Time Together: A nursing intervention targeting everyday life in psychiatric inpatient care
Patient and staff perspectives

Jenny Molin
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Department of Nursing
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“To discover new lands, one must be willing to lose sight of the shore for a very long time”

André Gide
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>vii</td>
</tr>
<tr>
<td>SVENSK SAMMANFATTNING</td>
<td>ix</td>
</tr>
<tr>
<td>ABBREVIATIONS</td>
<td>xi</td>
</tr>
<tr>
<td>ORIGINAL PAPERS</td>
<td>xii</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>BACKGROUND</td>
<td>2</td>
</tr>
<tr>
<td>Psychiatric inpatient care</td>
<td>2</td>
</tr>
<tr>
<td>Everyday life as a concept</td>
<td>2</td>
</tr>
<tr>
<td>Everyday life in psychiatric inpatient care</td>
<td>3</td>
</tr>
<tr>
<td>Nurse-patient interaction</td>
<td>6</td>
</tr>
<tr>
<td>Nursing interventions in psychiatric inpatient care</td>
<td>8</td>
</tr>
<tr>
<td>Recovery and the Tidal Model</td>
<td>9</td>
</tr>
<tr>
<td>RATIONALE</td>
<td>10</td>
</tr>
<tr>
<td>AIM</td>
<td>11</td>
</tr>
<tr>
<td>Specific aims</td>
<td>11</td>
</tr>
<tr>
<td>METHODS, Part One</td>
<td>12</td>
</tr>
<tr>
<td>Grounded theory</td>
<td>12</td>
</tr>
<tr>
<td>Context</td>
<td>12</td>
</tr>
<tr>
<td>Participants</td>
<td>13</td>
</tr>
<tr>
<td>Data collection</td>
<td>13</td>
</tr>
<tr>
<td>Analysis</td>
<td>14</td>
</tr>
<tr>
<td>Ethical considerations</td>
<td>15</td>
</tr>
<tr>
<td>FINDINGS, Part One</td>
<td>16</td>
</tr>
<tr>
<td>Quality of interactions influence everyday life (I)</td>
<td>16</td>
</tr>
<tr>
<td>From ideals to resignation (II)</td>
<td>19</td>
</tr>
<tr>
<td>Theoretical understanding of everyday life processes</td>
<td>21</td>
</tr>
<tr>
<td>METHODS, Part Two</td>
<td>24</td>
</tr>
<tr>
<td>Design</td>
<td>24</td>
</tr>
<tr>
<td>The Time Together nursing intervention</td>
<td>25</td>
</tr>
<tr>
<td>Context</td>
<td>25</td>
</tr>
<tr>
<td>Participants</td>
<td>26</td>
</tr>
<tr>
<td>Data collection</td>
<td>27</td>
</tr>
<tr>
<td>Analysis</td>
<td>30</td>
</tr>
<tr>
<td>Ethical considerations</td>
<td>31</td>
</tr>
</tbody>
</table>
ABSTRACT

BACKGROUND Patient and staff descriptions of everyday life in psychiatric inpatient care are consistent, revealing a challenging environment with over-reliance on medication and, power imbalances. Patients and staff ask for the opportunity to develop relationships; however, the literature on nursing interventions targeting these issues is sparse. This thesis comprises four studies with a twofold overall aim. The first part constructs a theoretical understanding of everyday life processes in psychiatric inpatient care, and the second part evaluates a nursing intervention in psychiatric inpatient care.

METHODS Studies I and II used a grounded theory design with individual interviews (I, II), dyadic interviews (II) and focus group discussions (II). Study III used mixed methods, a single system experimental design with questionnaires and a qualitative process evaluation with logs and participant observations. Study IV used a qualitative design with individual semi structured interviews. The participants were 16 patients with experiences of psychiatric inpatient care (I), 36 staff members who worked in psychiatric inpatient care (II), 80 patients and 50 staff members in the evaluated wards (III) and 11 patients who had taken part in the nursing intervention Time Together (IV). In studies I and II the analysis followed grounded theory. In study III data were subjected to visual analysis, percentage of non-overlapping data and qualitative content analysis, also used in study IV.

RESULTS Patients in psychiatric inpatient care experienced everyday life as being influenced by interactions between patients and staff, the environment and the content of care. The quality of interactions was what tied these components together. Having trustful interactions could compensate for an otherwise poor environment and a confusing care content, while adapting to absence of, or obstructive interactions contributed to experiences of the environment as stigmatizing and the care content as confusing (I). Staff had ideals regarding everyday life on the wards but obstacles hindered them from putting their ideals into practice. To cope with this, they appeared to shift their focus from the patient’s best to their own survival. This resignation made it even more difficult for them to work in a way that aligned with their ideals (II). The theoretical understanding that was constructed from study I and II revealed that what patients described as absent or obstructive interactions, or passivity, were mirrored by staff descriptions of obstacles in their everyday life on the wards. Furthermore, what patients described as trustful interactions and satisfying activities were mirrored by staff descriptions of having the patients’ best interest at heart. This is interpreted as when staff is able to focus on the patients’ best interests, improvements in the everyday life in psychiatric inpatient care are possible.

The nursing intervention called Time Together was feasible to introduce in psychiatric inpatient care. The intervention was enabled by shared responsibility, a friendly approach
and a predictable structure, whilst it was hindered by a distant approach and unpredictable structure. Measurements showed no effect on the quality of interactions between patients and staff, but questionable effects on perceived stress and stress of conscience among staff, as well as on staff satisfaction with interactions with patients (III). Patients described their experiences of taking part in the intervention as being seen as a human among other humans, that it contributed to hope for recovery but also, that feelings of distance to staff were fostered when Time Together sessions were not offered (IV).

CONCLUSION By implementing Time Together in psychiatric inpatient care, staff is allowed access to a nursing intervention that can meet patients’ needs for high-quality interactions in everyday life and that may have potential to decrease perceived stress and stress of conscience among staff and increase their satisfaction with interactions with patients. By using joint activities as bridging actions, this intervention could lead to the development of nurse-patient relationships built on reciprocity and engagement, something that is emphasised in recovery-oriented mental health nursing.

KEYWORDS engagement, everyday life, experiences, grounded theory, interaction, interprofessional teams, intervention, mental health nursing, ordinary relationships, psychiatric inpatient care, patient perspectives, single-system experimental design, Time Together, qualitative content analysis
SVENSK SAMMANFATTNING


Metod I delstudie I och II användes en grounded theory design med individuella intervjuer (I, II), dyadiska intervjuer (II) och fokusgruppsdiskussioner (II). I delstudie III användes mixade metoder, en single system experimental design med enkäter och en kvalitativ processutvärdering med loggar och deltagande observationer. I delstudie IV användes en kvalitativ design med individuella semistrukturerade intervjuer. Deltagarna var 16 patienter med erfarenhet av psykiatrisk heldygnsvård (I), 36 personal med erfarenhet av arbete inom psykiatrisk heldygnsvård (II), 80 patienter och 50 personal från de utvärderade avdelningarna (III) och 11 patienter som deltagit i omvårdnadsinterventionen Tid Tillsammans (IV). I delstudie I och II följde analysen grounded theory. I delstudie III analyserades data med hjälp av visuell analys, percentage of non-overlapping data och kvalitativ innehållsanalys som även användes i delstudie IV.

patienternas bästa, då finns möjligheter till förbättringar av vardagslivet inom psykiatrisk heldygnsvård.

Omvårdnadsinterventionen Tid Tillsammans var genomförbar inom psykiatrisk heldygnsvård. Delat ansvar, ett vänligt bemötande och en förutsägbar struktur möjliggjorde interventionen medan ett distanserat bemötande och en oförutsägbar struktur utgjorde hinder. Mätningarna visade inga effekter på kvaliteten i interaktionerna mellan patienter och personal samt osäkra effekter på personalens upplevda stress och samvetsstress samt på personalens nöjdhet med interaktionerna med patienterna (III). Patienterna beskrev sina erfarenheter av att ha tagit del i Tid Tillsammans som att bli sedd som en människa bland andra människor, att det bidrog till hopp om återhämtning men också att känslor av distans till personalen utvecklades när Tid Tillsammans inte genomfördes (IV).

**Konklusion** Genom att införa Tid Tillsammans inom psykiatrisk heldygnsvård får personal tillgång till en omvårdnadsintervention som kan möta patienternas behov av interaktioner med hög kvalitet och som kan ha potential att minska deras upplevda stress och samvetsstress samt öka deras nöjdhet med interaktionerna med patienterna. Genom att använda gemensamma aktiviteter kan relationer som bygger på ömsesidighet och engagemang mellan patienter och personal utvecklas, något som betonas inom återhämtningsinriktad psykiatrisk omvårdnad.

**Nyckelord** engagemang, grounded theory, interaktion, interprofessionella team, intervention, kvalitativ innehållsanalys, patientperspektiv, psykiatrisk heldygnsvård, psykiatrisk omvårdnad, single system experimental design, Tid Tillsammans, upplevelser, vardagliga relationer, vardagsliv
### ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPS</td>
<td>Caring Professional Scale</td>
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<tr>
<td>EN</td>
<td>Enrolled Nurses in mental health</td>
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<td>GT</td>
<td>Grounded Theory</td>
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<tr>
<td>HAD</td>
<td>Hospital Anxiety and Depression scale</td>
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<td>PET</td>
<td>Protected Engagement Time</td>
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<td>PIC</td>
<td>Psychiatric Inpatient Care</td>
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<td>PND</td>
<td>Percentage of Non-overlapping Data</td>
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<td>PSS</td>
<td>Perceived Stress Scale</td>
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<td>RN</td>
<td>Registered Nurse</td>
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<td>SCQ</td>
<td>Stress of Conscience Questionnaire</td>
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<td>SSED</td>
<td>Single-System Experimental Design</td>
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<td>TT</td>
<td>Time Together</td>
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<td>UmU</td>
<td>Umeå University</td>
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<td>VAS</td>
<td>Visual Analogue Scale</td>
</tr>
</tbody>
</table>
This thesis is based on the following papers. In the text they will be referred to by their Roman numerals:


Papers I-III have been published and reprinted by kind permission of the respective journals.
INTRODUCTION

Mental ill-health has been increasing for a long period of time and is considered one of the major public health problems today. In Sweden 2015, 105,000 admissions were registered in psychiatric inpatient care (PIC), which was an increase compared to previous years. It is reported that health care has failed to give people with mental ill-health access to effective, equal, high-quality, knowledge-based, patient-focused and safe care. Furthermore, patients in PIC report experiences of poorer-quality treatment and lower levels of involvement in care than patients in somatic care (Social Board of Health & Welfare, 2015). Consequently, the requirements for the specialised care are both extensive and growing, and the needs to improve current conditions are urgent.

My main professional experience comes from several years working in a psychiatric emergency unit. During those years I met a variety of persons being admitted, voluntarily or involuntarily, to various kinds of PIC wards. A PIC ward should be a safe place for people in need. However, patients and colleagues told many stories that paint a different picture and that led me to reflect on everyday life in PIC wards: what happens there and why? My PhD studies have given me the opportunity to explore this topic, and also the opportunity to influence the prevailing circumstances in these settings.

The ontological and epistemological assumptions of this thesis imply that there are multiple subjective realities constructed through interactions between human beings. To reach an understanding of these realities requires immersion and not just external observation. By entering into the reality of others, the researcher co-creates understandings of various realities. This assumption implies that there cannot be just one truth (Lincoln et al., 2011).

The thesis is ordered following the steps taken during this project and is divided into two parts. Following an overall background description, I describe the two studies in the first part and conclude with a theoretical understanding of everyday life processes in PIC. Then I describe the two studies in the second part and discuss the overall results and methods used in the project. Finally, I present my conclusions, clinical implications and suggestions for further research.
BACKGROUND

Mental health is a central part of health and well-being (WHO, 2013), but an increase in mental ill-health is reported globally (WHO, 2015). The mental ill-health in Sweden is following this global trend, presenting an extensive issue that affects the whole of society (Mission Mental Health, 2016). Globally, there are a range of mental health services: for example, outpatient and day care facilities, as well as community-based residential care facilities and PIC (Lora et al., 2017). PIC is a significant component of health care for people with acute mental ill-health (Jacob et al., 2007), and globally, such care is offered at psychiatric hospitals, as well as at psychiatric wards within general hospitals (Lora et al., 2017). In Sweden, psychiatric care is provided in both primary and hospital care, and patients who are most ill and vulnerable are cared for by psychiatric specialists through general hospitals, sometimes within PIC wards (Mission Mental Health, 2016).

