

## Caring in intensive psychiatry

*To my beloved wife Maria and my children Perla and Isidor*

*Örebro Studies in Care Sciences 47*



MARTIN SALZMANN-ERIKSON

**Caring in intensive psychiatry**  
**Rhythm and movements in a culture of stability**

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*Title:* Caring in intensive psychiatry  
Rhythm and movements in a culture of stability.

*Publisher:* Örebro University 2013  
[www.publications.oru.se](http://www.publications.oru.se)

*Print:* Örebro University, Repro 08/2013

ISSN 1652-1153  
ISBN 978-91-7668-956-1

## Abstract

Martin Salzman-Erikson (2013): Caring in intensive psychiatry – rhythm and movements in a culture of stability. Örebro Studies in Care Sciences 47.

The overall aim of this thesis is to describe and explore the concept of caring in intensive psychiatry. An initial inventory was made of nursing care activities in a PICU, based on an analysis of critical incidents. This inventory resulted in four categories: supporting, protecting and use of the structured environment (Study I). Caring in intensive psychiatry was also studied through ethnographic fieldwork that led to the conceptualization of the PICU staff as projecting a culture of stability. Within this culture, the overall goal was to prevent, maintain and restore stability as turbulence occurred. Cultural knowing, as expressed through nursing care, was further described in terms of providing surveillance, soothing, being present, trading information, maintaining security, and what has been termed reducing (Study II). A focused approach was applied to study the staff's different approaches to observing patients in relation to the practice of surveillance in psychiatric nursing care. PICU staff moved flexibly between a latent and a manifest approach to surveillance (Study III). Having conceptualized the culture as one of stability, a concept analysis was conducted upon the concept of stability. The analysis revealed that stability is by no means a static condition; it fluctuates and can be distorted. Intervening with nursing care when turbulence occurs, can involve both the use of active and passive stability systems (Study IV). Further, I argue that caring in intensive psychiatry can be accurately described as the projection of rhythm and movements. Nursing care in terms of movements creates fluctuations in stability as it entails a rhythm of caring in intensive psychiatry. In conclusion, physical boundaries and incorporated control along with tactful sensibility involve rhythm and movements within limited structures and closeness in care. This thesis contributes to articulating advanced nursing practice within intensive psychiatry.

*Keywords:* Acute psychiatric care, concept analysis, critical incident technique, ethnography, intensive psychiatry, nursing staff, psychiatric care, psychiatric hospitals, psychiatric nursing

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## ORIGINAL PAPERS

This thesis is based on the following original papers, which are referred to by their respective Roman numerals:

- I. Salzmänn-Erikson, M., Lützn, K., Ivarsson, A-B., Eriksson, H. (2008). The core characteristics and nursing care activities in psychiatric intensive care units in Sweden. *International Journal of Mental Health Nursing*, 17, 98-107.
- II. Salzmänn-Erikson, M., Lützn, K., Ivarsson, A-B., Eriksson, H. (2011). Achieving equilibrium in a culture of stability – cultural knowing in nursing care on psychiatric intensive care units. *Issues in Mental Health Nursing*, 32(3), 255-265.
- III. Salzmänn-Erikson, M. & Eriksson, H. (2011). Latent or manifest observers – two dichotomous approaches of surveillance in mental health nursing. *Nursing Research and Practice*, ID 254041, 7 pages. doi:10.1155/2011/254041
- IV. Salzmänn-Erikson, M. (2013). Stability in intensive psychiatry: a concept analysis. *Perspectives in Psychiatric Care*. doi: 10.1111/ppc.12030.

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## ABBREVIATIONS AND KEY CONCEPTS

Several key concepts that are used in the thesis warrant clarification here. The concept ‘psychiatric intensive care unit’, and its associated acronym ‘PICU’, refers to a spatial and physical unit where patients reside, see ‘Settings’ for further elaboration. Within these units the term ‘psychiatric intensive care’ is used as a general term to refer to the multi-professional care that is provided for the patients who are admitted there. ‘Nursing care activity/-ies’ refers more specifically to individual nursing acts or the presence of nursing activity as performed by registered nurses or enrolled nurses. To vary language use nurses are also referred to as ‘staff members’, ‘cultural members’, ‘participants’, ‘informants’ and ‘PICU-staff’. Further, the concept of ‘nursing practice’ refers collectively to the recurring events comprising nursing care activities. ‘Intensive psychiatry’ is an unofficial term, and is used here to describe the principle of psychiatric care that is applied within a specific area in which psychiatric intensive care is practiced. This type of care is distinguished from ‘acute psychiatry,’ which is also an unofficial speciality of psychiatric care. Intensive psychiatry refers to the most acute form or level of in-patient psychiatric care and differs from emergency psychiatry that focuses on short-term assessments in emergency rooms, receptions and triage. Lastly, ‘caring in intensive psychiatry’ is applied to both the clinical practice of nursing care and the academic practice of research among professionals within care sciences focusing on intensive psychiatry. The concept of ‘caring’ is used as an overarching concept while the concept of ‘nursing’ is a more practical activity.

## INTRODUCTION

My name is Martin Salzmänn-Erikson and this is my thesis: “Caring in intensive psychiatry - rhythm and movements in a culture of stability”. Ontologically I adhere to a worldview of relativism in that I argue for the existence of multiple realities that cannot be studied objectively as there is no absolute truth. I hold that our perception of reality is the projection of an ongoing construction and reconstruction from points of reference that we experience through life. When our perceptions of reality are experienced together with other people and communicated through language, this arranges our modes of thinking, interpreting and behaving and projects a shared understanding of the world - culture. Epistemologically I adhere to the tenets of subjectivism and hold that knowledge is a projected product that is created on the basis of the researcher’s position as a subject who actively engages with the phenomena under study and interacts with those people who are being studied. Such a subjectivist approach unites the researcher and the academic product and regards them as inseparable. Having abandoned objectivist assumptions and their hallmark of distancing the researcher from the object of study, my adoption of subjectivism entails taking a different type of responsibility as I argue that knowledge is co-constructed with the informants. The subjectivist approach demands transparency and therefore this thesis begins with a presentation of myself and a reflection over my own experiences of psychiatric care; for as Malterud (2001) states "Preconceptions are not the same as bias, unless the researcher fails to mention them" (p. 484).

I was introduced to psychiatric care in 1995 when, as a 17 year old high school student, I had a practical student internship on a general acute psychiatric ward suited for patients diagnosed with various forms of depression and other mood disorders. During my first week out of four, the staff had a meeting that I was not allowed to participate in. Before leaving for the meeting, my supervisor instructed me to “put out some coffee and hold down the fort.” Without further instruction I was left alone on the ward with 15 patients - I was terrified. I clearly remember that two patients were dancing in the dining room while another patient took a pitcher of water and had a “shower” on top of the coffee table all the while laughing a “crazy laugh”. I was ordered to keep the ward under surveillance but I was clueless as to what that meant or what I was supposed to do. I was shocked. Finally, a middle-aged man, likely a psychiatrist, passed by. I grabbed him and asked what I should do; while disappearing from view he mumbled, “Well...I’m sure you will figure out something.” In the first instance this situation left me scared, but at the same time, I was filled with

a curiosity about the idea of “going mad”. After this episode I was hooked on psychiatric care and had formulated some of the basic questions I continue to pose to psychiatric nursing, and which resulted in this thesis almost 20 years later.

I tested working in different areas within psychiatric care; long-term care for patients diagnosed with schizophrenia, acute psychiatric care and also psychiatric intensive care. When I took a summer replacement job at the local psychiatric intensive care unit (PICU) I was excited as it reminded me of the chaotic situation two years earlier. The unit had ten beds and most of the patients walked back and forth along the corridor, some screamed, some sang out loudly, one patient kept telling me bizarre stories, and yet another individual incessantly threatened staff and other patients. One afternoon a nurse gathered some of the new summer workers, like myself, for a ten-minute lecture on encountering patients and the basic tenets of the job we were supposed to do. I was told that my job was to sit and listen to the patients. I also tried to learn by watching colleagues and I was told that as long as the patients were able to “behave” in the ward, they were allowed to occupy the public spaces, otherwise they should be placed in their rooms. A colleague informed me that the standard procedure was to tell the patient to keep quiet if he or she was singing, being loud or behaving “improperly”. If the patient continued to make disturbing noises they should be guided to their room. If the patient came out and showed the same behaviour I should repeat the action. If the patient came out a third time, he or she should be mechanically restrained.

