment is quite bare, reflecting a type of safety discourse that prioritizes the management of risk (Slemon et al., 2017). The TV is behind plexiglass and the microwave is bolted down. There is typically minimal clutter as most objects (such as puzzles or crafts) are locked behind cupboards. The windows are unbreakable and permanently shut. The walls are bare, but at times, completed colouring sheets and drawn pictures may be found taped to the wall. Patient belongings are locked away into bins and cell phones are prohibited.

In giving this short description of my everyday workplace, I am struck yet again at how young people are restricted in what they can do. Adolescence is a period of exploration and risk-taking (Steinberg, 2004), thus one would expect youth to find this environment boring. While youth are still constricted in the outside world by school and parental expectations, for the most part, they can engage in activities that are meaningful for them. This is not the case for youth in confinement. For these youth, Bengtsson (2012) wrote that boredom “sits in the walls” (p. 527). It is within this context and within this feeling that I will discuss the friendship between nurses and young patients.

A Short Summary of Boredom

Boredom has often been described in multiple ways, depending on the disciplinary lens. Psychology literature has often painted boredom as a deterioration in attention or arousal due to a lack of stimulus (Loukidou et al., 2009). In describing the nature of the inpatient unit that I work

on, I hope to have conveyed the lack of stimulus that exists in such a liminal space. Other writers, particularly in philosophy, have focused on a lack of meaning rather than stimulation. Heidegger (1983/1995), for example, discussed the boredom of waiting at a train station. While waiting is a necessary act, it is not meaningful in and of itself. In inpatient mental health settings, this is a bit like waiting for discharge. Both patients and nurses ultimately derive meaning as the patient becomes well. However, during the patient's stay, they may spend copious amounts of time waiting and doing nothing (Binnema, 2004; Shattell, 2007; Shattell et al., 2008; Steele et al., 2013).

What is common between the stimulus and the meaning view of boredom is that in both there may be a feeling of time stretching and the yearning for something new. O'Donnell (2012) gave a striking description of this in his memoir as a psychiatric orderly:

> There came a time of little change. Days came and then departed, sometimes strings of them. So many of them, in fact, where so little happened that I was forced to examine the days themselves. Often days came that were thin or set at slight angles to the rest of the week. Raw afternoons were not uncommon, nor mornings that were slightly oblong if you looked at them in a certain light. It was not seldom then that I had the unpleasant sensation of somehow unravelling slowly from the spool. One particular day we were short staffed. We had all grafted in the morning. We had all had shortened morning breaks. We had all done the lunches. And then the afternoon turned out to be sixty-four shades of grey, like a monochrome TV. We were all bored: the patients were bored; the staff were bored. The afternoon, with a slight aftertaste and devoid of any embroidery, sat there like a quite heavy thing and then seeped into evening. (pp. 189-190)

In the boredom that O'Donnell described, there is a sense of "losing the days," so much that one must reflect on what actually happened during these periods (likely nothing). Taken as a whole, he conveyed how this mood permeates the inpatient environment, day-after-day, sparing nobody. What is interesting from this description is that O'Donnell contrasts periods of busywork with times of lull. Moreover, the busywork, seems to be just that: mundane tasks. There is no indication of why they are there in the first place. Mental health units are meant to be places for staff to assist patients in recovering from a mental illness. On the contrary, the only activities mentioned are distributing lunches, taking breaks, and then watching TV. While treating mental illness is the overarching function of the mental health ward, in my experience, most of the time is spent doing other, often mundane things.

Friendships as Coping Together

To deal with such experiences, people turn to a variety of coping strategies (Loukidou et al., 2009; Svendsen, 2005). For example, when waiting for a train, one might read a book, scroll through their phone, or critique the ads on the wall. The affordances of the environment may influence what coping strategies are available. On locked mental health units with minimal enrichments, activities to cope may be limited. Nevertheless, what seems to be an option for many patients is social interaction. Talking is one of the most basic ways to "fill time" and requires no specific "equipment." All that is required is two or more people in the same space. Indeed, this is how the two main characters pass the time in Samuel Beckett's (1954) play

Waiting for Godot. The entire play takes place on a country road with no notable features except for a single tree. In this void-like landscape, as the two characters await the arrival of Godot, they engage in idle chatter to pass the time. They tell lewd jokes, share stories, and commiserate. This is not unlike the social landscape of a locked inpatient ward.