Psychiatric inpatient care

The English-language literature on PIC, which primarily reflects the context of the Western world, is relatively consistent in describing PIC in a manner similar to the Swedish system, even though legal, cultural, educational and economic differences are present.

In general, adult PIC in the Western countries is offered in locked wards where the medical paradigm predominates. Within such wards, patients vary in age, sex and ethnicity and suffer from various mental ill-health, including depression, anxiety, bipolar syndrome, personality disorders, psychotic disorders, suicidal thoughts and addictive syndromes. PIC wards are staffed by registered nurses (RN), some of whom have specialised training in psychiatric care, mental health enrolled nurses (EN), managerial staff and consultants whose time may be divided between outpatient and inpatient care. Psychologists, social workers, occupational therapists and physiotherapists are usually brought in on a consulting basis. In general, routines and rules regarding mealtimes, access to smoking and opportunities to go outdoors determine how everyday life on the wards unfolds.

Everyday life as a concept

The fields of sociology and occupational therapy make frequent use of the concept of everyday life. It includes the ways in which people typically act, think and feel on a daily basis. Everyday life refers to tedious routines, the ongoing march of daily existence, and consists of daily actions that are taken for granted. It is the foundation for human efforts and encompasses components that provide both comfort and boredom (Lefebvre, 1971). Through interactions and communication, we as human beings share the reality of the
everyday with each other, but our perspectives of ‘the everyday’ might differ (Berger & Luckmann, 1967).

Leaning on the definitions mentioned above, this thesis use the concept of everyday life processes to describe how the days unfold in PIC apart from medical treatment, and with the awareness that everyday life in the wards progresses in different ways for patients and staff, the former of whom are there to receive care and the latter of whom are there to perform work. Still, everyday life is the venue for patients and nursing staff in PIC wards, and therefore everyday life is the arena for mental health nursing.

**Everyday life in psychiatric inpatient care**

During the 2000s, PIC in Western countries has been studied through observations and interviews with patients and staff. This leaves descriptions from both outsider and insider perspectives. Overall, these descriptions are complex but relatively consistent across different countries and over the span of the last couple of decades.

Observational studies have shown that the environment for PIC has been described as dominated by control, and patients as being surrounded by disorder (Johansson et al., 2006; Lindgren et al., 2015). Furthermore, staff both held and lacked control; they attempted to master the situation in alignment with organisational demands at the same time as they tried to share the responsibility of caring with patients and next of kin (Deacon, 2003; Hummelvoll & Severinsson, 2001; Johansson et al., 2006; Lindgren et al., 2015). Researchers have reported that patients were controlled by staff, dependent on them and subjected to rules and routines. Patients tried to make themselves heard and reacted to this control by developing counter-strategies; the literature has framed these as expressions of an imbalance in power between patients and staff (Hummelvoll & Severinsson, 2001; Johansson et al., 2006; Lelliot & Quirk, 2004; Lindgren et al., 2015). The traditional power structure has further been observed through artefacts, such as covered nametags, keys, restraint beds and locked doors, which may be camouflaged in the current PIC environment (Berlin & Carlström, 2015).

Researchers have reported that the environment for PIC offered space for various kinds of encounters between people, including various kinds of relationships. Encounters between patients and staff included contrasting qualities, such as respect and flexibility but also lack of respect and mistrust. Patients in PIC developed relationships with each other and turned to each other for support, care and companionship. These relationships seemed to include both supportive and intrusive qualities, which were described as a consequence of the lack of time spent with staff (Johansson et al., 2007; Lindgren et al., 2015).

Studies have shown that most of the time, patients in PIC were socially disengaged and only participated in few organised group activities (Csipke et al., 2014; Folke et al., 2017; Radcliff & Smith, 2007). Furthermore, patients in PIC spent less time participating in
activities than they did 50 years ago (Csipke et al., 2014). Researchers have also reported that less than half of nurses’ time at work was spent in patient contact and that the proportion of working hours devoted to therapeutic interaction with patients, was limited (Goulter et al., 2015; Sharac et al., 2010; Whittington & McLaughlin, 2000).

**Patients’ experiences**

In Western countries, patients’ descriptions of everyday life in PIC are relatively consistent. In previous studies, patients described care as coercive and over-reliant on medication while they longed for dialogue with staff instead of medication. Patients felt disconfirmed when they were not listened to or not taken seriously, and when there was a lack of collaboration with staff. They also described staff as unavailable, which contributed to feelings of disconnection and powerlessness. The power imbalance between patients and staff contributed to negative experiences. In addition, rules and routines were experienced as controlling and as contributing to a lack of stimulation and engagement (Cutcliffe et al., 2015; Johansson et al., 2009; Lilja & Hellzén, 2008; Looi et al., 2015; Rose et al., 2015; Salzmann-Eriksson & Söderqvist, 2017; Stenhouse, 2011; Thibeault et al., 2010; Wood & Alsawy, 2016). Lilja and Hellzén (2008, p. 284) interpreted this as patients’ “struggle for dignity in the face of discrimination and rejection”. On the other hand, Johansson and co-workers (2009) reported that patients also experienced that PIC alleviated their suffering through experiences that strengthened their integrity and self-determination, and that PIC wards provided support and offered a place of refuge.

In previous studies, patients have compared being in a PIC ward to being in a prison or a cage, being cooped up and not allowed to go outside. Patients commented that this provoked frustration and anger in them, which in turn could lead to restraint or forced medication (Rose et al., 2015; Stewart et al., 2015). Researchers have reported that patients also described the ward environment as a barrier, as being impersonal and unwelcoming and as not meeting many of their needs (Wood & Alsawy, 2016; Quirk & Lelliot, 2001). The literature has revealed many descriptions of patients experiencing boredom and feeling caged in by the locked doors. The nurse-patient relationship has also been reported as practically non-existent (Johansson et al., 2009; Lilja & Hellzén, 2008; Shatell et al., 2008; Stenhouse, 2011). Instead, the literature has reported that patients experienced care as mainly consisting of interactions with other patients (Johansson et al., 2009; Lilja & Hellzén, 2008; Shatell et al., 2008; Stenhouse, 2011), something that has been described as either helpful or as an emotional burden (Stenhouse, 2011).

**Staff experiences**

The research literature reveals a consistency in staff descriptions of everyday life in PIC wards. Studies have shown that nurses described medicine as ‘an authority’ in PIC, and did not feel that their knowledge of patients was integrated into the clinical decision-making process (Barker, 2001; Berg & Hallberg, 2000). Several researchers have reported
that nurses cited excessive administrative duties, job insecurity, the nature of patients' problems, staff attitudes, the organisational context and poor management as sources of dissatisfaction with their work (Berg & Hallberg, 2000; Dallender & Nolan, 2002; Johansson et al., 2013; Lelliot & Quirk, 2004; Rose et al., 2015). Shatell and co-workers (2008) reported that nurses described time as a source of stress and experienced pressure and chaos in their jobs. Nurses felt caged-in by the plexiglas-enclosed offices and confined in a prison-like world. Furthermore, they felt pessimistic about the effects of the treatment provided and questioned its ability to help patients.

Studies have shown that nurses described their everyday life in PIC as complex, containing delivery of nursing care, relationships, power and control but also overwork and support (Cleary, 2004; Cleary et al., 2012; Delaney & Johnson, 2014; Fourie et al., 2005; Johansson et al., 2013; Shatell et al., 2008; Wyder et al., 2017). According to these studies, this resulted in challenging environments, characterised by competing priorities and new demands, where nurses had to deliver care from a crisis management perspective. They struggled to fit a changing care philosophy to traditional models of practice within a constantly changing environment (Cleary, 2004; Cleary et al., 2012; Delaney & Johnson, 2014; Fourie et al., 2005; Johansson et al., 2013; Shatell et al., 2008; Wyder et al., 2017). Cleary and co-workers (2012) reported that nurses described ethical issues as a feature of their everyday life on the wards and that at times it were difficult for them to achieve safety and optimal functioning in the PIC ward while still respecting patients’ autonomy. Studies have shown that what most enabled nurses in their jobs was the nursing team and their own sense of self-direction in their roles and, when they were able to rely on their own capacity to act (Berg & Hallberg, 2000; Cleary et al., 2012; Delaney & Johnson, 2014). Furthermore, nurses described leadership, morale and time as crucial components in everyday life on their wards (Gabrielsson et al., 2016; Graneheim et al., 2014; Wyder et al., 2017).

Despite the above-mentioned complexities, researchers have reported that nurses in PIC appreciated the worthwhileness of their work, autonomy, creativity, variety and patient contact as contributing to their overall job satisfaction (Dallender & Nolan, 2002). Several studies have shown that nurses felt a yearning for relationships with patients and thought of this relationship as fundamental in care. However, they felt that administrative tasks and organisational roles detracted from patient contact and that these tasks were so demanding and time-consuming that little time was left for interaction with patients (Berg & Hallberg, 2000; Fourie et al., 2005; Graneheim et al., 2014; Lelliot & Quirk, 2004; Shatell et al., 2008). Furthermore, studies have shown that nurses were aware that the care they provided was less than perfect and that they did not spend enough time with patients. Nurses commented that this left them with complex emotional responses, feelings of frustration, a feeling of inability and concerns that they were becoming deskilled (Fourie et al., 2005; Rose et al., 2015). Gabrielsson and co-workers (2016) showed that when this occurred, and when patients did not receive proper care, nurses felt forced to pursue their own survival.
In summary, research on PIC in Western countries from 2000 to the present paints a consistent picture in patient and staff descriptions on everyday life at the wards. The literature reveals a challenging environment, over-reliance on medication and power imbalances. Both patients and staff describe experiences of being excluded from the clinical decision-making processes in PIC and also feeling locked in. Furthermore, patients and staff ask for the opportunity to develop relationships with each other. Unfortunately, the consistency in the literature indicates little improvement in PIC during the first decades of the twenty-first century, and there are few studies that look into the overlap in patient and staff experiences and understandings of what constitutes hinders and what enables everyday life in PIC.

**Nurse-patient interaction**

Based on the descriptions above, opportunities for interactions between patients and staff in everyday life in PIC seems both critical and complex. The concept of interaction has been defined as an interplay where individuals mutually influence each other and where their actions create conditions and support for the relationship (Nilsson & Waldemarsson, 2016). Because communication has been identified as a feature of human interaction, the influence is transmitted through language, gestures and symbols (Watzlawick et al., 1967). Nurse-patient interaction falls under this definition, and has further been defined in terms of nurses’ multidimensional role within the interaction and its aim of improving the patient’s health (Evans, 2016).

The literature highlights the significance of nurse-patient interaction, since such interactions are required to establish nurse-patient relationships – highlighted as a central aspect of mental health nursing (Altshul, 1972; Peplau, 1991). According to Peplau (1991), nurse-patient interaction is said to have a qualitative influence on patient outcomes, often more valuable than many routine procedures. Peplau (1992) stated, “The behaviour of the nurse-as-a-person interacting with the patient-as-a-person has a significant impact on the patient’s well-being and the quality and outcome of nursing care” (p. 14). Halldórsdóttir (1996) similarly concluded that whether interactions are uncaring or caring can decrease or increase patients’ levels of health and well-being.

**Nurse-patient relationship**

Since the 1950s, research has emphasised the nurse-patient relationship, especially in the field of mental health care. Researchers have concluded that the significance of the nurse-patient relationship cannot be emphasised enough and that it is furthermore a vital factor in patient recovery (Freeman et al., 1958). It is described that patients benefit from relationships based on liking, interest, concern and understanding communication (Rogers, 1961), and that patients experience relationships between themselves and staff as therapeutic (Altshul, 1972). According to Peplau (1991) the thing that is therapeutic within the nurse-patient relationship is the possibility for them both to grow, which is related to
the learning that occurs in the nursing situation. Researchers have also acknowledged that
the input from such relationships, promoted by an active, collaborative role between
patients and staff, is essential (Barker & Reynolds, 1994). Studies have shown that staff in
PIC are in a central position to establish nurse-patient relationships, something that
patients ranked as being more significant to their recovery than other factors such as
medical treatment (Cameron et al., 2005; Längle et al., 2003).

Researchers have described several active components in the nurse-patient relationship
and used various concepts interchangeably for relationships that contain such
components. For example: *therapeutic relationship* (Dziopa & Ahren, 2009; Morena-
Poyato et al., 2016; Wyder et al., 2015; Scanlon, 2006), *helping relationship* (Borg &
Kristensen, 2004; Denhov & Topor, 2012), *therapeutic alliance* (Cameron et al., 2005) and
*caring relationship* (Wiechula et al., 2016). In this thesis the concept *caring relationships*
will be used.