I became a registered nurse at the age of 22 and was employed at a PICU. Initially, I was focused on gaining an understanding of what the work entailed. During my training period I was very task-oriented when it came to different administrative and medical procedures. Once I had begun my specialist education to become a mental health nurse I gradually started to take nursing theories into account when considering patient care. Implementing nursing theory into clinical practice took my nursing skills to a whole new level and I believe it gave me confidence and direction in what can be a vague practice. General theories of health and suffering were often too blunt when applied to nursing practice in the PICU. As I matured as a nurse, I was eager to contribute to developing the care on the ward. During ward meetings and on planning days, an ongoing discussion took place that was guided by some basic questions ‘What is a PICU?’, ‘What are we doing with our patients?’ and ‘What is specific to the care on our PICU?’. These questions gave rise to this thesis and continue to be the driving force behind my research.

By way of introduction it is important to position PICUs within the context of the key issues that motivated this thesis as well as to delineate the area of knowledge. There are no national guidelines in Sweden addressing care in PICUs, nor their position in relation to other facilities, such as acute wards. An articulated but informal agreement on the role of PICUs states that they are to provide care for those patients who suffer from the most severe symptoms during the most acute phase of mental illness. Another role the PICU plays is to be a remittent for patients who cannot be cared for in acute psychiatric wards due to the severity of their illness. Patients are admitted to the PICU with reference to the Mental Health Act, most often with diagnoses of schizophrenia, mania and personality disorders. Younger male patients are over-represented and aggression and violence are common reasons for admission. Defining the PICU in these terms gives rise to expectations of a high-quality specialized care. Yet, only a few studies have addressed the work of nurses in PICUs. Nursing interests and assumptions in intensive psychiatry have not yet been fully investigated in relation to the concept of caring. There also seems to be a shift in perception with respect to how to approach patients and which care ideology to adopt in inpatient psychiatry. Traditionally care has been highly influenced by a perceived need to control and correct patients' deviant behaviours through the use of power and rigid rules. However, alternative ideologies that focus more on the interests of the patients and flexibility in care are growing in acceptance.

Previous research indicates a lack of knowledge in how to interact with the most acutely ill patients in psychiatric care. In the absence of such basic knowledge, nurses in PICUs rely heavily upon traditional psychiatric nursing techniques such as high doses of medications, restrictions and confinement of patients and use of basic communication skills. Anecdotal evidence reveals typical PICU staff statements such as “we cannot do anything while we wait for the patient to land”, or “the patients are admitted to bide time until their medicine takes effect”. Viewing the PICU in terms of a “waiting room” not only downplays advanced nursing practice it also manifests a pessimistic clinical view and subordinates the role of nurses to that of passive bystanders. However, patients are being discharged or transferred to less restrictive settings and this implies some sort of improvement or progression in mental illness. This may be the result of isolated pharmacological interventions, although I hold that other aspects are central as well - caring. Caring for the most ill patients demands a highly specialized facility equipped with resources, competence and clarity of mission. It is beyond the limits of a single doctoral thesis to fully cover the entire spectre of research questions here. It is the intention of this thesis to illuminate and elaborate on the underlying prerequisites and principles of caring in intensive psychiatry.

## BACKGROUND

This background begins with an overview of the theoretical body of knowledge that has been developed through previous research in the field of psychiatric intensive care. I introduce the concept of psychiatric intensive care units (PICUs) and present the position of the PICU in relation to the wider context of psychiatric care. I will also summarize my views on the existing research literature in the field of psychiatric intensive care and how it directs the notion of how to care for the most acutely ill patients. Next, I will narrow the perspective and focus on theoretical aspects from a nursing science perspective. Lastly, I will provide a summary and rationale for the thesis as a whole.

In an early phase of this project, I understood that PICU research is a strictly limited area of academic investigation. My literature search was broadly defined and sought to identify articles addressing PICUs from any perspective or discipline. Different librarians were consulted at different times during the project in order to find further studies, reports, policy documents and non-scientific published material. I was also in contact with the National Board of Health and Welfare as well as the Swedish Association of Local Authorities and Regions to identify published documents, though no official documents were located. The search using scientific databases resulted in a few hundred articles, but the search results for other kinds of material was strictly limited to non-Swedish documents, for example guidelines published by the British authoritative Department of Health. Some hospital webpages provide a brief description of their PICU and similarly describe these in terms of what professions are represented there and the bed capacity. The published articles that address psychiatric intensive care tend to be small reports from single hospitals, reporting descriptive statistics for the respective PICU. These reports typically present patient characteristics and the prevalence of coercive measures and interventions along with how use of such approaches can be reduced and the outcome. While patient aggression and violence is addressed in the research literature, other severe symptoms are relevant within the PICU environment. Crowhurst and Bowers (2002) note the absence in knowledge regarding how to effectively care for the most ill patients who demonstrate agitation due to psychosis, delusional talk, and over-activity to mention a few symptoms that are frequent in PICUs.

As a result of my literature review I identified different strategies in care that are presented under separate headings: providing care on the basis of risk assessment tools, use of pharmacological interventions, use of seclusion and restraints, and less restrictive interventions.

## **Rachlin constructed the first PICU in the Bronx**

Stephen Rachlin, while working at Lincoln Service of Bronx State Hospital, New York, USA, coined the concept of psychiatric intensive care in a research article in the 1970s (Rachlin, 1973). He noted that almost one-third of the patients left the hospital without permission through general psychiatric wards using the open door policy and were discharged due to these elopements. Rachlin recognized an urgent need for a special unit for high-risk patients who did not respond to treatment in open acute wards. He opened a new unit with the possibility to lock the entrance door to the general psychiatric hospital. The new ward was described as being able to treat patients with special needs in the acute phase. Rachlin published his article in *Hospital and Community Psychiatry* where he reported on the first 11 months of running the unit and included data from the first 50 patients. Rachlin observed that PICU patients differed significantly from acute ward patients in some regards. They were significantly younger, male patients were significantly over-represented when compared to other wards, and to a greater extent they had been admitted previously to the hospital. Further, patients were admitted mostly due to risk of elopement and due to being a danger to themselves or others. Rachlin addressed some drawbacks of this new ward. He reported that the purpose of the PICU was misunderstood by those working on other hospital wards, where staff spread incorrect rumours about violent patients and the treatment of these patients. Another problem Rachlin addressed was that patients were dumped there from other wards. Rachlin addressed liaison problems with other wards as it was sometimes problematic to send patients back to the referral ward. Despite these difficulties, the PICU provided a safety measure for society as it reduced elopements and was able to provide short-term quality care. Due to the high staff-patient ratio, the care was described as including a whole new therapeutic experience for patients as some refused to leave the PICU. Rachlin's PICU had a clear structure within an intensive environment, applied liberal use of medicines, and staff were able to engage more closely with fewer patients due to the high level of staffing. Rachlin's study is well cited although it is more of an evaluation report than a presentation of research results. Nonetheless it provides an important contribution to inpatient psychiatry by conceptualizing an aspect of intensive care. Although Rachlin reported on a PICU located in the USA over 40 years ago, it is of interest here as much of his depiction could apply to a contemporary Swedish PICU.