These types of units may lack in material objects, but they do provide something very important to friendships: closeness. Certainly, there is physical closeness in the confined space of a locked ward but thinking about the description of boredom that O' Donnell (2012) gave, there also seems to be an affective closeness or rather, a shared experience. While a particular nurse and a particular patient might not be friendly in the outside world, in the cramped, enclosed space of the inpatient ward these relationships may play out differently. Boredom's yearning to do something new may disclose the possibility of a connection.

In engaging with the other, nurses and patients may be able to produce something new. This is important because some boredom scholars believe that boredom is not a primary emotion but rather signifies a lack of emotion (Bench & Lench, 2013). This is consistent with metaphors of boredom which tend to express boredom as lifeless, lacking in colour, or empty (Toohey, 2012). Such words express that there is something missing in our lives and hint at a dull suffering. While mental health nurses see the suffering of mental illness in their patients, they may also see the suffering of boredom that permeates a patient's stay. Asking to chat or play a game is one way for nurses to add colour and meaning into the lives of patients. Likewise, it may also provide meaning for the nurse. I suspect that many mental health nurses enter the profession to therapeutically support others and without these opportunities, they too may fall prey to boredom. Thus, friendship on mental health units between nurse and patient could be seen as a form of mutual affect production.

Affect, Humour, and Play

This idea of creating emotion is in line with Confucian thought and the belief that friendship is an affective event (Lambert, 2022). Simply put, when friends are together, they have fun. This co-creation of positive affect could be seen in many aspects of the nurse-patient relationship, but as I work with young people, it is most evident to me in humour and play.

Humour has been shown to have a positive effect on mental health patients by increasing connectedness and providing a sense of meaning (Kafle et al., 2023). Humour presents in many ways such as absurd stories, puns, silliness, exaggerated expressions, or jokes. In many ways, humour reflects Gadamer's (1960/2013) play of conversation. For humour to be successful, there must be a back-and-forth understanding. Otherwise, we may lose the punchline. Recently, a coworker of mine was asked by a patient, "If you're a therapist, shouldn't you know how to read?" After jousting back-and-forth quips, both she and her patient were full of smiles. A particular intimacy shows up through humour. Take for instance, the inside joke, told over and over again, paying dividends within a particular context, but scratching heads outside of it. Evidently, there is a closeness is that is required for this type of humour to be successful. In my experience, jokes about "the rules," having a mental illness, or the quirks of particular staff members are not uncommon on mental health units. Such conversations would not be possible

without some level of friendship. In the absence of this, such jokes could easily be misconstrued as hostile or insensitive. Indeed, Carroll (2002) wrote:

> … one of the pleasures of friendship is the opportunity to share laughter. [It] reveals something about who we are—our beliefs, attitudes, and emotions and, for that reason, we are often only willing to be so open about our sensibilities around friends. We don't joke with the Pope, though we may tell jokes about the Pope to friends—to friends rather than to strangers, since we usually have no idea about their attitudes about religion. (p. 205)

Play is another way that friendship manifests on locked inpatient wards. While play can be solitary, it is common for many forms of play to involve groups of people. Indeed, for Johan Huizinga (1944/1949), a historian of play, play is a cultural activity that is reflected in all aspects of life, from everyday childhood games to more formal rituals. Huizinga had many thoughts on play, but what is important for the topic of friendship is that he thought play generated a temporally and spatially-bound community. Moreover, when such a community is formed through play, it presents us with an opportunity to "[step] out from real life" (Anchor, 1978, p. 79).

As a mental health nurse, this immediately calls to mind the evenings spent with patients, after all the nine-to-five staff have gone home. In these hours, a perceptible change in mood could be felt on the wards. Watching the daylight fade together, staff and patients often brainstormed about how to spend the evening. Some days, we could not think of anything. We succumbed to the boredom, resigning ourselves to watch whatever was on television. On other days, we were more creative: we baked cookies, had movie nights, built forts, and played games. For the briefest of hours, the air of the hospital dissipated and was replaced by a glint of homeliness. In hindsight, this description of uncountable evenings calls to mind the nostalgia of a childhood sleepover, an activity usually done with friends.