*Features of a caring relationship*

The literature has described the features of a caring relationship in a consistent manner,
and the significance and expectations of this type of relationship has been described
similarly by patients and staff (Moreno-Poyato et al., 2016; Wiechula et al., 2016). This
could be due to the fact that one party to the relationship wish to help and the other wishes
to be helped (Moreno-Poyato et al., 2016). Studies have shown that staff in PIC should
convey understanding and empathy, accept patients’ individuality, provide support, ‘be
there’ and be available, be genuine, promote equality, show respect and maintain clear
boundaries (Borg & Kristiansen, 2004; Denhov & Topor, 2012; Dziopa & Ahren, 2009;
Wiechula et al., 2016; Wyder et al., 2015). Moreno-Poyato and co-workers (2016) argued
that the relationship should rest on trust in order to establish a basis for staff to provide
care for patients in a number of ways, using theoretical models and a range of nursing
interventions. Patients valued staff who were honest and friendly, and they hoped to be
empowered by staff to deal with their condition and to engage in self-care (ibid.). Studies
have shown that patients in PIC wards valued staff who conveyed hope, shared power and
were willing to stretch the boundaries of what the professional role was expected to be.
Furthermore, patients appreciated staff members who had the courage to deal with the
complexities and the individuality of the change process and, were able to use their
professional skills and expertise in a collaborative partnership (Borg & Kristiansen, 2004;
Denhov & Topor, 2012; Wyder et al., 2015). Researchers has pointed to a need for renewed
attention to the basics of relationships in a complex health care context, since the human
aspects of relationships could have the potential to increase the quality of care and nurture
patient recovery (Barker et al., 1999; Gunasekara et al., 2014). Studies have shown that staff
members need to be aware that their behaviours and attitudes need to align with what
patients value about the relationship (Barker et al., 1999; Moreno-Poyato et al., 2016;
Wiechula et al., 2016). Furthermore, to develop relationships, staff knowledge and
communication skills are essential (Gilburt et al., 2008; Gudde et al., 2015).
Nursing interventions in psychiatric inpatient care

In a review, Mullen (2009) reported that PIC was devoted to managing high risk of harm and difficult behaviours among patients; as a consequence, nursing staff essentially operates within an observational framework. However, other researchers have reported that in general, nursing interventions in PIC could include empowering, social and activating interventions, as well as interventions for safety and administration of medication (Frauenfelder et al., 2013; Pitkänen et al., 2008).

Mullen (2009) stated that as a consequence of the complex context, there were few reported empirical findings regarding the implementation of psychosocial interventions in PIC. However, in recent years studies have evaluated nursing interventions focusing on things such as reduction in absconding (Bowers et al., 2005), violence prevention through staff education (Björkdahl et al., 2013), reducing conflict and containment rates in PIC (Bowers et al., 2015), improving the physical environment as a tool for violence prevention through staff education (Espinosa et al., 2015), introduction of comfort rooms in PIC (Björkdahl et al., 2016; Novak et al., 2012) and nursing staff–led behavioural activation groups (Salberg et al., 2018). Overall, these evaluations reported positive results.

There is also literature on nursing interventions in PIC that has addressed the significance of the nurse-patient relationship in PIC. Kent (2004) developed Protected Engagement Time (PET) as a response to the strained work situation for staff and patients’ limited time with staff. This intervention has roots in “The Refocusing Model” (Bowles & Dodds, 2001), based on Karasek and Theorell’s theory on job strain (1990). The aim of this intervention is to enable interactions between patients and staff without interruption from other ward tasks. During PET, staff exclusively interact with patients, while other duties of an administrative nature, visits and meetings are scheduled for other times of the day (Nolan et al., 2016). Janner (2007) devised the intervention Star Wards, which includes recreation, conversations and ward community-building to increase patient autonomy. This intervention emphasises the roles that both the ward and staff have to accomplish this. Delaney and co-workers (2017) constructed a web-based educational course for staff based on Peplaus’ framework (1991) and with a focus on learning interpersonal engagement, responses, personal knowledge and reflection. Aremu and co-workers (2018) implemented a trauma-informed care model and brief solution–focused therapy to increase engagement on a PIC ward.

In summary, the literature consistently emphasises the significance of nurse-patient relationships in everyday life in PIC. Research has described and evaluated a handful of nursing interventions in PIC that consider the significance of the nurse-patient relationship. Unfortunately, the number of such interventions and scientific evaluations are limited.
Recovery and the Tidal Model

The PIC literature employs the concept of recovery, with two variants that can be distinguished: (i) medical or clinical recovery (cure from illness), and (ii) personal or life recovery – a process of change and personal growth (Collier, 2010; Tuffour, 2017). According to Anthony’s widely accepted definition (1993), personal recovery is a process that involves the patients’ whole life and involves the long-term development of the individual’s self-image. It involves reclaiming both oneself and power over one’s own life and is thereby a unique and active process. Furthermore, Topor (2001) as well as Topor and co-workers (2011) have stated that the process also involves social aspects, it being emphasised that social relationships contribute to personal recovery. The perspective of this thesis, based on the assumption that there are multiple realities, utilises these definitions. In mental health nursing the concept of personal recovery is widespread, and for PIC contexts specifically, Barker and Buchanan-Barker’s nursing theory, The Tidal Model (2005), provides guidance on recovery-oriented practices for nursing staff.

The Tidal Model (Barker & Buchanan-Barker, 2005) starts from the assumption that there are multiple subjective realities and that we as human beings co-create an understanding of these realities. The model is based on the assumption that patients are admitted to PIC wards as a consequence of difficulties in their lives rather than as a result of disease. Furthermore, the kind of help that patients with mental ill-health need is related to the development of self-awareness and improved education (Barker, 2001). This model emphasises the significance of interactions and interpersonal relationships, drawing on Peplau’s theory (1991). Barker and Buchanan-Barker (2005) highlight ordinary relationships and conversations between patients and staff by pointing out how they are actually extraordinary. They state that nursing staff should act as followers instead of controllers and emphasise engagement. The model further develops the concept of engagement, using the metaphor of bridging as a guide for staff in their attempts to reach patients (Barker & Buchanan-Barker, 2004). Engagement is seen as essential in PIC, both for patients and for staff. The model then suggests various sorts of engagement during the patient’s crisis and hospital stay, from engaging actively with the patient at all times to engaging on a structured basis daily, depending on the patient’s needs. The model also emphasises active care, which is required in order to address patients’ specific needs for nursing care. The authors define nursing as a discipline with a focus on nurturing patient growth. By this they mean that nursing cannot be performed from a distance, since it includes engagement with patients (Barker & Buchanan-Barker, 2005).
RATIONALE

Annually, more than 100,000 PIC admissions are recorded in Sweden (Social Board of Health & Welfare, 2015). Because the needs are extensive, this places high demand on the quality of care. However, there are reports on shortcomings and inequality in care for patients with mental ill-health.

Research on PIC in Western countries during the first two decades of the twenty-first century contains consistent descriptions of patient and staff experiences of everyday life on the wards. The literature reveals a challenging environment, over-reliance on medication and power imbalances. Both patients and staff feel excluded from the clinical decision-making processes in PIC wards, and they also report feeling locked in. Furthermore, both patients and staff ask for the opportunity to develop nurse-patient relationships. Unfortunately, little research has looked at the overlap in how patients and staff understand their experiences and what constitute hinders and enables everyday life in PIC wards.

The literature also consistently emphasises the significance of the nurse-patient relationship in everyday life in PIC. Some nursing interventions in PIC that include the significance of the nurse-patient relationship have been described and evaluated. Unfortunately, the number of, and scientific assessments of such interventions are limited.

Exploring everyday life processes in PIC wards from both patient and staff perspectives and constructing a theoretical understanding of the findings can provide valuable insight into what constitutes hinders and enables everyday life in PIC wards. There is a need to learn more about these components in order to develop nursing interventions that can be realistically introduced in the complex context of PIC and that target relevant goals. The need to develop nursing interventions in PIC is urgent, as the literature review reveals both challenges and little improvement in PIC during the first two decades of the twenty-first century. Even though some studies describe nursing interventions in PIC, few focus on the significance of the nurse-patient relationship, and few are specifically designed to improve everyday life in PIC. Based on the review of the literature, it is reasonable to believe that the development of such interventions can improve the current situation in PIC for both patients and staff.
AIM

The overall aim of this thesis is twofold: first, to construct a theoretical understanding of everyday life processes in PIC; and second, to evaluate a nursing intervention in psychiatric inpatient care.

Specific aims

Paper I  To explore everyday life in psychiatric inpatient care based on patients’ experiences.

Paper II  To explore everyday life processes in psychiatric inpatient care as described by staff in interprofessional teams.

Paper III  To evaluate the feasibility and effects of the Time Together nursing intervention.

Paper IV  To illuminate patients’ experiences of taking part in the nursing intervention Time Together.
METHODS, Part One

The methods in this section apply to studies I and II. To construct a theoretical understanding for everyday life processes in PIC, a Grounded theory (GT) approach was used. Table 1 presents an overview of participants, data collection and analysis.

Table 1. Overview of participants, data collection and analysis (I, II)

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Data collection</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>16 patients:</td>
<td>Individual interviews</td>
<td>Grounded theory</td>
</tr>
<tr>
<td></td>
<td>14 women and 2 men</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>36 staff members:</td>
<td>Individual interviews (3)</td>
<td>Grounded theory</td>
</tr>
<tr>
<td></td>
<td>23 women and 13 men</td>
<td>Dyadic interviews (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Focus group discussions (7)</td>
<td></td>
</tr>
</tbody>
</table>

Grounded theory

GT aims to discover new theories on social processes by exploring reality in an unconditional manner (Dahlgren et al., 2007). The original version of GT combined traditions from positivism, symbolic interactionism and pragmatism, and the approach was further developed by Charmaz (2014) who took it in a constructivist direction. Constructivist GT uses an inductive, comparative, emergent and open-ended approach, as did the original version of GT, but further highlights flexibility, subjectivity and reflectivity. Furthermore, it draws on the conviction that because reality is multiple, the researchers’ perspectives and interactions need to be taken into account as a part of the research reality (ibid.). This method was considered as suitable for exploring processes and constructing an understanding that would provide answers to questions such as what happens in everyday life in PIC, what are the ensuing consequences, and why do these consequences occur?

Context

Three psychiatric departments in two county councils in northern Sweden were invited to participate in the overall project and agreed to do so. This part include descriptions from five acute PIC wards for adults in those departments. The catchment area for two of the departments meant that some patients had to travel 150 kilometres one way to visit the departments, depending on where they lived. For the third department the longest travel distance was approximately 60 kilometres one way.
Participants

Participants were recruited for studies I and II following an emergent methodology. The inclusion criteria for study I was adult patients with an experience of PIC from 2011 through 2015, and for study II it was staff with experience working in PIC.

The patients in study I were recruited from both outpatient and inpatient care. Posters about the study were put up in waiting rooms and public areas at the wards. Patients who wanted to participate were asked to contact the researcher, either personally or with help from staff. A total of 16 patients (14 women and 2 men) participated, ranging from 20 to 51 years old (median 31 years). Self-reported diagnoses were borderline personality disorder, depression, bipolar syndrome, post-traumatic stress disorder, eating disorders, dissociative syndrome, anxiety, burnout, and Tourette’s syndrome. Four patients reported that they did not know their diagnosis. The patients had received PIC between three and seven times, and their most recent admissions had lasted anywhere from a few days to 12 months. The most common causes for their most recent admissions were suicidal thoughts or attempts. Six of the patients were currently admitted to PIC at the time of the interview.

In study II, staff in interprofessional teams were informed of the study on workplace meetings. A total of 36 staff members – 23 women and 13 men – participated. They included 5 general RNs, 5 RNs with specialised training in psychiatric care, 13 ENs, 7 ward managers, 4 physicians and 2 consultants. Their ages ranged from 27 to 66 years, with a median of 42 years, and their length of time working in PIC ranged from 2 months to 30 years, with a median of 6 years.

Data collection

During this part of the project various kinds of interviews were conducted. Study I used individual interviews (16), and due to practical reasons and in some cases staff members’ wishes, study II used a combination of individual interviews (3), dyadic interviews (2) and focus group discussions (7). The interviews took place either in a room at the hospital (I, II) or in a room at the university (I). Intensive interviewing techniques (Charmaz, 2014) were used consistently in both studies I and II, aiming for an in-depth exploration of the participants’ experiences through the use of open-ended questions that encourage description and reflection in order to obtain detailed responses (ibid.). Because GT has an emergent design, this also meant that questions could be changed from one interview to another to further explore everyday life processes in PIC based on participants’ experiences. The opening question in both studies was: Can you please tell me about an ordinary day at the unit? Because the analysis was performed in parallel with the data collection, new questions that emerged were added on an ongoing basis. All interviews were audio-recorded and transcribed verbatim.
**Individual interviews**

The individual interviews (Dahlgren et al., 2007) that were performed in both studies I and II focused on participants’ stories on their experiences with PIC. Intensive interviewing techniques (Charmaz, 2014) were used to help participants to elaborate their story by adding questions and listening (Charmaz, 2014, Dahlgren et al., 2007). In this way, the interviews were a co-creation between the interviewer and the participant (Charmaz, 2014). The interviews in study I lasted 39–120 minutes (median 56), while those in study II lasted 60–89 minutes (median 80).