## **PICU in the post-Rachlin era**

After Rachlin's (1973) introduction of the concept, other hospitals followed suit and opened their own PICU. Goldney, Bowes, Spence, Czechowicz and Hurley (1985) reported from a PICU opened in Adelaide in Australia, noting the hospital was then able to treat acutely ill patients. One year later another study reported from a newly opened PICU for mainly suicidal patients in Edmonton, Canada (Warneke, 1986). The first PICU in Europe was opened 1972 in England at St. James's Hospital in Portsmouth (Mounsey, 1979) and at the end of the 1970's in Scotland (Basson & Woodside, 1981). A review of the articles from that time indicates that the overall trend was to report descriptive statistics regarding patient demographics (Basson & Woodside, 1981; Jeffery & Goldney, 1982; Musisi, Wasylenki & Rapp, 1989) and presence of violence (Goldney et al., 1985; Goldney, Spence & Bowes, 1986; Mitchell, 1992). Many studies published in this research area are based on small samples and do not address interventions, and few articles have used randomization and control groups. Despite these methodological weaknesses, these early publications were an important starting point for the spread of the concept to other countries around the world. Later on, research articles tended to report on the use of neuroleptics as a treatment option (Brown & Bass, 2004; Hyde, Harrower-Wilson & Morris, 1998; Wynaden et al., 2001), use of seclusion (Cohen et al., 2008; Dye, Brown & Chhina, 2009) and strategies to decrease the use of restraint and seclusion (Canatsey & Roper, 1997; Georgieva, de Haan, Smith & Mulder, 2009; Sullivan, Wallis & Lloyd, 2004). On the basis of published peer-reviewed articles it can be determined that PICUs were also established in other countries: Sweden (Palmstierna, Huitfeldt & Wistedt, 1991), Japan (Hatta et al., 1998), in Slovenia (Dernovsek et al., 1999) and in Netherland (Georgieva et al., 2009). However, it is not possible to fully determine to what extent the concept of PICU has been accurately applied in the different countries since the organisation of healthcare differs radically. However, based on the descriptions in these articles, they seem to be quite similar regarding patient characteristics, number of beds, length of stay and treatment. Beer, Pereira & Paton (2008) address the lack of a clear concept and argue that the lack of coherency creates difficulties as some use 'extra care wards', 'high dependency', 'special care', and 'locked wards'. In Norway and Denmark, the concept of the PICU has not been adopted; rather the concept of '*skjerming*' is used (this roughly translates to "sheltering", though the word cannot verbatim be translated into English) but has been translated to PICU by Vaaler (2007). In Sweden, 14 out of 21 councils and regions use the concept of PICU while seven do not. This might indicate that the

most acutely ill patients in these seven counties and regions do not receive a proper level of care. Another interpretation is that acute care wards operate as PICUs. Some researchers have addressed this conceptual confusion and have called for a universally agreed upon definition (see for example Beer, Paton & Pereira, 1997; Georgieva et al., 2009).

### **Creating the structures of PICUs and process of legitimization**

Although the PICU was first conceptualized and developed in the USA, researchers and clinicians in the UK have been highly engaged in the process of legitimizing the concept of psychiatric intensive care. Several British researchers have tried to determine the role of the PICU, as they describe it, focusing on short-term patient treatment for those who demonstrate highly challenging behaviours that are difficult to manage in acute wards and those patients who require close observation due to a risk of self-harm or risk of harm others (Brown & Langrish, 2007a; Stewart & Bowers, 2011). Further, both research articles as well as anecdotal evidence support the claim that the diffuse definitions of PICU create a tension between acute and intensive care and their different roles (see for example Bowers et al., 2003; Gentle, 1996; Rachlin, 1973). The question becomes even more relevant as most acute wards have locked doors like PICUs (Bowers, 2012). Beer and colleagues (2008) point out that the key differences between PICUs and acute wards are levels of staff, facilities and level of security. In a later study Bowers and colleagues (2003) summarize appropriate reasons for admissions to PICUs. These include: patients who pose a risk to others, risk causing intentional and/or unintentional harm to themselves, patients who benefit from the low stimulus environment in the PICU and the legitimization of acute ward care. In 2002 the Department of Health in the UK published the first version of the Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments, more recently updated in in 2012. In this guide, PICU are defined as follows:

“Psychiatric intensive care is for patients compulsorily detained usually in secure conditions, who are in an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self-control, with a corresponding increase in risk, which does not enable their safe, therapeutic management and treatment in a general open acute ward.

Care and treatment offered must be patient-centred, multidisciplinary, intensive, comprehensive, collaborative and have an immediacy of response to

critical situations. Length of stay must be appropriate to clinical need and assessment of risk but would ordinarily not exceed eight weeks in duration.

Psychiatric Intensive Care is delivered by qualified staff according to an agreed philosophy of unit operation underpinned by principles of risk assessment and management.” (DoH, 2012, p.3).

To summarize, minimum standards are presented that address key areas of psychiatric intensive care related to admission criteria, care, environment, leadership, user involvement and discharging patients, among other areas. However, the standards provide guidance in point form only and do not address the nuances and in-depth knowledge of nursing practice.

This background has so far considered more structural issues related to psychiatric intensive care units. In the next section we will look at issues related to the humans within.

### **Care recipients in the PICUs**

Few recently published studies report on PICU patient characteristics. In the early years of PICUs, Rachlin (1973) reported some demographic differences between PICU and general patients and noticed that the mean age was lower in the PICU-population than in general psychiatric wards, 27 years versus 34.1 years. Males were overrepresented in the PICU, 68% versus 48% and the number of readmissions was higher in the PICU-population, 70 % contra 52 %. Similar to Rachlin’s study, most studies are based on a small sample. Age, sex, diagnosis, reasons for admission and presence of violent behaviour are the most commonly reported items. Several articles report that the mean age is about 30 years old (Cohen & Khan, 1990; Eaton & Ghannon, 2000; Mitchell, 1993; Wykes & Carroll, 1993), males are overrepresented (Dolan & Lawson, 2001; O’Brien & Cole, 2004; Pereira, Sarsam, Bhui & Paton, 2005; Wynaden et al., 2001). Some articles indicate that schizophrenia is the most common diagnosis (Brown & Bass, 2004; Pereira et al., 2005; Wynaden et al., 2001). Further, Bowers and colleagues (2008) report that many studies from the UK demonstrate a consistency in reporting that about half of the patients are diagnosed with schizophrenia followed by about one-fifth suffering from mania. Other common diagnoses are personality disorders (Brown & Bass, 2004; Pereira et al., 2005). Patients in PICUs are likely to express violent behaviour both as a reason for admission as well as during their stay (Gintalaite-Bieliauskiene, Tandon & Wochit, 2011; Saverimuttu & Lowe, 2000; Wynaden et al., 2001). Regarding length of stay, DoH (2012) recommends a duration not exceeding eight weeks and studies report short

stays of about one week (Saverimuttu, 1996; Wynaden et al., 2001), but Gintalaite-Bieliauskiene and colleagues (2011) report that patients diagnosed with personality disorders tend to stay longer than recommended by DoH (2012). Sociodemographic data show that a majority of the PICU patients are single (Brown & Bass, 2004; Gintalaite-Bieliauskiene et al., 2011; Pereira et al., 2005) and unemployment rates among this population exceed 75 % (Feinstein & Holloway, 2002; Cohen & Khan, 1990).

### **Aggression and violence in PICUs**

Nolan, Soares, Dallender, Thomsen & Arnetz (2001) define violence as: ‘an act that includes physical force such as slapping, punching, kicking and biting; use of an object as a weapon; aggressive behaviour such as spitting, scratching and pinching; or a verbal threat involving no physical contact’ (p. 421). Several articles report on the occurrence of violence in PICUs (Saverimutti & Lowe, 2000; Wynaden et al., 2001) and one study reports that violence is three times more likely in PICUs compared to acute wards (Brown & Bass, 2004). According to Hyde and Harrower-Wilson (1994) temporary staff, crowding, and architecture are factors contributing to violence in PICUs. Since schizophrenia is the most frequent diagnosis in PICUs (Abderhalden et al., 2008; Brown & Bass, 2004; Pereira et al., 2005) it is meaningful to highlight some meta-studies focusing on the positive correlation between schizophrenia and violent behaviour (see for example Fazel, Gulati, Linsell, Geddes & Grann, 2009; Volavka & Citrome, 2008). Duxbury and Whittington (2005) identify discrepancies in perspective over who initiates violence. In their study, psychiatric nurses linked patients’ violence to mental illness while the patients viewed poor communication and ineffective listening skills as the main reasons. Björkdahl, Palmstierna and Hansebo (2013) report on several important items that had a significant impact upon violence prevention and management in the PICU environment, including good rules on the ward, approaching aggressive patients calmly, staff trying to understand why patients are aggressive, and the ability to approach patients upon the first signs of aggression. There are several approaches in research that indicate an attempt to reduce aggression and violence. Some strategies are more focused on risk assessment while other strategies focus on how to approach aggression and violence in the actual situation.