This is not meant to paint a rosy picture. There are many instances when nurses and patients cannot land on friendly terms. McCaffrey (2014) drew from Derrida's concept of *hostipitality* to discuss the ways that hospitality and hostility manifest in different ways on mental health wards. While in popular culture, nursing can be seen as a benevolent profession, on locked wards, nurses can also be interpreted as captors (Bengtsson, 2012) as they hold the keys to the outside world. Both patients and nurses may have valid reasons not to form friendships with each other. For example, they can both be instigators of violence or victims of trauma. Other times, the reasons that professional friendships may not develop may be more mundane. On the nursing end, some nurses may simply prefer more of a technician role. An extreme example of this is "nursing from the desk" where nurses spend their day watching patients from within the station (McCaffrey, 2014, p. 243). For nurses and patients, there may also be irreconcilable differences in language, personality, interests, and opinions. The proximity and the shared affective experience (of boredom) in locked wards may afford opportunities for connection. However, one cannot ignore that there are many other factors at play.

Concluding Thoughts

Perhaps what is so "scary" about professional friendship is that it is ambiguous, complex, and uncertain. There is always the possibility of harm in professional friendships, and the yet same possibility is there with our more conventional friends. The caution tape that surrounds friendships between nurses and patients seems to be justified by the imbalance of power between provider and patient. While the presence of a hierarchy may be true, I discussed that it is not always stable or harmful. Nurses may, at times, position themselves to inhabit the "lower" end of the hierarchy based on life experience, skill, or other factors. Moreover, as Confucian ideas of friendship showed, the presence of a hierarchy can actually stimulate growth within persons. To say that nurses should not be friends with their patients falsely paints such friendships as inherently harmful when they are more accurately described as contextual. The anti-friendship view does not recognize that degrees of friendships exist (such as "professional friends") or that qualities of friendship may exist in each unique relationship. Blanket advice to avoid friendship at all costs may discourage emotional vulnerability between patient and nurse. This may inadvertently reinforce the professional-patient dynamic (Papastavrou Brooks et al., 2025).

The anti-friendship view is also unhelpful and unrealistic for mental health nurses whose very jobs are to form trusting, friendly, and intimate relationships with their patients. The confined quality of a locked mental health ward puts both patients and nurses into an ongoing shared experience—one of boredom and yearning. Under these conditions, patients and nurses may engage in the co-creation of alternative affects through humour and play. In the small acts of "filling time," staff and patients may experience joy, community, intimacy, and friendships. While a hierarchy will always exist, through humour and play, the labels patient and nurse can be loosened and alternative ways of viewing each other are made possible.

With all of this in mind, I conclude with a quote from O'Donnell (2012)'s memoir as a psychiatric orderly, where he described accompanying a posse of patients off the ward for a therapeutic pass:

> Out of the lift we tumbled and along the main corridor we progressed. Gally was in front, striding out, swinging his extendable arms and kicking his extendable legs. Bill loped along behind him in his ocelot swagger, grinning like a turnip lantern, chattering to every passer-by. Lola tripped along next to him on her ludicrous heels, her big stubbly jaw jutting out over her sable coat. And I brought up the rear with Biggles.
>
> People were running away. Jumping into cupboards. Diving behind trolleys. Scrambling into bins and pulling the lid on after them.
>
> All that was missing was a stirring rendition of 'Entry of the Gladiators', a strongman carrying a barbell, somebody dressed as Uncle Sam on stilts and an oiled Levantine breathing fire to make the circus complete. It was one of my favourite moments in all my seven and a half years in the Locked Ward. In fact, few moments in my entire life come close to it. I've never been prouder to be in a company.
>
> And then we passed through the big front doors of the hospital and out into the night, where we turned into winking golden fireflies and vanished in the darkness. (O'Donnell, 2012, pp. 191-192)

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