**Dyadic interviews**

Study II made use of dyadic interviews. Morgan and co-workers (2013) describe dyadic interviews as having similarities with focus group discussions, as they both represent a collaborative interviewing approach in which participants interact in response to open-ended questions. However, in dyadic interviews the participants are partners in an ongoing series of exchanges; the difference from an ordinary conversation is the presence of the interviewer (Morgan et al., 2013). Participants get the opportunity to inspire each other to recognise and remember various experiences that could contribute to their stories. In study II, for practical reasons, staff members with similar professions working at the same department were paired together for dyadic interviews. The interviews were conducted in a room near the participants’ workplace and lasted for 58 and 61 minutes.

**Focus group discussions**

Study II also used focus group discussions. One advantage with this kind of discussions is that they allow participants to share and compare their experiences (Morgan, 2012). In this way, the staff members in study II were able to broaden each other’s stories and create an opportunity to hear several perspectives on their experiences. The size of the focus groups ranged from 3 to 6 participants. Physicians were interviewed as separate groups, while RNs and ENs were grouped together, since staff members share everyday life on the wards in close collaboration with each other. The interviews were conducted in a room near their workplace and lasted for 41–87 minutes (median 62).

**Analysis**

In line with GT, the analysis was initiated after the first interview by reflecting on the interview and writing memos, and then constructing additional questions for the next interview based on the initial analysis. This analytical process continued by reading the interview transcripts. After reading, the interviews were imported into the Open Code software package (version 4.02) for initial line-by-line coding. The participants’ own words, which captured actions and responded to the question “What is happening?”, guided this coding. Codes were grouped with the help of memos taken during the initial
coding. For example, in study I, codes like *taking initiative, starting to get to know each other, establishing trust, talking about feelings* and *engaging in help* were grouped together and formed the subcategory *Having trustful interactions with staff*. In study II, codes like *giving time, interacting with patients, having dialogues* and *respecting the person* were grouped and then developed into the subcategory *Having the patients’ best interests at heart*. A higher level of abstraction was used to name the categories. In the next step the relationships between the categories were examined, and through that process the core category in each study was defined. Along the way constant comparisons were made between codes, categories, emerging ideas and the text. Memos were taken during the initial process, and models were drawn after the codes were grouped. These were used to prompt further questions, to examine relationships between the categories and as reflective tools for understanding the whole set of data.

**Ethical considerations**

The project was approved by the heads of the participating clinical departments of psychiatry and The Regional Central Ethical Review Board (Dnr 2014/168-31M).

All participants were informed that their participation was voluntary and that they could withdraw from participation at any time without consequences. They received both written and verbal information, and all gave their written consent. In each study, the participants are presented anonymously by adding the number of the interview in connection to quotes that are used.

Introducing people regarding their experiences with PIC might evoke memories that could include unpleasant experiences, for both patients and staff members. Questions could be experienced as too personal or probing and could even induce painful emotions. On the other hand, having the opportunity to share one’s experiences with someone who listens might be experienced as providing relief and contributing to increased well-being (Biddle et al., 2013; Gaydos, 2005). The participants’ reactions were observed during the interviews, and there was a readiness to pause or end the interview if the participants seemed to be in distress or expressed discomfort in any way. However, this was never needed. Instead, all participants were keen to tell their stories and expressed a wish to contribute both to research and to improvements in PIC.
FINDINGS, Part One

The aim of the first part in this project was to construct a theoretical understanding of everyday life processes in PIC. First separate findings from studies I and II are presented, followed by a presentation of the theoretical understanding that was constructed from these findings.

Quality of interactions influence everyday life (I)

The results from study I show that quality of interactions between patients and staff influenced everyday life processes on the wards. This core category encompasses three categories: Looking for shelter in a stigmatizing environment, Facing a confusing care content and Staff makes the difference. Figure 1 shows an overview of the results.

Looking for shelter in a stigmatizing environment

The patients commented that they looked for shelter in a stigmatizing environment. They adapted to a destructive environment and searched for safety. Everyday life took place in an environment they returned to for protection but where instead they experienced stigma. The wards were described as devoid of furniture and interior décor, which staff attributed to safety concerns. Patients also noted that staff, through their words, conveyed the idea that patients should not expect to thrive on the ward. On the other hand, they also described being admitted as potentially being a return to a safe place. They did not want to be there, but they could not remain at home. The locked door protected them from their own behaviours and risks outside the ward. Recognizing the ward and thriving fostered feelings of being safe and contributed to recovery, in their descriptions.

Facing a confusing care content

The patients described care content as being confusing and felt they had to adapt to an unclear structure and a passive role; however, they also commented that they joined in satisfying activities. It was an unclear structure with inconsistent routines on the wards. Patients observed that staff only handled acute events, and their sense was that no one took control. They described the daily structure as hard to understand and filled with times when they were waiting in uncertainty. Patients expressed a need for leadership from physicians and ward managers and for these staff members to be visible and available. They thought that a great deal depended on how they guided staff and influenced the ward atmosphere. Patients commented that the unclear structure fostered confusion and a questioning atmosphere, as well as the feeling that staff did not care.
Patients described activity on the ward as unequal and irregular. Medical visits were also described as irregular, and because of that planned activities were often put on hold. Patients described their experiences in terms of being offered nothing but unfilled time and medication. They spent most of their time socializing with fellow patients, resting, watching TV or reading the newspaper. Opportunities for activities that aligned with their own needs were limited, due to the ward’s rules. Patients wanted to spend time with staff in conversations and meaningful activities, and they were aware that this could contribute to their own recovery. Instead, however, they described the actual situation as fostering negative thoughts, triggering thoughts of self-harm and hindering recovery.

Patients experienced everyday life on the wards as satisfying when they had the opportunity to spend time doing things with staff. They also believed that this would be valuable for staff and that it reduced the feeling of ‘us versus them’. They also expressed that spending time with staff softened the ward atmosphere. They felt more understanding of the situation that staff members were in and felt more accepting of the everyday life
situation. Patients described having confidence in staff engagement and felt that when staff was engaged they had time for everyone and were good at keeping promises.

Staff makes the difference

Interactions with staff were described alternatively as absent, obstructive and trustful. When patients described interactions as absent, this led to feeling invisible to staff or staff being invisible, either because they were spending time in the ward office or because they were unavailable for communication even if they were physically close. This kind of interaction also elicited feelings not being involved in decision-making or being treated like children. This, in turn, fostered feelings of being ignored, something that patients adapted to by turning to fellow patients instead for help, something described both as good and as less constructive.

Patients’ descriptions of obstructive interactions included comments from staff that felt like rejection, and staff keeping distance. They commented that there was a ‘them vs staff’ mentality, and they described receiving care in relation to feeling liked or disliked. Furthermore, obstructive interactions included being exposed to abuse of power and having to suffer the consequences of staff behaviour. This fostered feelings of humiliation, violation, unsafety and fear. Patients felt that they wanted to defend themselves, either by absconding or by requesting a discharge. If they stayed at the ward, the patients described the need to adapt to these interactions by pretending to be happy or by keeping away from staff.

Patients’ descriptions of trustful interactions with staff alluded to knowing one another and seeing good treatment in action. They also referred to staff being humble, trying to find solutions together and making situationally appropriate exceptions to normal routines. The patients described wanting to share responsibility with staff, something that made them feel more equal to staff. They valued conversations with staff and stated that doing things together and sharing humour was “the glue” for these relationships, fostering friendship. This led to a better understanding of the situation that staff were in and fostered feelings of hope. These interactions were described as leading to feeling that one was listened to, involved and had control.

In summary, exploring everyday life processes in PIC as described by patients leads to an understanding that everyday life is influenced by interactions between patients and staff, the environment where these interactions take place, and the content of care offered in the PIC ward. The quality of interactions tied these components together and governed the various aspects of everyday life. Having trustful interactions could compensate for an otherwise poor environment and care whose content was confusing, whereas adapting to an absence of, or to obstructive interactions contributed to the perception of the environment as stigmatising and the content of care as being confusing.
From ideals to resignation (II)

The findings in study II show that staff moved from their ideals to resignation in their everyday life on the ward. Staff knew where to go, but they encountered obstacles that had a negative influence on everyday life. This meant that they shifted their focus from the patient’s best interests to their own survival. Figure 2 shows an overview of the results. In the following section on the results from study II, RNs and ENs are referred to as ward staff, while the group of participants as a whole are referred to as staff. On topics where physicians and ward managers had opinions that differed from those of ward staff, their experiences are described separately.

Knowing where to go

The staff had ideals about everyday life in PIC. They knew where to go and had the patients’ best interest at heart. This consisted of having personal responsibility in relation to patients and being able to give them time. They described the importance of interaction and dialogue with patients and taking a holistic approach to their work. Staff saw availability, continuity, meaningful activities and humour, in combination with respect, trust and confirmation, as essential components in the relationships with patients. They often returned to these components in their descriptions. Also, an attractive environment, structure and patient safety were considered to be the foundation of good PIC. Together, this was what they wanted to offer patients, not only in words but also in practice. Staff also sought collaboration with each other in everyday life. The requirements they expressed included supporting one another, keeping lines of communication open and being available in times of difficulty. Teamwork provided assurance and was regarded as an enjoyable form of working. Overall, staff described working in psychiatric inpatient care as satisfying.

Walking a path of obstacles

Staff also described obstacles that hindered them from putting their ideals into practice in everyday life. The environment was described as poor and shocking and regarded as indefensible; it reflected a disrespectful approach to those suffering from mental ill-health. They also described the power relationship between the patients and staff as a main feature of everyday life that was asymmetric, sometimes necessary but difficult to manage. According to staff descriptions, power dynamics constituted an obstacle in their relationship with patients and, with respect to formal and informal hierarchies, even among staff.
The ward staff described structure as lacking: patients were offered only meals and medication. They lacked guidance, experienced a shortage of staff and had expectations that ward managers should both be clear on what was to be carried out and should evaluate the care provided. The ward managers experienced their jobs as fragmented and primarily focused on handle staffing issues. Furthermore, the ward staff commented that their everyday life revolved around managing chaos and ‘putting out fires’. Organizing their days required energy and time, both of which they felt were in short supply. Both ward staff and physicians commented that what they could offer differed from the expectations of patients.

**Shifting focus from the patient’s best interest to self-survival**

The obstacles encountered in everyday life created an uphill struggle, and ward staff observed that they stopped trying to put their ideals into practice. They noted that the
situation in the wards fostered feelings of both shame and guilt, which further affected their actions and had a negative effect on their level of job satisfaction and energy. This, in turn, fostered feelings of inadequacy, and the everyday situation gave rise to an atmosphere of questioning and conflicts.

Physicians reported that they deliberately chose to distance themselves in order to cope with everyday life on the ward, and that this strategy was embedded in the system of care. Ward staff said it was easy to become cynical, question admissions and joke about serious situations. Furthermore, they reported that they sometimes lost their temper with patients. Staff sought support within their fellow professional but also sometimes turned away from each other. In a worst-case scenario, ward staff mentioned that violent situation had arisen in the context of them being abandoned by physicians.

In summary, this process suggest that staff held ideals regarding everyday life on the wards but encountered obstacles such as a poor environment, power asymmetry, lacking structure and the need to manage chaos that prevented them from putting their ideals into practice. To cope, they shifted their focus from the patient’s best interests to their own survival. They sometimes felt unable to act and distanced themselves from patients and abandoned each other. This attitude of resignation made it even more difficult for them to put their ideals into practice.

**Theoretical understanding of everyday life processes**

Based on the findings in studies I and II, a theoretical understanding of everyday life processes was constructed. Figure 3 shows an overview of the theoretical understanding.