### **Prevention using risk assessment tools**

A relatively large amount of research has been conducted on the management of aggression and violence in inpatient psychiatry and some research

has been conducted within PICU settings. Björkdahl, Olsson and Palmstierna (2006) hold that predicting violence in PICUs must be considered as the most important task if one wishes to avoid coercive interventions and create a safe environment. The popularization of strategic and targeted interventions for predicting violence in psychiatric care was first initiated in the 1970's, though more structured predictive assessment scales were not developed until the 1980's and 1990's (Levander, 2011). Some of the most established violence predicting scales are the Violence Risk Appraisal Guide (VRAG) by Harris, Rice and Quinsey (1993), the Violence Prediction Scheme (VPS) by Webster, Harris, Rice, Cormier and Quinsey (1994), Violence Risk Scale (VRS) by Wong and Gordon (1996) and HCR-20 by Webster, Douglas, Eaves and Hart (1997). It is reasonable to question the value of these assessment tools in intensive psychiatry as they are more or less used to make long-term predictions and were mainly developed for forensic psychiatry. Long-term predictions are predicated on actuarial data such as previous violence, drug abuse and certain diagnosis (Levander, 2011). In PICU settings, short-term assessment tools are needed since other risk variables are more relevant. Almvik and Woods (1999) and Almvik, Woods and Rasmussen (2000) first developed the Brøset Violence Checklist (BVC) for short-term prediction of violence within the next 24 hours, which takes up to five minutes to fill out. BVC is based on six variables: confusion, irritability, boisterousness, verbal threats, physical threats, and attacking of objects. Björkdahl, Palmstierna and Hansebo (2010) implemented the use of BVC in PICUs. They report that if a patient demonstrates one of the variables, it is six times more likely that the patient will be aggressive within the next 24 hours compared to if a zero was scored.

### **Providing care using pharmacological interventions**

Pharmacological therapy in PICUs aims to reduce symptoms as fast as possible and build an alliance for long-term management (Okocha, 2008). The use of pharmacological interventions in PICUs is supported by the literature, and is sometimes addressed as rapid tranquilization (Cornwall & Scott, 1996; Hyde & Harrower-Wilson, 1994; Parker & Khwaja, 2011). Holmes and Simmons (2008) distinguish between rapid tranquilization (RT) that is used to control agitation and destructive behaviours and rapid neuroleptics (RN) which is used to reach remission in illness. Mullen and Drinkwater (2011) conducted a retrospective study to report upon the use of PRN over a four-year period in a PICU in Australia. They report an observed 52% reduction in the total PRN medication given over the four years. Diazepam was the most commonly used drug and represented about one-third of all PRN medication given, the second most given drug was

Haloperidol. For further reading about pharmacological treatment in PICUs readers are directed to Holmes and Simmons (2008) and Okocha (2008) as this topic is not the focus of this thesis.

### **Providing care through seclusion and restraint**

An alternative to pharmacological interventions is the use of seclusion and restraint (S&R), which is practiced in both acute and intensive psychiatry as a strategy for dealing with patients who demonstrate aggression and violence. The therapeutic reason for using seclusion is held to be that patients require a reduction in stimuli and also to prevent harm, aggression and risk of violence (Norvoll, 2008; Vaaler, 2007). According to Swedish legislation (SFS 1991:1128), seclusion is justified in situations where a patient expresses aggressive or disruptive behaviour that seriously complicates other patients' care. During seclusion, the patient is continuously monitored. The law also justifies the brief use of a belt or similar device when patients are in immediate danger of hurting oneself or others. In a review article conducted by Stewart, Van der Merwe, Bowers, Simpson & Jones (2010), seclusion is defined as "the temporary isolation of a patient in either a specifically designed room, usually non-stimulating, bare, or sparsely decorated (seclusion room), or any other single room, locked from the outside, usually with a window for observation." (p. 414), while restraint is defined as "the use of straps, belts, or other equipment to restrict movement" (p.413). Vaaler (2007) distinguishes between physical restraint, when a patient is restricted by staff holding him/her manually, and mechanical restraint, when the patient is restrained by belts or similar to totally prevent the patient from moving. The literature shows that S&R is frequently used in PICUs (Brown & Bass, 2004; Cohen et al., 2008; Dye et al., 2009; O'Brien & Cole, 2004; Tunde-Ayinmode & Little, 2004). Some studies provide evidence that S&R is used more frequently in PICUs compared to acute wards (Brown & Bass, 2004; Cohen & Khan, 1990; Wynaden et al., 2001). Dye et al. (2009) state that property damage and violence are two factors that are most associated with the use of seclusion in PICUs. A national survey conducted in the UK using data from 164 units (including 96 PICUs) reports that almost 50 % of the PICUs had facilities for seclusion (Pereira, et al. 2005). Dye et al. (2009) report on the frequency of use of S&R. Their study is based on retrospective data from 46 seclusion and 208 episodes of physical restraint from seven PICUs in the UK on the basis of 332 admitted patients over an 18-month period. The duration of seclusion ranged between 20-600 minutes and mean length was 101 minutes and median 80 minutes. Dye and colleagues also found that 27 % of the patients in PICUs were physically restrained, and further that

restraining patients was used five times as often as seclusion. Regarding duration in restraints, this ranged between 3-150 minutes, with a mean length of 5 minutes and a median of 7.2 minutes.

Coercive measures such as seclusion are questioned as a strategy in psychiatric care (Salias & Fenton, 2000) as this is a traumatic experience and is associated with feelings of anger, humiliation, and loneliness both during and after being secluded (Hoekstra, Lendemeijer, & Jansen, 2004). Seclusion as well as mechanical restraint are controversial as these methods stem from centuries-old practices and are questioned due to lack of alternatives and progression in treatment methods in the discipline and practice of psychiatric care. Further, evidence regarding efficacy of S&R has not been verified in any randomized control trials (Salias & Fenton, 2000). More recently, Nelstrop et al. (2006) also conclude that there is insufficient evidence to determine that seclusion and restraints are effective measures for managing disturbed behaviours. Though it is argued that seclusion is justified in certain violent situations as there is no effective alternative to date (Hoekstra et al., 2004), S&R can be fraught with physical injury to the patient. Heart problems, asthma, previous muscle and skeleton injuries, pregnancy, extreme fear, fatigue, substance abuse and high doses of medicine are factors that increase the risk of injury under restraint (Beer et al., 2008). The reviewed articles focus on the need to expand alternative strategies to seclusion and restraint. In the next section, alternative interventions will be reviewed.

### **Providing care in PICUs via less restrictive interventions**

As discussed above, different factors contribute to the use of S&R, although much of the contemporary research addresses alternative strategies to decrease its use. Georgieva et al. (2009) report on successful changes in a PICU in the Netherlands where seclusion was almost eliminated. The authors stress staff skills in de-escalation techniques, environmental factors and close involvement with patients, attitudes changing from control to negotiation, having a skilled leadership and implementing a crisis-management plan on an individual basis as factors that contributed to such a successful decrease in seclusion episodes. Similar to Georgieva and colleagues (2009), Mullen and Drinkwater (2011) emphasize the implementation of a patient-centred nursing model and a change in leadership as having had a major impact on reducing seclusion. Qurashi, Johnson, Shaw & Johnson (2010) report in their study that seclusion episodes decreased by 67 % over a five-year period as a result of a wide range of interventions. Each month, all seclusion episodes were analysed in order to learn from them and challenge cultural norms. In addition, they used the hospital

gymnasium as an alternative to traditional rehabilitation activities and this proved beneficial as it provided a time-out for both patients and staff. Lee, Cox, Whitecross, Williams and Hollander (2010) developed Safety Tools which included the identification of stress triggers, warnings signs and calming strategies. They report that the use of physical activity or exercising, playing or listening to music, and talking to the staff were the most effective calming strategies and reduced seclusion rates from 65 % to 26 % over a six-month period.

In his review of the current literature on interventions to reduce the use of S&R in psychiatric settings Scanlan (2010) identifies clear leadership, policy changes and determination as the significant variables. Other kinds of measures include staff training, change in attitude, increasing knowledge of de-escalation techniques, increasing the staff ratio as increased interaction between staff and patients reduces seclusion episodes, modifying the ward environment by reducing distress, involving patients in daily programmes and changes of ward routines. A violence prevention and management training programme called the TERMA was developed at Haukeland University Hospital in Norway and has become known as the 'Bergen model' in Sweden. The model is based on three levels of prevention and management. The first level is about building and maintaining good relationships with patients in daily settings. The second level is about setting limits and calming upset and aggressive patients to avoid further escalation, while the third level is about taking physical control of violent situations and debriefing following incidents with the patient (SLSO, 2013).