What the patients described as absent or obstructive interactions, a destructive environment or as passivity were mirrored in staff descriptions of a lacking structure, managing chaos, choosing to distance oneself and abandoning each other. Studying patients’ descriptions of how they adapted to staff actions, this can be understood as when staff was hindered to work in line with their ideals and shifted their focus to their own survival, patients turned away from them and felt unsafe and angry. Patients blamed, or defended themselves, and together this contributed to a vicious cycle where both patients and staff focused on their own survival. This is interpreted as when staff focus on managing chaos, a chaos can also be constructed by their actions, revealing risks in everyday life for both patients and staff. For patients, everyday life ran the risk of being counterproductive to their recovery, and for staff everyday life ran the risk of leading to personal disengagement followed by perceived stress and stress of conscience.

What the patients described as trustful interactions and satisfying activities were mirrored in staff descriptions of having the patients’ best interests at heart. Studying patients’ descriptions on how they acted in response to staff actions, this can be understood as when staff was able to work in line with their ideals, patients turned to them, felt safe, increased
their motivation, expressed a will to collaborate, felt understanding for staff’s situation and cared for their relationship. This is interpreted as when staff focus on the patients’ best interests, chaos can be managed, revealing improvements in everyday life for both patients and staff. For patients, everyday life fulfills its purposes by contributing to recovery through reciprocity and fellowship with staff (Topor, 2001; Topor et al., 2011). For staff, everyday life becomes aligned with their ideals, which allows for work engagement (Van Bogaert et al., 2013) and decreases the risk of perceived stress and stress of conscience (Tuvesson et al., 2011a; Tuvesson et al., 2012).

As a response to this theoretical understanding, it seems reasonable to intervene on conditions that allow staff to work in alignment with their ideals. Creating time for high-quality interactions through joint activities could promote patient recovery (Topor, 2001) and possibly decrease perceived stress and stress of conscience among staff (Tuvesson et al., 2011a; Tuvesson et al., 2012). As the review of the literature shows, few researchers have evaluated such nursing interventions in the context of PIC. However, Protected Engagement Time (PET) (Nolan et al., 2016), with the addition of an emphasis on patients’ needs for high-quality interactions and engagement, could address the issues that the above theoretical understanding points to as needing improvement in PIC.
Figure 3 Theoretical understanding of everyday life processes in PIC.
METHODS, Part Two

This part involves study III and IV. To evaluate the nursing intervention, several data collection methods were used. Table 2 presents an overview of participants, data collection and analysis for these two studies.

Table 2. Participants, data collection methods and analytical methods

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Data collection</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>III</td>
<td>80 patients:</td>
<td>Questionnaires</td>
<td>Visual analysis</td>
</tr>
<tr>
<td></td>
<td>42 women and 38 men</td>
<td>Logs</td>
<td>Percentage of non-overlapping data</td>
</tr>
<tr>
<td></td>
<td>50 staff members:</td>
<td>Participant observation</td>
<td>Qualitative content analysis</td>
</tr>
<tr>
<td></td>
<td>35 women and 15 men</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>11 patients:</td>
<td>Individual interviews</td>
<td>Qualitative content analysis</td>
</tr>
<tr>
<td></td>
<td>7 women and 4 men</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Design

The second part of the project employed a mixed-method approach with a single-system experimental design (SSED) to evaluate the effects of the intervention, and a qualitative process evaluation to study its feasibility. Such an approach is suggested when introducing a complex intervention in health care (Craig et al., 2008), facilitating evaluation of effects and assessment of fidelity and quality of the introduction of the intervention, as well as clarification and identification of contextual factors that could be associated with variations in outcomes (ibid.).

SSED (Ottenbacher, 1986; Bloom et al, 2009) was employed to evaluate the effects of the intervention (III). The literature uses several terms to refer to this design for equivalent purposes: for example, single case design (Kazdin, 2011; Morgan & Morgan 2009) and single subject design (Carter & Lubinsky, 2015). In this project, the term SSED is chosen, because study III focuses on PIC wards with the aim to seek changes for the whole wards as systems and not for one subject (Bloom et al., 2009).

SSED is idiographic, focusing exclusively on experimental research involving purposively-chosen manipulation of the studied system (Carter & Lubinsky, 2015). Using this design, with its focus on the unique and not on comparisons between systems, the research process carefully follows possible changes in outcomes using repeated measurements across different phases. This enables the researcher to focus on the system’s response to the active manipulation: in this case the introduced intervention (Morgan & Morgan, 2009).
SSED was combined with a qualitative process evaluation to evaluate the feasibility of the intervention. This evaluation looked at logs (III), participant observation data (III) and individual semi-structured interviews with patients who had taken part in Time Together (IV).

The Time Together nursing intervention

For the development of this project’s intervention, the intervention PET was chosen as a starting point. However, because the aim was to highlight the nurse-patient relationship in everyday life in PIC wards, based on what the theoretical understanding arrived at, Barker and Buchanan-Barker’s theory (2005) was added as a theoretical framework. Thus, the emphasis was on patients’ needs, ordinary relationships and conversations, as well as on engagement. Supplementing the description of PET (Nolan et al., 2016) with Barker and Buchanan-Barker’s theory (2005) resulted in the Time Together (TT) nursing intervention, in which five strategies constituted the practical starting points:

- Regular times for TT were established on Mondays through Fridays, for a total of 5 hours/week.
- Nursing staff engaged in joint activities with patients during TT.
- The engagement involved interactions in either one-on-one sessions or group sessions, including joint activities chosen by patients.
- During TT, one or two staff members handled administrative duties on the ward. All other staff members engaged with patients.
- During TT, the ward was closed to visitors and professionals from outside the ward.

Context

Studies III and IV were conducted at the same departments as in the first part. One ward at each department introduced TT. One of the wards was involved in the first part of the project while two were not. In alignment with the SSED approach, the wards will be called systems (1–3) in the sections of study III. Table 3 shows an overview of these systems’ characteristics.

Because TT was tailored to the specific circumstances of each system, using the strategies above as a basic guide, a group of staff members from each system was appointed to support planning for TT. For staff members to be able to offer activities of the patients’ choosing during the intervention, patients were also involved in planning the intervention.
Table 3. Characteristics of systems 1–3, January – May 2017

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>System 1</th>
<th>System 2</th>
<th>System 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of ward</td>
<td>Addictive syndromes</td>
<td>Addictive syndromes</td>
<td>Acute mental ill-health</td>
</tr>
<tr>
<td>Hospital beds, n</td>
<td>12</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Registered nurses, n</td>
<td>12</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>Enrolled nurses, n</td>
<td>11</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Occupational therapists, n</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total admissions 16/1-31/5, n</td>
<td>202</td>
<td>221</td>
<td>142</td>
</tr>
<tr>
<td>Eligible patients* study III, n</td>
<td>73</td>
<td>75</td>
<td>71</td>
</tr>
<tr>
<td>Mean length of stay (days)</td>
<td>4.7</td>
<td>6.1</td>
<td>13.8</td>
</tr>
</tbody>
</table>

*Unique patients, admitted on measurement days.

Participants

All patients admitted to the systems during the whole intervention period, as well as all staff members, were informed about TT and the project. In study III, patients admitted on days when data collection took place were invited to participate in the evaluation of TT. The inclusion criteria were: being 18 years or older and having experienced at least one TT session (if included during the intervention phase). Patients who were unable to read Swedish were excluded. Inclusion continued throughout the intervention period. Table 4 shows an overview of included patients’ characteristics. The appointed staff members supported the recruitment process in both studies.

Table 4. Characteristics of included patients

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>System 1</th>
<th>System 2</th>
<th>System 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants, n</td>
<td>35</td>
<td>21</td>
<td>24</td>
</tr>
<tr>
<td>Age, mean (range)</td>
<td>37.5 (22-59)</td>
<td>44 (21-68)</td>
<td>32.8 (18-53)</td>
</tr>
<tr>
<td>Sex, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>14 (40)</td>
<td>10 (47.6)</td>
<td>18 (75)</td>
</tr>
<tr>
<td>Male</td>
<td>21 (60)</td>
<td>11 (52.4)</td>
<td>6 (25)</td>
</tr>
<tr>
<td>Currently taking medication, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>32 (91.4)</td>
<td>21 (100)</td>
<td>24 (100)</td>
</tr>
<tr>
<td>Hospital stays last 2 years, n, (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 3</td>
<td>25 (71.4)</td>
<td>16 (76.2)</td>
<td>16 (66.7)</td>
</tr>
<tr>
<td>4-6</td>
<td>3 (8.6)</td>
<td>2 (9.5)</td>
<td>7 (29.2)</td>
</tr>
<tr>
<td>&gt; 7</td>
<td>7 (20)</td>
<td>3 (14.3)</td>
<td>1 (4.2)</td>
</tr>
</tbody>
</table>

The self-reported diagnoses of patients were neuropsychiatric disorder, bipolar syndrome, anxiety and stress disorders, depression, personality disorders and self-harm behaviour, along with addiction in systems 1 and 2 and anorexia in system 3. The self-reported causes for admission were personal crisis, psychotic symptoms, mania, suicidal...
thoughts/plans/attempt, anxiety and self-harm, as well as drug-related problems in systems 1 and 2, and anorexia, depression and insomnia in system 3.

Staff who were employed at the systems during the baseline or intervention phase were invited to participate in study III. Table 5 shows an overview of included staff members’ characteristics.

Table 5. Characteristics of included staff

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>System 1</th>
<th>System 2</th>
<th>System 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants, n</td>
<td>16</td>
<td>19</td>
<td>15</td>
</tr>
<tr>
<td>Age, mean (range)</td>
<td>46.75 (26-67)</td>
<td>38 (23-58)</td>
<td>41.33 (23-62)</td>
</tr>
<tr>
<td>Sex, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>12 (75)</td>
<td>12 (63.2)</td>
<td>11 (73.3)</td>
</tr>
<tr>
<td>Male</td>
<td>4 (25)</td>
<td>7 (36.8)</td>
<td>4 (26.7)</td>
</tr>
<tr>
<td>Profession, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN</td>
<td>2 (12.5)</td>
<td>5 (26.3)</td>
<td>5 (33.3)</td>
</tr>
<tr>
<td>Specialist trained RN</td>
<td>2 (12.5)</td>
<td>2 (10.5)</td>
<td>2 (13.3)</td>
</tr>
<tr>
<td>EN in mental health</td>
<td>8 (50)</td>
<td>4 (21.1)</td>
<td>6 (40)</td>
</tr>
<tr>
<td>Other*</td>
<td>4 (25.1)</td>
<td>8 (42.1)</td>
<td>2 (13.4)</td>
</tr>
<tr>
<td>Years in profession, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 1 year</td>
<td>1 (6.3)</td>
<td>2 (10.5)</td>
<td>3 (20)</td>
</tr>
<tr>
<td>1-4 years</td>
<td>2 (12.5)</td>
<td>9 (47.4)</td>
<td>5 (33.3)</td>
</tr>
<tr>
<td>5-9 years</td>
<td>8 (50)</td>
<td>2 (10.5)</td>
<td>1 (6.7)</td>
</tr>
<tr>
<td>&gt; 10 years</td>
<td>5 (31.4)</td>
<td>6 (31.6)</td>
<td>6 (40.1)</td>
</tr>
<tr>
<td>Years on the ward, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 1 year</td>
<td>4 (25)</td>
<td>3 (15.8)</td>
<td>6 (40)</td>
</tr>
<tr>
<td>1-4 years</td>
<td>6 (37.5)</td>
<td>10 (52.6)</td>
<td>4 (26.7)</td>
</tr>
<tr>
<td>5-9 years</td>
<td>3 (18.8)</td>
<td>5 (26.3)</td>
<td>2 (13.3)</td>
</tr>
<tr>
<td>&gt; 10 years</td>
<td>3 (18.8)</td>
<td>1 (5.3)</td>
<td>3 (20)</td>
</tr>
</tbody>
</table>

*includes enrolled nurses, occupational therapists, physicians and ward managers

In study IV, admitted patients who had experienced at least one TT session participated in semi-structured interviews. A total of 11 patients (7 women and 4 men) participated. Their ages ranged from 20 to 48 years (median 35 years). Their self-reported diagnoses were borderline personality disorder, depression, bipolar syndrome, posttraumatic stress disorder, eating disorder, anxiety and addiction. The patients had been treated in PIC on anywhere from three to seven occasions.

Data collection

During the second part of the project, data were collected using four different methods. Study III used questionnaires, logs, and participant observations, while study IV used individual interviews. For an overview of data collection timepoints, please see Figure 4.
Questionnaires (III)

To evaluate the effects of the intervention, repeated measurements of the outcome variables were taken during both the baseline- and the intervention phase. During both phases, measurements were taken every seventh weekday, with an assigned staff member at each system distributing the questionnaires to the participants.