### **Rigidity versus flexibility: discrepancies in ideology of care**

As discussed above, the frequency of S&R may be decreased through the use of activities (see for example Lee et al., 2010). However, the meaning of the concept of 'intensive' in psychiatric care varies in the literature. Cohen and Khan (1990) refer to intensive as implying a lack of activities and hold that the PICU environment is therapeutic in terms of being antipsychotic. Similarly and more recently, Vaaler (2007) argues that the current principle of stimulus reduction and segregation from other patients is an effective strategy in PICU ideology. Another Norwegian doctoral thesis (Norvoll, 2008) identifies ideologies for the use of '*skjerming*' (meaning sheltering, in this context comparable to the concept of seclusion/isolation or PICU). First, she addresses the ideology of reduction of stimuli since the patients she studied were regarded as being prone to anxiety if they were exposed to social activities and visual impressions. Norvoll reports upon another ideology for improving patient recovery that rests on providing structure through the environment, setting limits and correcting deviant

behaviours. This is based on the idea that patients are in chaos and must be aided in “settling down” through structure and limitations. Norvoll regards the PICU as protective and supportive as patients are closely monitored and staff are present to ease fear and anxieties when necessary. A final ideology that is applied to the PICU is that such units can be utilized where there is a need to reduce violence and when extra safety precautions are in order, because the PICU prevents access to items or instruments that can be used by patients in confrontational situations. These ideologies contradict the work of other researchers such as Rosen (1975) and Gentle (1996) who refer to the intensive aspect as the close relationship between staff and patients. Recently the assumptions underlying claims for stimuli reduction as a solution for PICU care have come into question. Newer studies indicate that what is needed is the implementation of comfort rooms, also called sensory rooms, with carpets, paintings, music, jump ropes, etc. (Sivak, 2012; Novak, Scanlan, McCaul, Macdonald & Clarke, 2012). The ideology in care that Norvoll (2008) reports on is restrictive and is constantly being challenged by those who advocate for more flexible ideologies among nursing approaches. In an editorial, Freeth (2007) poses the question of whether there is room for another paradigm in psychiatric intensive care that focuses on relationships. The notion of how to approach patients in PICUs is less described in the literature. Delaney and Johnson (2006) emphasize a framework for staff on acute care wards that involves an ideology of tolerance and flexibility rather than controlling to keep the unit safe. More specifically in PICU care, Björkdahl, Palmstierna & Hansebo (2010) emphasize two separate nursing approaches. The first is metaphorically referred to as the bulldozer approach because it is grounded in the existence of sufficient power to keep the unit safe through controlling and setting limits. In contrast, the second approach is metaphorically called the ballet dancer as it adheres to softer core values that direct the staff to use themselves as fine-tuned instruments, and primarily make use of one-on-one communication. Carlsson (2003) addresses the problems of violent encounters in psychiatric care and argues that the ability of the staff to be in the moment by being responsive and sensitive is crucial. As these approaches are central for the nurses in PICUs it is meaningful to also position caring and nursing in psychiatric care against the backdrop provided above. These discrepancies in ideology give rise to the need to further discuss the concept of intensive and the construction of care within intensive psychiatry.

## **Caring and nursing in psychiatric care**

The concept of caring is central to this thesis with a specific focus on caring in intensive psychiatry. In order to connect caring to the claims I make in this thesis, it is meaningful to view caring from a broader perspective. Many researchers have defined caring. For example, Brykczynska (1997) emphasizes that caring includes both a philosophical level of moral obligation in relation to humanness and an ethical level centred on our way of being and behaving. Roach (1985) identifies five attributes of caring in nursing: compassion, confidence, competence, conscience and commitment. Also, caring in nursing is defined by Finfgeld-Connett's (2006) whose meta-analysis reveals interpersonal sensitivity and intimate relationships as central to caring, which she synthesizes in her article to argue for an interpersonal process. The processes that take place between nurses and patients were addressed in nursing science as early as 1952 when Hildegard Peplau published her interpersonal relational theory which emphasizes that the nurse-client relationship is at the heart of the nursing process (Peplau, 1992). The centrality of the relationship between the nurse and the patient/client has since become a hallmark within the nursing discipline and Peplau's theory has been significant in the speciality of psychiatric and mental health nursing. Løkensgard (1997) further emphasises the ability to listen, understand, accept, give feedback and be clear as important in psychiatric nurses' communication. More recently, Dziopa and Ahern (2009) conducted a literature review that shows that the therapeutic relationship in psychiatric and mental health nursing involves understanding and empathy, individuality, providing support, being there and being available, being genuine, promoting equality, and demonstrating respect, clear boundaries and self-awareness. Besides the skills involved in developing therapeutic relationships with patients, nursing is described as a process of assessing patients, setting nurse diagnoses, identifying outcomes, intervening and evaluating (Boyd, Bell & Williams, 2008). Empirical studies based on interviews with nurses indicate that the role of the psychiatric and mental health nurse is not clearly defined (Jackson & Stevenson, 2000). Fourie, McDonald, Connor & Bartlett (2005) studied these diffuse roles among nurses in inpatient settings in New Zealand. They also reveal a lack of clarity as nurses are involved in many tasks, some related to patient care as well as tasks related to coordination and administration. According to Løkensgard (1997), the primary aim of the psychiatric nurse in inpatient settings is to create a therapeutic environment that promotes the patient's sense of safety, ability to thrive and to practice responsibility and social skills. Johansson (2009) used an ethnographic approach to study the health care environment on a locked ward. He concludes that the encounters that

take place between patients and staff members in the milieu are significant for care even though encounters also involve an imbalance in the structures of power between staff and patients. Fourie and colleagues (2005) discuss the centrality of high acuity and safety precautions, stressing the need to address patients' acute problems here and now. Delaney and Johnson (2006) studied how nurses prevent psychiatric patients' behaviour from escalating into violence. They conclude that this entails a complex process of keeping the unit safe, which is grounded in the culture.

## **Concepts and concept analysis**

The background projects several concepts that are relevant for psychiatric care in general in addition to those that are relevant specifically for psychiatric nursing. Concepts are central in all academic domains and not restricted to the field of caring and nursing. The development of concepts in nursing is important as they direct practice, education and research (Cutcliffe & McKenna, 2005). The scholarly practice of concept analysis is argued to be an important endeavour since it contributes to scientific knowledge (Baldwin, 2008). A general assumption is that concepts and concept analysis are used as building blocks for theory development (Walker & Avant, 1995; Watson, 1991). However, this view has been criticized since the idea is grounded in the ontology of realism with its goal to define concepts on the basis of an absolute truth (cf. Paley, 1996). An alternative ontological view of concept analysis is the construction of useful understandings of the concepts (Duncan, Cloutier, & Bailey, 2007; Wilson, 1963). Wuest (1994) criticizes traditional concept analysis in nursing for being stiff, rigid, static and for using distinct boundaries. She proclaims a feminist approach to concept analysis that centres on creating the meaning of concepts through dialogic engagement with those who have lived experiences of the concept. Rodgers (2000) argues for an expansion of thinking when it comes to data sources, as data might be derived from performances, for example music and dance. In an earlier publication Rodgers (1989) proposes an evolutionary approach to concept analysis. A general aim of concept analysis is to give rise to descriptions, clarifications, and definitions (Kim, 2010). As shown in the literature review above, less attention has been paid to specific concepts in the field of intensive psychiatry in terms of caring and nursing in general and even less to analysing the concept and its specific meaning in this context.

## Summary and rationale

The term psychiatric intensive care was constructed in the academic literature in the early 1970's. Since then, the concept has been adopted in many countries. Both the research literature and anecdotal evidence support the claim that the PICU is a fuzzy concept. However, some attempts have been made to construct guidelines, for example in the UK. Research has focused on descriptive statistics using demographic data. Secondly, research regards different strategies to meet the challenge of caring for patients in PICUs who demonstrate aggression and violence. The strategies that are reported in the research literature mainly encompass four domains (i) prevention using risk assessment tools, (ii) providing care with pharmacological interventions, (iii) providing care in terms of the practice of seclusion and restraints, and (iv) providing care with less restrictive interventions. Research indicates a discrepancy in ideologies in care. This is centred on whether to use a rigid approach in care and correct deviant behaviour or to adopt a more flexible approach that includes involving staff in care and activating patients rather than deactivating and confining. While all of these domains are important to nurses as professionals working in multidisciplinary teams, the first three are to a greater extent medically and technically oriented. The fourth domain is the most underdeveloped and relates to basic nursing knowledge and practice. While research has catalogued what nurses do in PICUs, questions related to how nursing is practiced have been given less attention, while an investigation of why nursing practice is arranged in certain ways is almost completely absent. It is interesting to ask what motivates studies in particular PICU settings given that acute psychiatric nursing is a relatively developed area of research. The fundamental rationale is simply based upon the fact that the PICU has been constructed because there is a need for an extra level of care due to the patients' severity of symptoms. There tends to exist a clinical pessimism that views the PICU as 'a waiting room' – where patients are placed while they wait to get better, wait for medication to take effect or wait for their symptoms to abate. I argue that it is important to explore what happens in these periods of waiting in this specialized area of psychiatric care in order to articulate advanced nursing care. Both previous research and a general opinion among PICU staff reveal a lack of clear boundaries between acute and intensive care. Assessments of where a patient should be treated are often based on personal judgement and are a starting point for frustration and perceived lack of control among staff. While this thesis does not differentiate these two concepts, the main concern and the contribution of this thesis is to describe the concept of caring in intensive psychiatry in order to clarify the staff practices and bring clarity to the fuzzy concept of PICU. By way

of this description, this thesis may offer direction to clinicians as it distinguishes the specifics of intensive psychiatry and as such offers a tool for improving the efficacy and quality of care. Previous research indicates that psychiatric intensive care is about rapidly taking control of patients' symptoms in order to keep the unit safe and reduce the level of confusion or aggression. Research indicates that intervening actions have predominantly focused on use of medication, confinement and observation in terms of seclusion and restraints. These are issues that point to the more overarching concept of psychiatric intensive care. Moreover, this thesis sharpens these perspectives as it focuses on exploring and describing caring in intensive psychiatry. There are good reasons to assume that additional culturally specific knowledge remains unexplored. To seek out the prerequisites and principles of caring in intensive psychiatry this thesis takes its point of departure in everyday nursing practices to understand how knowledge is learned, shared and collectively interpreted in order to understand how nurses organize their cultural knowledge.

## **AIMS**

The overall aim behind the studies presented in this thesis was to explore and describe caring in intensive psychiatry. Specifically, the aim was to describe the care activities provided for patients admitted to the PICUs. The second aim was to describe cultural knowing as expressed in nursing care in psychiatric intensive care units. The third aim was to describe how mental health nurses use different approaches to observe patients in relation to the practice of surveillance in psychiatric nursing care. The fourth specific aim was to describe, explore, and explain stability in the context of mental health nursing in intensive psychiatry.

## MATERIAL AND METHODS

Since the research leading to the articles presented here was mainly explorative and descriptive, an inductive working process guided me throughout the project. Even though ethnography was not the only research methodology that I used, its epistemological assumptions guided me in that I was not able to fully control, in advance, the forthcoming steps in the research process. Instead, I continuously discussed my work and data with my supervisors and adopted an open and flexible approach to working with the data and what I saw. Epistemologically, this non-linear way of conducting research could best be described metaphorically as my having walked the 'path of discovery'. It is relevant to explain *the process* because it also mirrors the way I have chosen to structure and present the method section below. Due to the working process, I will present the main steps for the different studies in chronological order. I will first describe the settings, i.e. the PICUs. Then I will present some further epistemological frameworks that have been influential for constructing this thesis. Thereafter I give a brief presentation of the chosen research designs, the methodologies and methods that have been used and lastly, I will describe how these were applied in my research (Study I-IV).

### Settings

Inpatient psychiatric care is available in all county councils and regions in Sweden. Most inpatient wards are called acute wards and these are most often profiled due to patients' diagnoses. In addition to these acute wards, 14 out of 21 county councils and regions, employ yet another level of inpatient psychiatry, namely PICUs. There are 18 PICUs in the country, with approximately one PICU per county. Out of these eighteen, four were represented in my research. These were located in buildings that also housed other psychiatric inpatient wards. Together these buildings were labelled as psychiatric clinics that were part of a general hospital, although located a bit separated from the main hospital building. The hospitals were located in the outer regions of the city centres. Some of the PICUs were located on the ground level with access to a secured garden while others were located on higher floors with a secured balcony. Security was evident at different levels; all PICUs had a sluice at the entrance secured with locks and some with tempered glass. Most doors were locked, for example the nursing station and the storeroom. Some PICUs had the toilets locked permanently, while others were locked only if necessary. The PICUs offered 7-10 beds, all with single rooms. The day was divided into three working shifts, day shifts between 06:45-15:30, evening shifts 14:30-21:30 and night shifts

21:00-07:00. At each shift change a formal report was prepared. The staff included both men and women and a general rule was that there should be at least one to two men on each shift. The staff was aged from early 20's to 60's, one nurse and three enrolled nurses were generally allocated to each shift. Medical rounds were conducted twice to five days a week. The patients were predominantly diagnosed with schizophrenia and psychosis disorders, bipolar disorders and personality disorders although no patient's diagnosis was excluded, rather the need for a PICU environment directed admissions. In cases where patients were diagnosed with dementia and substance abuse this was often in combination with aggressive behaviours or an immediate risk for self-harm and risk for absconding. The care was set to be as short as possible, varying from less than a full day to one to three weeks, although some patients were admitted for several months. Most patients were also admitted on the basis of the Mental Health Act. Some PICUs had access to a separate isolation room with mechanical restraints.

### **Overall epistemological frameworks**

During the time of designing this thesis I became inspired by Spradley's (1979; 1980) structured way of arranging and sorting ethnographic data. This is important to note since Spradley came to influence my way of thinking about how knowledge is produced. Throughout the process of learning ethnography, Spradley's view of knowledge surprisingly grew in importance as the project developed. From pragmatically using Spradley's ethnography as a tool for guiding my interview technique, I later engaged even further with his epistemological ideas and his basic assumptions regarding the interrelation between language and culture. At the time this thesis was initiated, I deliberately chose to adopt an inductive approach that led me to adopt a flexible approach towards data and my perceptions. Due to this uncertainty of progression, I have not been able to fully control for the many forms of contemporary understandings of caring in intensive psychiatry that were possible to adopt in the thesis. As the work progressed it became rooted in an anthropological tradition. Based on Spradley's ethnographic "seeing" it is both language and culture that stipulate the epistemological statements for this thesis. The manifestation of culture as collectively learned and shared knowledge together with the position that such knowledge generates social behaviours and has an impact on a united way of interpreting experiences, is what epistemologically distinguishes ethnographic claims of knowledge and qualitative research in general. Spradley holds that it is social knowledge that studies address, not the individual.

## Research designs, methodologies and methods

The four qualitative studies (Study I-IV) applied different designs, methodologies and data collection methods to study caring in intensive psychiatry. These are presented in Table 1 and are further described under separate headings below. The working process behind this thesis work was highly inductive and therefore it is important to also understand the progress of the thesis over the past years, as each study was a springboard for the next.

Table 1. Overview of the four studies

STUDY	DESIGN	SAMPLE	DATA COLLECTION TECHNIQUE	RESEARCH METHOD	DATA ANALYSIS
I.	Descriptive	Purposive sample of staff from one PICU	Semistructured questionnaires and semistructured open-ended interviews	Critical Incident Technique (CIT)	Flanagan's (1954) five step procedure.
II.	Descriptive	Purposive sample of staff from three PICUs	Fieldwork (participant observation, structured and informal interviews, field notes)	Ethnography	Spradley's (1979, 1980) 12-steps ethnography
III.	Descriptive	Purposive sample of staff from one PICU	Semistructured questionnaires and semistructured open-ended interviews	Focused approach of ethnography	Spradley's (1979, 1980) 12-steps ethnography
IV.	Explorative	Online material, academic literature, selfperceived experiences	Online dictionaries, Wikipedia and YouTube surfing, Away-From-Keyboard Experiences	Concept Analysis	Combination of Wilson's (1963) concept analysis and Spradley's (1979, 1980) 12-steps ethnography.

## Scratching the surface using Flanagan's work (Study I)

As a starting point, I conducted a literature search and concluded that caring in intensive psychiatry was far from a theorized concept. On the basis of this review research questions surfaced, including 'what is characteristic for a PICU?' and 'what kinds of nursing care activities takes place on PICUs?' Critical incident technique (CIT) was selected as it is considered to be a suitable methodology for generating new knowledge when little is previously known and it may generate insights that can be used as a springboard for designing forthcoming studies (Bitner, Booms & Tetreault, 1990; Gremler, 2004). Five methodological steps were followed as described in Flanagan's (1954) original article: (I) Determination of the general aim; (II) Development of plans for collecting incidents regarding the activity; (III) Collecting the data; (IV) Analysis of the data; and (V) Interpreting and reporting.