The theoretical understanding constructed during the first part of the project was used to identify and model relevant outcomes for patients and staff (Buhse & Mühlhauser, 2015). Thus, the primary outcome measure for patients was quality of interactions, and for staff it was perceived stress. Secondary outcomes for patients were levels of anxiety and depressive symptoms, while for staff it was stress of conscience. The following questionnaires were used (complete versions of the questionnaires are found in Appendix):

The CPS (Caring Professional Scale) (Swanson, 2000) was used to measure the quality of interactions according to patients. The scale consists of 15 items, answered on a 5-point Likert scale, resulting in a score ranging from 15–75. The lower the number, the higher the quality of the interaction. Cronbach’s $\alpha$ for CPS was 0.95 in our sample.

The HAD (Hospital Anxiety and Depression Scale) (Zigmond & Snaith, 1983) was used to measure anxiety and depressive symptoms among patients. The scale contains 14 items, seven for symptoms of anxiety and seven for symptoms of depression, scored on a 4-point scale, resulting in scores ranging from 0–21 for each symptom type. The higher the number, the more serious the symptoms. Cronbach’s $\alpha$ for the HAD was 0.86 in our sample.

The PSS (Perceived Stress Scale) (Cohen et al., 1983; Nordin & Nordin, 2013) was used to measure stress among staff. The scale consists of 10 items answered on a 5-point Likert...
scale, with total scores ranging from 10–50. The higher the number, the higher the perceived stress. Cronbach’s $\alpha$ for PSS was 0.86 in our sample.

The SCQ (Stress of Conscience Questionnaire) (Glasberg et al., 2006) was used to measure stress of conscience among staff. The questionnaire assesses nine situations that are challenging to the conscience. The frequency of each situation is rated on a 6-point scale (part A), and the severity of each situation is assessed using a 100 mm Visual Analogue Scale (VAS) (part B). Multiplying the scores in Part A by the scores in Part B creates an index with a maximum total score of 225. The higher the score, the higher the level of stress of conscience. Cronbach’s $\alpha$ for SCQ was 0.83 in our sample.

A VAS (Visual Analogue Scale) (Huskisson, 1974) was used to measure satisfaction with interactions among both patients and staff. The scale measures 100 mm in length, with terms expressing the most positive and most negative rating anchored at each end.

**Logs (III)**

As one component in evaluating the feasibility of TT, logs similar to substantive field notes (Dahlgren et al., 2007) were used to arrive at a detailed picture of each TT session, not only in terms of the number of participants, offered activities and duration but also in terms of how many sessions were cancelled and why. Each system kept two written logbooks: one for patients and one for staff. Staff was informed to document the details and reflections made on each session, while patients were only asked to document their reflections.

**Participant observations (III)**

Participant observations (Roper & Shapira, 2000) were conducted during the latter part of the intervention phase as part of the evaluation of TT feasibility. The aim was to describe actions and interactions between patients and staff during TT sessions. The observations started and ended about one hour before and after the TT sessions themselves. In total, 36 hours were spent within the systems, comprising 18 hours of general observations and 18 hours of focused observations. As an observer I took a passive participant role (Roper & Shapira, 2000). This meant that I was visible and close to the activities but not involved in the TT sessions. However, if someone approached me, I responded. No predetermined protocol was used; instead detailed notes on actions and interactions were taken during these observations. These notes were transcribed for analysis.

**Individual interviews (IV)**

During the latter part of the intervention phase, individual, semi-structured interviews (Kvale & Brinkmann, 2009) with patients were conducted as part of the evaluation of the
feasibility of the intervention. The aim was to illuminate patient’s experiences of taking part in TT sessions. Because this was the focus, the interviews followed a guide with questions to be covered (ibid.). Patients were interviewed during their hospital stay in a room at each ward, with interviews lasting 10–35 minutes (median 24 minutes). The initial question was: Can you tell me about what Time Together means to you? This question was followed by: How have you experienced taking part in TT? Additional questions were asked during the interviews to broaden the patients’ stories. The interviews were audio-recorded and transcribed verbatim.

Analysis

Demographic data on the participants in study III were analysed using descriptive statistics, presented in table 4 and 5, and data from the logs (III) were sorted and compiled into a summary of how TT was performed in each system. Data from the questionnaires (III) were analysed using visual analysis and percentage of non-overlapping (PND) analysis, and data from the participant observations (III) and the individual interviews (IV) were subjected to qualitative content analysis.

Visual analysis and PND (III)

The focus in study III was on the systems and not on individuals. Therefore, measurement data for one system at each measurement point consisted of the mean ratings from each of the questionnaires from participants answering at that point in time (Kazdin, 2011). Missing data in the instruments were replaced with the individual mean value for that participant on that instrument at that measurement point (Shrive et al., 2006). If more than 10% of the items in each instrument were missing, the value was left empty.

The mean ratings from each measurement point were plotted in graphs. Each system had separate graphs for patient and staff outcomes, leaving a total of 21 graphs to analyse. Using SSED, changes in outcomes were analysed by comparing the frequent mean ratings during baseline with frequent mean ratings during intervention phase (Morgan & Morgan, 2009). This project used two methods for this analysis: visual analysis and PND.

Visual analysis, an approach supported by methodologists, is a viable and long-practiced strategy within SSED. This type of analysis means that data are graphed out for various types of visually analysis: for example, by comparing differences in levels, changes in trends or changes in variability (Morgan & Morgan, 2009). In study III, visually analysis meant that possible changes in trends in the graphs were studied to explore whether the measurements showed effects from the intervention.

In addition, calculations of percentage of non-overlapping data (PND) were performed. Calculating PND, one of the most frequently utilised numeric methods for analysing SSED data, means that percentage calculations are made for how many values in the
intervention phase exceed the best value in the baseline (Morgan & Morgan, 2009). Using PND, values < 50% indicate an ineffective intervention, 50–70% indicate a questionable effect, 70–90% indicate an effective intervention and values > 90% indicate a very effective intervention (ibid.). As a precaution, in study III, PND values that lacked measurements from participants taking part in both phases were not considered significant.

**Qualitative content analysis (III, IV)**

Data from the participant observations (III) and the individual interviews (IV) were subjected to qualitative content analysis (Graneheim & Lundman, 2004; Graneheim et al., 2017). This method takes both the context and the subject into consideration in a systematic analysis that searches for variations in the text. Both manifest and latent content can be analysed and abstracted, either into categories or themes, depending on the content in the text (Graneheim & Lundman, 2004).

For both studies, the transcripts were read through initially to get a sense of the whole. Furthermore, the texts were divided into meaning units that were condensed and then labelled with codes. In study III, the codes were sorted into two content areas: enabling and hindering factors and then sorted and abstracted into sub-categories and eventually into categories. In study IV, codes with similar content were sorted, abstracted and interpreted into sub-themes. Sub-themes with similar content were interpreted and abstracted into three themes. During the analysis of both studies III and IV, comparisons with the original text were made, and the abstraction levels and degrees of interpretations were discussed among the research team.

**Ethical considerations**

The evaluation of the intervention was approved by the heads of the participating clinical departments of psychiatry and The Regional Central Ethical Review Board (Dnr. 2016/339-31). The intervention was registered at ClinicalTrials.gov (study ID: NCT02981563), and a study protocol has been published (Molin et al., 2017). In addition to the ethical considerations made in the first part, some further considerations were taken into account during the second part.

In agreement with administrators and with decisions taken by staff members within the systems, TT was introduced as a routine. Thus, TT included all patients and all staff. Staff members were not able to choose whether or not they wanted to work with the intervention. The assumption was that joint activities entailed no risk of harm for staff and that the benefits would outweigh any disadvantages. Patients, however, were able to choose whether they wanted to participate in TT sessions or not, since such a choice was built into the strategies of TT. Participating in the evaluation of TT was voluntary for both patients and staff.
Filling out questionnaires is often time-consuming and could be experienced as strenuous. This required careful consideration in order to select questionnaires with the least number of items possible. Furthermore, participants might experience being observed as uncomfortable and staff especially might feel examined by the observer. Because of this, it was emphasised that the observations were focused on describing actions and interactions during TT and not on judging whether or not someone acted properly or improperly.
FINDINGS, Part Two

The aim of part two in this project was to evaluate the Time Together nursing intervention.

Feasibility and effects (III)

Study III describes the feasibility and effects of TT. Based on the logs and the participant observations, when the intended structure was maintained and staff engaged in the intervention, TT proved to be feasible in the evaluated systems. Based on the measurements, no effects were shown with respect to the quality of interactions, and questionable effects were shown with respect to perceived stress and stress of conscience among staff as well as to staff satisfaction with interactions with patients.

Logs (III)

Both systems 1 and 2 introduced TT on Mondays through Fridays, while system 3 chose Tuesdays through Fridays. This meant an opportunity for 51 or 63 TT sessions in each system during the entire intervention phase. Log entries were made with varying frequencies, with a result of 9, 42 and 46 documented sessions. Reasons for cancelling sessions reported by the systems included excess workload, chaos and low staffing numbers. The most common activities were outdoor walks, board and card games, colouring pictures, puzzles and table tennis. One system reported the number of participants for 33 sessions. This yielded a mean of 4 patients (range 1–7) and 3 staff (range 1–5) participating/ session and, a mean of 7 patients (range 3-10) that were admitted to the system/ session, and a mean of 6 staff (range 4-9) were working/ session. One system reported the number of participants for 46 session with a mean of 5 patients (range 2-8) and a mean of 5 staff (range 1-7) participating/ session. One system did not report on these numbers.

Participant observations (III)

During the observations, actions and interactions that enabled and hindered TT were noted. These were mainly related to relational factors but also to organisational ones. Shared responsibility, a friendly approach and a predictable structure enabled TT, whilst a distant approach and unpredictable structure hindered TT. Table 6 shows an overview of the results.
Table 6 Overview of content areas, subcategories and categories

<table>
<thead>
<tr>
<th>Content areas</th>
<th>Subcategories</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enabling factors</td>
<td>Coming together</td>
<td>Shared responsibility</td>
</tr>
<tr>
<td></td>
<td>Taking care of each other</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enjoying the moment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Being inviting</td>
<td>Friendly approach</td>
</tr>
<tr>
<td></td>
<td>Being courteous</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Being present</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Giving clear information</td>
<td>Predictable structure</td>
</tr>
<tr>
<td></td>
<td>Having clear roles</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Taking care of the time</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Offering a variety of activities</td>
<td></td>
</tr>
<tr>
<td>Hindering factors</td>
<td>Being absent</td>
<td>Distant approach</td>
</tr>
<tr>
<td></td>
<td>Being off-putting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Giving unclear information</td>
<td>Unpredictable structure</td>
</tr>
<tr>
<td></td>
<td>Ignoring the time</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Having unclear roles</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Offering a limited range of activities</td>
<td></td>
</tr>
</tbody>
</table>

Enabling factors

When patients and staff came together, took care of each other and enjoyed the moment, this seemed to create a shared responsibility for the TT sessions. They seemed to have equal roles during the sessions and agreed on and planned activities together. It was observed that they took care of and helped each other, showed appreciation and curiosity. Furthermore, there was an acceptance of those who wanted to join in without having to engage in any particular activity. When they enjoyed the moment together, humour, laughter and engagement in conversations were observed. Being inviting, courteous and present contributed to a friendly approach during the sessions. Staff seemed keen that everyone should be involved and being together seemed more important than the activities during the sessions. Staff shared personal characteristics and acted in a courteous and present manner towards patients. They left their phones outside the room and apologized if they needed to leave the activity for a while. Clear information and roles, taking care of time and a variety of activities seemed to create a predictable structure for the sessions. Preparing materials in advance and gathering at the start and the end of TT contributed to this. It enabled to have clear roles arranged so that specific staff members took responsibility for the session while another 1-2 staff members took responsibility for other tasks and acute needs. Furthermore, taking care of time by starting on time and reminding one another about TT seemed to enable the sessions. Keeping the door closed to make it clear that TT sessions were in progress and to shut out disturbances, along with offering a variety of activities, contributed to a peaceful atmosphere.
**Hindering factors**

When staff members were absent or off-putting prior to the start of TT, this seemed to create a sense of distance that fostered irritation among patients and thus influenced the upcoming session. Furthermore, activities could be suggested, but this failed when staff members did not join. Sometimes staff members had difficulties being present during the activities, and activities such as private discussion among staff left the patients out of the conversations. Unclear information, staff ignoring the time, having unclear roles and a limited range of activities led to an unpredictable structure. Sometimes activities were changed without informing patients, which created a frustrated atmosphere. Also, ignoring time by not preparing sessions, experiencing delays, holding meetings during sessions and distributing medication during sessions seemed to disturb the intervention. Unclear roles, with too many or too few staff participating in one activity, also constituted a hindrance. Finally, lack of variety of activities, activities that did not create a fellowship between patients and staff, unsuitable facilities, dirty furniture and worn-out materials hindered sessions from achieving their purpose.