One PICU was selected by convenience sampling due to personal knowledge of key persons, facilitating access to the field. At a staff meeting verbal and written information was presented and resulted in staff members' consent to participate. The staff were handed a semi-structured questionnaire including three questions regarding: (a) incidents involving patients that were typical in the PICU; (b) the staff's perceptions of PICU patients' caring needs; and (c) the staff's views on the kind of skills that are needed in the situations they described earlier. In order to gain more in-depth data, interviews with five informants were held. Interviewees were purposefully selected on the basis of a discussion with the head nurse. The interviews began with the question 'What is it like to care for a patient in the PICU?' The interviews lasted 20–50 minutes and were audio-recorded and transcribed verbatim. Analytic work followed the steps described by Flanagan (1954). The repeated readings of the text involved the initial step of perceiving situations. The data set included 41 incidents/situations in total. An incident was determined to be a description of an experience that related to the aim of the study (Butterfield, Borgen, Amundson & Maglio, 2005). After this phase of familiarization, incidents or situations about nursing care activities were identified and isolated and placed in different categories according to their similarities and differences. One excerpt exemplifies the construction of the category *supporting*:

“...they (patients) afterwards are often aware of what they have done, and to keep the patient from feeling ashamed, which often occurs, you need to be there for them to help them overcome their shame. This is an important task for a caregiver”’. (Study I, p.100)

During the analysis, the research group discussed incidents to ensure consistency in the construction of categories. This study was important for

later progress in the project as it allowed us to scratch the surface of what had hitherto been a relatively unknown area in research and it directed the design of the forthcoming studies.

### **Uncovering the structures using Spradley's approach (Study II and III)**

The next step in this thesis was to further explore caring in intensive psychiatry by digging deeper, driven by questions addressing how nursing care was practiced in PICUs on a daily basis. I assumed that it would not be enough to study the nurse-patient relationship, but rather I wanted to study caring in intensive psychiatry from a wider point of view - the idea of studying the care culture was born (cf. Sandelin Benkö & Sarvimäki, 1999). This meant that I had to go out and experience for myself, participate, interact and explore. These assumptions guided me to design a study that included methods such as participant observation and interviews. Therefore, the most suitable methodology for this part of the thesis was to take advantage of an ethnographic tradition, especially that of James P. Spradley who presents a clear process of gathering and analysing data.

### **Use of the ethnographic tradition in nursing research**

The tradition of cultural and social anthropology has been practiced for more than one hundred years. The hallmark of the tradition has been the scholarly practice of conducting fieldwork to collect data that in turn allows one to study cultures. Malinowski (1922) published his famous work from living with Trobrianders in Papua New Guinea. During the 20th century, a shift took place in the anthropological discipline and researchers started to conduct ethnographic studies 'at home' (Messerschmidt, 1981). Karra and Phillips (2008) argue that the shift implied many advantages, including easier access to study sites and the need for fewer resources, as well as making translation easier. However, they also point out disadvantages such as the lack of critical distance, conflicts of roles, and a limited serendipity. A further milestone in the development of ethnography was Goffman's (1968) work of describing the social situation for patients in asylums. In the 1970's, Spradley introduced an alternative way of working with ethnographic data, illustrated in his ethnography of the culture of tramps (Spradley, 1970) and study of culture in a college bar (Spradley & Mann, 1975). Leininger and McFarland (2002) developed the ethn nursing research method to study transcultural care within the nursing discipline. Today, ethnography is a well-established research method in several widespread nursing contexts, such as patient council (Brooks, 2008), nurs-

ing on an acute stroke unit (Seneviratne, Mather & Then, 2009), privacy and dignity of cancer patients (Woogara, 2005), and nursing in a pediatric intensive care unit (Scott & Pollock, 2008). Hem and Heggen (2004) used ethnography in order to describe nurses' rejection of psychotic patients, Johansson, Skärsäter and Danielsson (2007) focused on encounters in a locked psychiatric ward, while Hamilton and Manias (2007) conducted an ethnographic study about how psychiatric nurses used observation as an intervention in an acute psychiatric ward. As Wolcott (1999) states, "One can do ethnography anywhere, anytime, and of virtually anything, as long as human social behavior is involved (or was involved [...])" (p. 68).

### **Entering the fields**

At the time the study was designed there were 14 PICUs in Sweden, these were identified and located by reviewing the county council web pages one by one and in doubtful cases I telephoned the clinics. Three PICUs were selected, according to the principle of achieving maximum variation as far as this is possible (cf. Creswell, 2007). Most of the PICUs were similarly described and therefore the three units were selected because they were located in different large cities. Prior to the study, all included PICUs were initially contacted in order to assure administrative approval.

The fieldwork was conducted in tandem, meaning that it did not overlap in time. I visited the units with my head supervisor some weeks before and verbally presented the project. In all three meetings, I got the sense of being welcomed and collectively accepted. More formally, informed consent was collected from all participants. The meetings offered a forum to discuss and plan for my presence. As I would exclude patients in the data collection, we discussed my role as a participant observer and other troublesome issues including ethical responsibility in relation to my presence. Practical questions related to safety precautions were also discussed. It was time to start as a participant observer:

When I arrived at the PICU I rang a bell outside an entrance door. Two staff members opened the door and let me in after I had identified myself. I stepped inside and found myself in a small locked room. The staff unlocked the second door and let me into the PICU. I noticed that the walls were painted in pale yellow colour with a board running along the walls. There were lot of doors, all of them were closed. I reflected that it was very clean and spartan furnished. Chairs were placed correctly at the tables, no magazines on the tables, no transport cycles or medical carts in the hallway and other things that you normally see in a hospital environment. Two staff members were standing in the corridor chatting with each other in low voices, while a third passed by and went into the nursing office without saying

anything. The overall feeling I got was of calm and silence. My first impression was that absolutely nothing happened here. I repeatedly asked myself, what is nursing care around here?

### **Participating in the fields, constructing and analysing data**

My motives for conducting fieldwork originated partly from Malinowski's (1922) explanation of the role of the ethnographer to "grasp the native's point of view, their relation to life and to realise their vision of their world" (p. 25). With this view of my role as an ethnographer, I soon realized that getting close to the participants was a process that I could not fully control. Since I had formally introduced myself in advance, my presence was in some sense already accepted among the group members, but the real work of experiencing the world behind the curtains was more of an ongoing process of sharing information about my previous work experiences, education and family situation, among other things. At times I felt excited as data poured forth. I was also uncomfortable when I witnessed a conflict that divided the staff in two groups. I could feel bored when nothing happened and the staff had private conversations. I even experienced feeling caught when a member of staff asked me what they could possibly teach me since I was already the expert. Discomfort arose again when I was asked about my project and my results so far. I was sometimes addressed as "the researcher", "the student", or jokingly called "the spy" or "time controller". During my participation I assumed a moderately active role (cf. DeWalt & DeWalt, 2010) as I engaged in simple procedures such as making coffee or cleaning a table, but I never fully worked as a nurse on the units. I was most active when I participated in a course on 'threats and violence' and I actively practiced self-defence, holdings and techniques to put a person in mechanical restraints with the other staff.

In advance of my observational sessions I prepared questions that I intended to focus on based on ideas and hypotheses that had emerged during previous sessions. I formulated questions as described in the method section above, descriptive, structural, and contrast questions. I mentally prepared myself, imagining an interview question or topic, 'Last time I was here, Thomas told me that you sometimes have to escort patients to their rooms - when do you do that?' I tried to avoid using why-questions as this might have been perceived as blaming and criticizing (Spradley, 1979). I checked that the tape recorder had enough batteries and enough recording space left, and that I had a good pen and my small notebook that fit in the pocket of the hospital clothes I was given to use.

Throughout the progress of fieldwork, the analysis honed in more narrowly upon specific domains, or in Spradley's (1979; 1980) terms, the analysis moved along levels of description, focus and selection. Descriptive questions and observations were the most explorative and naïve. Focused questions were more targeted and based on premature ideas and analysis while selective questions were the most purposeful and more or less confirmed my hypothesis. The practice of analytic work took place continuously.

Spradley advocates for domain analysis as this involves the meticulous process of identifying domains in data (i.e. observing a patient). When domains are determined, the analysis continues as included terms are searched for (i.e. sitting in a sofa, standing in the corridor, etc). All the included terms in this example are 'ways of' and semantically connect the included terms and cover terms to the domain. The taxonomy analysis is the analytic work of hierarchically arranging the domains into a complete taxonomy by asking further questions; for example, "agreeing with a patient" and "use of physical restraint" are both ways of soothing, but they differ and are therefore organized in different categories as a result of the taxonomy analysis. Lastly, the step also involves a componential analysis, which seeks to identify attributes that are interconnected with each domain by analysing differences. For example, the many forms of soothing a patient are connected to specific attributes, some are verbal strategies while others are physical. Through this ongoing analysis throughout the fieldwork, the domain and taxonomy and component analysis were frequently discussed with my supervisors as some paths were determined to be more relevant than others.