**Questionnaires (III)**

In total, 14 measurement points were planned for the whole intervention period, five during baseline and nine during the intervention phase. In system 1, one measurement point for staff in the intervention phase was missing, as were two measurement points for patients in the intervention phase. In system 2, one measurement point for staff was missing in each phase, and two patient measurement points were missing during the intervention phase. No measurement points were missing in system 3.

No specific trends were detected regarding either the primary or the secondary outcomes during the visual analysis of the 21 graphs. When calculating PND for each outcome, the measurements showed some effects of TT for all systems. In system 1, the PND for PSS was 62.5%, which indicates a questionable effect. In system 2, HAD-Depression showed a PND of 71.4%, indicating an effective intervention. However, none of the participants took part in both baseline and intervention phases, which meant that this value was not considered significant. In system 3, the PND for SCQ was 55.5%, and the VAS for staff satisfaction with patient interactions was 55.5%, indicating a questionable effect. Table 7 shows an overview of all PND values.
Table 7. Percentage of non-overlapping data for each system

<table>
<thead>
<tr>
<th>Variable</th>
<th>System 1</th>
<th>System 2</th>
<th>System 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPS</td>
<td>0</td>
<td>14.3</td>
<td>33.3</td>
</tr>
<tr>
<td>VAS</td>
<td>42.8</td>
<td>14.3</td>
<td>33.3</td>
</tr>
<tr>
<td>HAD-Anxiety</td>
<td>0</td>
<td>42.8</td>
<td>11.1</td>
</tr>
<tr>
<td>HAD-Depression</td>
<td>14.3</td>
<td>71.4</td>
<td>44</td>
</tr>
<tr>
<td>Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSS</td>
<td>62.5</td>
<td>0</td>
<td>44</td>
</tr>
<tr>
<td>SCQ</td>
<td>37.5</td>
<td>12.5</td>
<td>55.5</td>
</tr>
<tr>
<td>VAS</td>
<td>0</td>
<td>25</td>
<td>55.5</td>
</tr>
</tbody>
</table>

Patients’ experiences of taking part in TT (IV)

In study IV patients described their experiences of taking part in TT as being seen as a human among other humans, that it contributed to hope for recovery but also, that feelings of distance to staff were fostered when TT sessions were absent. Table 8 shows an overview of the subthemes and themes.

Table 8. Overview of the results.

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling confirmed</td>
<td>Being seen as a human among other humans</td>
</tr>
<tr>
<td>Participating on equal terms</td>
<td></td>
</tr>
<tr>
<td>Offering a break</td>
<td>Contributing to hope for recovery</td>
</tr>
<tr>
<td>Feeling strengthened</td>
<td></td>
</tr>
<tr>
<td>Feeling disconfirmed</td>
<td>Fostering feelings of distances when absent</td>
</tr>
</tbody>
</table>

Being seen as a human among other humans

The patients described that being seen as a human among other humans was a matter of feeling confirmed by staff engagement during TT and by participating in TT on equal terms. They commented that staff were more engaged after TT was introduced, and that staff members were eager to invite and encourage them to join in activities. They expressed that when staff engaged, it was a way of showing they cared. Furthermore, they experienced that staff noticed a difference in their mood and in the ward atmosphere after TT was introduced, and that staff acted to create fellowship. Offering medication was no longer the first choice of staff response when a patient experienced anxiety; instead they offered activities. Patients described TT as influencing the roles between themselves and staff, as if the difference between them was being erased. During TT sessions, they felt like
fellow human beings, participating on equal terms with staff. They stated that to achieve this change, both activities and fellowship was necessary. These changing roles created a special relationship toward those staff members who participated in TT. Time with staff made it easier to make contact and have conversations with staff even outside TT. Because of this, they felt it was essential that all staff members participate in TT on a regular basis. Furthermore, they commented that staff focused on the healthy parts of the patients and saw them for who they were as persons. This made them feel like ordinary people just like anyone else, and not neglected or like patients in treatment.

**Contributing to hope for recovery**

Patients described that TT contributed to their hope for recovery. The sessions offered a break from their mental ill-health and they felt strengthened by participating in TT. The activities were a distraction from their mental health issues, and observing fellow patients in the same situation as themselves had similar effects. They stated that they became calmer and more relaxed. TT sessions influenced the overall ward atmosphere, which they related to the activities, the conversations and sometimes to the scents from the kitchen. The patients expressed that they felt more present but were also reminded of their lives outside the wards and they meant that the intervention contributed to their well-being. Furthermore, they felt that the sessions brought joy to the wards and offered a break from boredom and the hospital atmosphere. Having access to undemanding, meaningful activities was described as satisfying and as a factor that contributed to the patients’ refraining from isolating themselves in the wards more than before. This also influenced their time outside TT sessions. Furthermore, they described that the fellowship and activities contributed to structure, enhanced a sense of control and served as a reminder of the future and as a source for hope. Patients stated that they discovered new coping strategies for their ill-health during TT sessions. This felt strengthening and was a way to push themselves towards a life outside the ward. They described that both the activities and the interactions during TT became additional tools for them. Furthermore, the patients felt that they could participate in TT on their own terms, and they stated that it being their own choice was important. They tried their best to be involved, and they appreciated it when they were asked for ideas and when activities matched their wishes.

**Fostering feelings of distance when absent**

The patients stated that when TT was not offered, they felt disconfirmed and this fostered feelings of distance toward staff. They commented that the sessions were dependent on staff engagement and that if staff was less engaged, TT did not work as intended. When TT didn’t take place, patients described staff as being stressed and as preferring to sit in the ward office. They stated that this created an irritated atmosphere and angered patients, as they felt unimportant to staff. Overall, they felt that TT was *their time*, that it was made for them and that TT was something they had a right to. They stated that they often anticipated TT far in advance, looking forward to the sessions. If TT was cancelled, they
missed what they had been looking forward to, which made them feel disappointed and depressed. Furthermore, patients described that when they sat at different tables doing separate activities it created a distance with respect to staff. They expressed that in everyday life on the ward, they avoided staff who showed no interest in engaging in TT.
DISCUSSION

The overall aim of this thesis was twofold: first, to construct a theoretical understanding of everyday life processes in PIC wards; and second, to evaluate a nursing intervention in PIC. The theoretical understanding revealed how everyday life in PIC was influenced by the quality of interactions between patients and staff. When staff worked in alignment with their ideals, patients turned to them and felt safe. This understanding reveals possibilities for improvements in everyday life in PIC for both patients and staff. For the patients, admission can achieve its goal and contribute to recovery and staff members work situation can become aligned with their ideals, which can lead to decreased levels of stress. As a response, the TT nursing intervention was introduced and evaluated. Based on the logs and the participant observations, TT proved to be feasible for the evaluated systems. TT was enabled by shared responsibility, a friendly approach and a predictable structure, and it was hindered by a distant approach and an unpredictable structure. The measurements showed no effects on the quality of interactions and questionable effects on perceived stress and stress of conscience among staff, as well as on staff satisfaction with interactions with patients. The individual interviews with patients (IV) revealed that patients taking part in TT experienced being seen as a human among other humans, that it contributed to hope for recovery but in its absence, it fostered feelings of distance toward staff.

In the overall understanding of the findings, reciprocity, engagement and bridging seem to be essential features in everyday life in PIC. For these features to arise, ordinary relationships and joint activities appear to be adequate, active ingredients.

A conceptual review by Sandu and co-workers (2015) describes reciprocity between patients and staff within the context of PIC as focused on everyday matters, and identified through the presence of interactions, emotions and the mutual recognition of each other as fellow human beings. These attributes have been highlighted throughout this project, both by patients and staff. Patients valued trustful interactions with staff who reached out to see the person instead of the disease, who asked for guidance in how to help and who used small actions to convey their willingness to help (I). Staff valued interactions with patients and often highlighted the significance of humour, respect and confirmation in their relationships with the patients (II). Consequently, helping by being human, through the use of micro affirmations, is valued by both patients and staff in PIC. Topor and co-workers (2018) state that micro-affirmations, ‘small things’, such as words, gestures and actions might appear trivial but play a significant role in conveying messages of shared humanity and hope embedded in a recovery-oriented practice. However, the summary of the literature and the results in studies I and II imply that current specialised psychiatric
care leans heavily on the concept of medical recovery. Under these circumstances, the value of helping by being human seems to be in jeopardy of being neglected within organisations, since care focuses more on medical treatment and less on personal or social aspects of recovery.

According to Barker and Buchanan-Barker (2005), in mental health, nursing staff has deceived themselves into thinking that complex problems always need complex solutions. They have looked to other professional categories skills and downgraded their own competence and unique knowledge in nursing. Furthermore, personal relationships between patients and staff have a history of being restricted in psychiatric care (Peplau, 1991; Strang, 1982; Topor et al., 2011), perhaps due to misunderstanding of what such a relationship means. According to Peplau (1991), in nursing practice a personal relationship is one in which two people come to know each other well enough to cooperatively face the problem at hand. Topor (2001) states that personal relationships built on reciprocity can be likened to friendships and suggests that “as friends” might work as an initial attempt to define a new type of professionalism. Jackson and Stevenson (1998) showed that staff who were able to ensure a basis for friendship within their relationships with patients found that this opened up to a more satisfying encounter. Furthermore, it has been noted that patients value and relate to staff who are able to move across the boundary between friend and professional (Jackson & Stevenson, 2000; Topor et al., 2011). Barker & Buchanan-Barker (2005) also discuss this topic, referring to such relationships as ordinary relationships. In their reasoning, ordinary relationships are built through ordinary conversations in which patients’ experiences are accessed through their stories, developed in a collaboration that is based on reciprocity and equal status with staff. Study IV found similar results. Barker and Buchanan-Barker (2005) state that by sharing experiences, the relationship becomes a springboard for caring responses that are specifically and individually tailored to the present circumstances of the patient. Based on this reasoning and the results of this thesis, current PIC wards have a lot to gain if organisations acknowledged reciprocity in ordinary relationships between patients and staff as extraordinary instead of neglecting their value or even making them taboo. Furthermore, nursing staff should feel confident in taking responsibility for, and emphasizing their own competence and unique knowledge in mental health nursing.

Following the results in this thesis, engagement from staff is needed to foster reciprocity and ordinary relationships within PIC. This is highlighted in both the interviews (I, IV) and the participant observations (III). Still, disengagement was also present in the results of these studies.

Engagement with the job in nursing is a “positive, fulfilling, work-related state of mind that is characterised by vigor, dedication and absorption” (Shaufeli et al., 2002, p. 74). Vigour refers to high levels of energy while working, a willingness to invest effort in one’s work and persistence even in the face of challenges. Dedication refers to a sense of enthusiasm, inspiration, pride and challenge. Absorption refers to being present to the
extent that time passes quickly, similar to what has been called “flow” (Schaufeli et al., 2002). Kahn and Heaphy (2014) argue that it is in the context of relationships that people make choices on engagement, when they are able to interact with people toward the accomplishment of meaningful purposes and meaningful goals. It is the nature of those relationships, and the actions and experiences they enable, that matters most in terms of engagement or disengagement. Furthermore, Van Bogaert and co-workers (2013) report that work engagement is dependent on relationships within the interprofessional team and involvement in decisions about the job. Engaged teams report better quality of patient care in PIC, and if they are able to perform well, team members become more engaged and satisfied and chose to remain in their jobs. Based on the results of studies II, III and IV, in line with this reasoning, this thesis suggests that relationships within the interprofessional team in PIC need to be maintained. It is reasonable to believe that a better developed understanding of one another’s work situation, clear roles and increased cooperation through stated, meaningful and joint goals would be beneficial for improving engagement among staff. The reasoning regarding the importance of relationships for engagement also includes the nurse-patient relationship, pointing to its significance and the need to put it at the forefront of everyday life in PIC. It is reasonable to believe that such a change, combined with TT, which seemed to promote both patient and staff engagement, also could contribute to extended engagement among staff in PIC.

Working in a context such as PIC, which includes contradictory duties for nursing staff (Wyder et al., 2017) and different perspectives on choices for actions (Looi et al., 2014) with unpredictability as a consequence, might influence staff engagement in a negative way (Wyder et al., 2017). This reasoning can be associated with the obstacles described by staff (II), the enabling and the hindering factors for TT (III) and to the patients’ experiences of taking part in TT sessions (IV). The common denominator, and one decisive factor in this reasoning concerns the degree of predictability within the context. Because unpredictability seems to be an inherent part of today’s PIC wards (I, II), striving for predictability in everyday life in PIC becomes essential. The results in studies III and IV indicate that one way to achieve this could be to introduce and keep the intended strategies for TT. The results of study III as well as from study IV, show that TT seems to add a calming influence to the PIC ward atmosphere, which expands even beyond TT sessions. According to Tuvesson and co-workers (2011b) enhancements to ward atmosphere through clarifying the structure and increasing activities could improve the work situation for staff. Therefore, it is reasonable to believe that the ward atmosphere created through TT sessions would have positive influences on predictability and thereby on the work situation for staff members. Furthermore, as study IV reveals, a homelike, calm ward atmosphere contributed to patients’ hope for recovery.

Resources and adequate support to engage are needed to achieve work engagement (Van Bogaert et al., 2013). This thesis indicates shortcomings on that point. Staff described having to manage chaos for much of their time (II), and further, it was observed that a lack of staffing and material resources sometimes hindered staff from work in alignment
with the intended strategies for TT (III). Similar circumstances are described in other studies (Gabrielsson et al., 2016; Graneheim et al., 2014), indicating that contextual factors are challenging for staff in PIC and that there is a need for clear leadership within this context. Study II, however, revealed complications on this point. While the staff requested guidance from their ward managers in everyday life, the ward managers experienced having enough time only to resolve staffing issues. Also, both Graneheim and co-workers (2014) and Gabrielsson and co-workers (2016) report that nurses in PIC wards experienced management as being absent, something that could have negative consequences such as leading to health problems and prompting nurses to leave their positions. As Gabrielsson and co-workers (2016) and study II show, the current situation in PIC wards could mean that staff shift their focus from the patients’ best interest to their own survival. This reasoning suggests a need for both guidance and work duties that follow staff ideals. According to the results in both studies III and IV, TT contributes this purpose. However, in order for TT to be successfully introduced, it looks as though the purpose and the predetermined strategies for TT need to be anchored in, and supported within the organisational culture. RNs with specialised training in psychiatric care should have, and take a significant role in this, since they are not only responsible for the care they give but also for working toward achieving high-quality care on an overall level (Wiklund Gustin, 2014). To some extent, this could be complementary to the leadership role of ward managers.

As a part of engagement, staff need to reach out to the patients, since the primary initiative for establishing the nurse-patient relationship belongs to staff and not to the patient in need of care. Ljungberg and co-workers (2016) discuss how organisations with a routinised, rule-governed approach, such as we see in current PIC, come with an inherent risk of making it challenging for staff to engage with patients, since the way of being a ‘good professional’ based on the aims of the organisational rules and routines does not necessarily correspond with patient needs. Furthermore, to meet those needs requires a constant mental effort to offer something good, but also creativity and imagination and not losing sight of the possibility of establishing a relationship. Such a reasoning follows the metaphor of bridging described by Barker and Buchanan-Barker (2004, 2005), who state that the purpose of bridging is to connect, to make contact by use of any means to reach across. The initiative for any action lies in the hands of staff, and both creativity and effort are needed. Based on the results from studies III and IV, TT can be used as a tool for such efforts. The interviews with the patients (IV) revealed that the combination of feeling a sense of fellowship with staff and the activities offered a break from their mental health issues and contributed to them feeling strengthened. Barker and Buchanan-Barker (2005) argue that patients in crisis need others to be close, engaging in activity and being socially productive. Within this “safe haven” patients can feel supported and begin their process of repairing and restoration on the road for recovery (Barker & Buchanan-Barker, 2005, p. 25). Built on this reasoning, activity becomes a tool for staff. The value in activity lies in its contribution to motivation by giving patients a sense of meaning and structuring of
time. Furthermore, activity builds competence, allowing patients to acquire skills and strategies to manage challenges and also develops an identity through creativity, usefulness and self-esteem (Persson et al., 2001). Activity can be conceptualised as both a means and a goal in order to help patients with mental ill-health. Thus, the meaningfulness and purposefulness find in activities have therapeutic qualities (Trombly, 1995).

Activity is linked to doing, and according to Sutton (2008) to a great extent doing constitutes the way that patients recover. It is possible to achieve balance, coherence, connection and belonging by doing things with and for others, but this can also awaken curiosity, making the patients discover what they care for (ibid.). Despite the extensive knowledge on activity and doing, current PIC seems to have lost these core components in everyday life (I, II). Patients describe having nothing to do, and staff describes having nothing to offer. Folke and co-workers (2017) found similar results and showed that the most common activity among patients in PIC was doing nothing. Following this, it seems as both the significance of relationships between patients and staff, and that of activity, have been lost in today’s PIC, which lean heavily on the medical paradigm striving for a medical recovery, as mentioned previously. Collier (2010) claims that medical recovery should be seen as part of personal recovery and suggests that PIC need to assume this perspective. This statement is echoed by Tuffour (2017), who argues that recovery is not only about reduction of symptoms but also includes influences of activities and social relationships, and that a strictly medical perspective of recovery fails to address personal interpretations of personal crisis. Supported by these arguments, the summary of the literature and the findings of this thesis point to an urgent need to balance perspectives between medical recovery and personal recovery in PIC. One step in that direction could be to construct opportunities for joint activities, which would serve as bridging actions between patients and staff. In turn, this could lead to the development of nurse-patient relationships built on reciprocity and engagement, something emphasised in the literature on personal recovery-oriented mental health nursing. Striving for this goal is in the hands of various stakeholders. However, staff in PIC are in a central position and RNs with specialist training in psychiatric care play an essential part in the pursuit of this goal.
METHODOLOGICAL DISCUSSION

This thesis used different research methods that were selected in the basis of their power to answer research questions about everyday life processes in PIC (I, II), feasibility and effects of the intervention (III) and patient experiences of taking part in TT (IV). All the studies include methodological considerations which should contribute to the credibility of this thesis.

Studies I and II used GT, employing four criteria to evaluate trustworthiness: credibility, originality, resonance and usefulness (Charmaz, 2014). To achieve credibility, data collection was continued in studies I and II, even though it was noted that additional data did not influence the analysis regarding processes in everyday life in PIC wards. This continued data collection helped ensure that the categories covered a wide range of empirical findings and that there was enough evidence for readers to assess and agree on the findings. The originality of the results can be discussed, as they are in line with findings from previous research. However, the core categories in both studies I and II help to clarify processes in everyday life in PIC, something that the literature rarely addresses. This can also be linked to resonance. The categories mirrors both positive and negative experiences of everyday life in PIC wards and when it comes to processes, they offer deeper insights into this everyday life. Furthermore, it can be concluded that the results from both studies I and II have been useful, as they originated in a theoretical understanding that contributed to the development of the evaluated intervention.

Study III used mixed methods, combining SSED with a qualitative approach that employed logs and participant observations. Using mixed methods facilitated the search for answers to the research questions (Johnson & Onwugebuzie, 2004). Because the literature describes the introduction of psychosocial interventions in PIC wards as a complex process (Mullen, 2009), this approach was chosen in an attempt to not only study the effects of the intervention but also to follow the introduction of TT and how it interacted with the context (Moore et al., 2015).

SSED is not often used in nursing research, even though it has its advantages for studying the small, heterogeneous and complex systems that are typical of this field. In this thesis, three systems were studied by taking frequent measurements, in order to observe the possible response of the systems to the intervention. The effects of TT could also have been explored using a randomised controlled design, for example. However, this would have entailed difficulties in recruiting a sufficient number of homogenous wards, in eliminating confounding influences in such a complex context, and would also have increased the cost of the study. Because SSED research design is idiographic, it is not possible to use it to obtain generalisable knowledge. However, there are conflicting
arguments on the value of generalisability (Johnson & Onwugebuzie, 2004; Morgan & Morgan, 2009), and in this context, such knowledge could be too general for direct practice.

The positive findings regarding TT as revealed in the participant observations (III) and in the interviews with the patients (IV) were not reflected in the quantitative outcomes for patients. This might be due to certain methodological challenges. One explanation could be that the CPS questionnaire was not sufficiently sensitive to capture changes to the same extent that the observations and interviews were able to capture them. Another explanation could be the way in which the patients participated in the evaluation. Because most patients stayed in the hospital for a short period of time, few of them participated in both the baseline- and intervention phases, and two systems missed two patient measurement points in the intervention phase. This could have affected both the trends in the graphs and the PND values. Also, individual data points that differed substantially from other data points could have affected the PND values (Morgan & Morgan, 2009). Furthermore, the length of the phases and the unpredictability in the systems could also serve as possible explanations, even for the questionable effects on staff outcome.

As an RN with specialised training in psychiatric care, my understanding of the context presumably influenced the interviews, the observations and the analytic process during this project. To a certain extent, my experience was used as a tool to connect with the participants during both the interviews and the observations. However, I also tried to have an approach of curiousness and unfamiliarity. Open-ended and clarifying questions were used rather than assuming that I had an understanding or drawing quick conclusions. The research team, which included members with and without experience in the context, also helped to balance this effect through their interpretations of the texts during the analysis. Furthermore, examples of the abstractions, interpretations and quotations have been used to ensure dependability and authenticity (Graneheim et al., 2017). The participant observations in study III required awareness of the preunderstanding of the context and the participants’ view of the observer. Some could argue that the observer’s preunderstanding of the context could be mirrored in the results and that the presence of the observer could influence the participants’ behaviours (Roper & Shapira, 2000). In study III, this was taken into account. As an observer I sought to employ an open, curious and non-judgmental approach, and I explained my role and how I was going to use the information I learned to the participants. In addition, some argue that possible reactive effects should not be seen as troublesome; rather, these effects could provide a means to learn more during the observations (Emerson et al., 2011; Roper & Shapira, 2000).

In study IV, 11 interviews were performed, lasting for 10-35 minutes (median 24 minutes). All the patients had previous experience in PIC and therefore were able to evaluate TT in comparison to their earlier experiences. Their experiences with TT were both positive and negative. According to Sandelowski (1995), what defines a suitable sample size is a matter
of judgment and experience in evaluating the quality of the data. In study IV, data were assessed as both varied and rich in their content.

Last but not least, it should be emphasised that the interpretations of the qualitative data in this thesis represents certain possible interpretations, and it is not claimed they are the only truth. All being well, the interpretations allow for the participants’ voices to be heard.
CONCLUSION AND CLINICAL IMPLICATIONS

This thesis sought to construct a theoretical understanding of everyday life processes in PIC and to evaluate the Time Together nursing intervention. Following the results of the studies, the main conclusion from this thesis is that both patients and staff members in PIC call for high quality interactions in everyday life on the wards. When staff members can work in alignment with their ideals, improvements in everyday life, which contribute to patients’ recovery and decrease risks for stress among staff, are possible. In the pursuit of this, TT could work as a tool for staff as it is feasible and can be introduced in PIC wards. A shared responsibility, a friendly approach and a predictable structure is highlighted as enabling factors for the intervention and patients experience that TT contributes to being seen as a human among other humans and to hope for recovery.

The clinical implication of this thesis concern the use of joint activities as bridging actions that could lead to the development of ordinary relationships built on reciprocity and engagement, something emphasised in personal recovery–oriented mental health nursing. Current PIC can have a lot to gain if organisations acknowledge this aspects of care as there seems to be an urgent need to balance the perspectives of medical recovery and personal recovery in this context.

Because the challenges that the intervention presents appear to be in keeping the intended structure, as well as in engagement among staff, the clinical implication also concern the need for organisations, ward managers and RNs with specialised training in psychiatric care to anchor the goal of the intervention among staff and to address the challenges when implementing the intervention. Also, all involved need to promote shared responsibility, a friendly approach and predictable structure on the wards when implementing TT, in order to facilitate the success of the intervention.
FURTHER RESEARCH

There is an ongoing need to both highlight and improve the current content of everyday life in PIC. The results of this thesis indicate that TT has the potential to contribute to patients’ recovery in PIC and to decrease perceived stress and stress of conscience among staff. It is therefore necessary to continue the evaluation of TT in order to build on the evidence for the intervention. Such a continuation of this line of research would also contribute to our understanding of evaluations of nursing interventions in this complex context.

In order to adjust and develop TT, there is a need to continue to illuminate staff experiences in taking part in TT sessions and to evaluate the processes of introducing TT by studying decision making within organisations. The literature contains few such evaluations of interventions similar to TT. A further idea would be to explore whether TT could be enhanced by providing staff with more extensive training on the purposes of the intervention and its theoretical framework. Furthermore, building on the evidence for TT requires the introduction and evaluations of the intervention in more psychiatric contexts, using other designs or an extended intervention phase, measuring additional outcomes and studying the intervention’s effect on treatment results and cost effectiveness.
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