Through the fieldwork and analysis it became obvious that 'observing patients' was particularly meaningful to the staff members and analysis showed it to be the most detailed and voluminous. Therefore, I decided that this area of nursing practice was in need of further descriptions and some of the interviews gave greater attention to this. I began to analyse this with a more focused approach. The analysis was conducted due to the meaning and practice of observation and surveillance (Study III). The focused analysis followed the same steps of asking questions and analysing as previously described.

### **Leaving the fields**

The time of my withdrawal from each PICU was not predetermined. Rather, I withdrew when I felt that I had met a certain level of redundancy and discussions with my supervisors concluded the same. The withdrawing process was similar yet also differed at the three PICUs. As I spent the most

time at the first PICU, the exit procedure was also the hardest. The decision to leave was based on my sense of progression in the study, but it also evoked a feeling of insecurity when I was faced with taking the definitive decision to leave. I asked myself - have I got it all? Leaving was also associated with a feeling of loss and separation from the group, which is addressed in ethnographic literature (see for example Hammersley & Atkinson, 2007). I especially remember “Anna” who was about to go on maternity leave and had recently bought a new home, “Mike” was newly employed and still in his oriented period – what did the future hold in store for them?

Table 2 demonstrates the extent of the data collection. The formal interviews were transcribed and resulted in 322 pages of text and the typed field notes resulted in 166 pages.

*Table 2. Overview of the data collection from fieldwork*

	PICU 1	PICU 2	PICU 3	SUMMARY
Hours of fieldwork	110	58	36	204
Visits	13	7	5	25
Formal interviews	15	6	3	24
Total length of formal interviews	8h 20min	5h 35min	1h 50min	15h 45min

### **Digging deeper - moving beyond the clinical setting (Study IV)**

Having uncovered the structures of caring in intensive psychiatry to conceptualize these collectively as a culture of stability using Spradley’s approach (Study II and III), the next phase was to consider the initial research questions above and beyond the clinical setting of the PICU in order to further theorize concepts within caring in intensive psychiatry (Study IV). I conducted a concept analysis to more deeply explore the key concept and moreover to develop a method for developing the concept being studied (Fawcett, 1978; Walker & Avant, 1995). Because stability is not a well-established concept in nursing science, I derived data from other subject areas (e.g. recovery research and aeronautic research) as well as from personal experiences. I became familiar with Wilson’s (1963) work and I took a liking to his method since it is grounded in the ontology of relativism and epistemologically adheres to contextualism. According to Wilson, concepts are not fixed in the sense that it is possible to determine their real meanings. However, we can identify useful understanding of concepts in a given

context. This constructivist worldview appeals to the ethnographic way of seeing that I had developed through the project to date. Therefore, as a supplement to Wilson's method, Spradley's (1979; 1980) ethnographic method inspired the concept analysis in particular with respect to collecting, constructing and organizing data (Study IV).

### **Data derivation**

In the concept analysis, I used five different sources for deriving data: Online dictionary reading; Wiki surfing; Video-clips streaming; Literature searches using databases and search engines; Away From Keyboard (AFK) experiences. As Spradley's ethnographic method guided me, the construction of data was an ongoing interplay between collecting and analysing data. I read through definitions in dictionaries and came to understand how the concept was used when de-contextualized. I also wrote memos to be able to maintain a reflexive approach (Hammersley & Atkinson, 2007). I constantly posed ethnographic questions (Spradley, 1979), for example, 'What are all the kinds of stability that can be found?' and 'What are all the ways stability is used in language?' During this phase, I began to develop the *isolated questions*, which is an initial step in Wilsonian concept analysis (Wilson, 1963).

In addition, vivid online material from YouTube ([www.youtube.com](http://www.youtube.com)) was used. The final way of deriving data was the use of AFK experiences. This was an important step in deriving data both as it provided the analysis with human emotions, and tangible hands-on knowledge of the concept and in addition it was also the point when I as a researcher transitioned from being a data collector to becoming data material myself. Spradley (1979; 1980) argues that when the ethnographer has become so familiar with the culture (read concept) he or she becomes the informant. Four AFK sessions provided the data: (1) riding a unicycle; (2) working in psychiatric intensive care units (PICU); (3) discussing the housing market with brokers, bankers and friends; (4) bench-pressing in the gym and use of a balance ball.

### **Data analysis**

Although data were not collected and analysed separately they are here presented as such out of pedagogical considerations. In the beginning, I posed broad descriptive questions such as: 'What are the definitions of stability?', 'What are the goals of stability?', and 'What are the ways to achieve stability?' Next, I asked structural questions to sharpen and deepen the investigation, i.e. 'What are the various ways to achieve stability?' Finally, contrasting questions were asked, 'A and B are both ways of achieving stability but what are all the differences between these two?' Data were

then sorted, categorized and compared (Spradley, 1979; 1980). In accordance with Wilson's method, isolated questions were constructed as these were grounded in the knowledge gained from data derivation. The initial isolated questions were rephrased during the research process and resulted in: 1) What is the core meaning of stability?; 2) How can stability be achieved?; 3) What is the outcome of stability?; 4) What are the threats to stability?; 5) How is stability relevant in psychiatric nursing?

## ETHICAL CONSIDERATIONS

The overall ethical principles guiding my thesis work were based on the World Medical Association's Helsinki Declaration from 1964 (WMA, 2008). As such, participants were fully informed that their participation was voluntary and they were apprised of their right to not be included in the data. The principle of confidentiality was practiced. Informed written consent was obtained. Two clinical data collections (DC) were conducted that were subjected to due to an ethical review. Ethical approval was obtained for DC 1 from the research ethical committee at Mälardalens University (CF33-522/06). Ethical approval was further obtained for DC 2 from the Ethical Review Act (2008/105). The notion that *ethics precedes ontology* (Eriksson, 2001) directed my work broadly, in designing the study, as well as in small-scale in situ situations. I continuously discussed with my supervisors the potential risks of involving persons to participate in fieldwork and considered how their contributions would benefit the work in light of constructing new knowledge. In addition, I critically reflected upon how my own presence would have an impact on the fields.

I adopted a novice and humble approach to the fields that restrained me from assuming a hegemonic position of determining and valuing the staff members' modes of thinking, speaking, interpreting and behaving. This approach was the most appropriate for me to adopt due to my ontological assumption of multiple realities. An information sheet about the study was hung by the entrance and on the bulletin board inside the ward when I was onsite. During my fieldwork I aimed to study staff members only, although I could not ignore the fact that patients were present in the same areas, for example corridors. My fieldnotes reflected staff perspectives only. Prior to the fieldwork, I discussed with the staff how to minimize my interaction with patients without being rude. A general policy was that I should not initiate contact with any patients although if someone approached me, I would answer them without offering an opinion or taking a position. Other issues regarding my role as an observer were discussed during the information meetings in advance with the staff. Another ethical issue was how to protect the confidentiality of the included PICUs. This was especially difficult when some staff on the PICUs had contact with each other. However, confidentiality was practiced as far as possible.

## RESULTS

The results presented here are based on the four studies (I-IV), and address the main aim to explore and describe caring in intensive psychiatry. My construction of caring in intensive psychiatry presents this as a culture of stability that aims to prevent, maintain and restore stability when turbulence occurs. The results begin by describing nursing care activities that were provided for patients (Study I). Under the next heading I elaborate upon the interplay of turbulence and stability. Further and in a more detailed way, I describe the many forms of nursing care that were projected as nurses strived for stability and intervened when turbulence arose. These are termed providing surveillance, being present, soothing, trading information, maintaining security, and reducing (Study II). In addition I elaborate on the practice of observation and surveillance (Study III). Further, I account for the active and passive stability systems as well as the different outcomes of stability when exposed to perturbations. These analyses are de-contextualized, and I therefore return to the theoretical structures in the final section in order to contextualize my results within the field of intensive psychiatry in light of explanatory models and contrary cases (Study IV).

### **Nursing care activities in intensive psychiatry**

The first results (Study I) provided an inventory of nursing care activities based on an analysis of critical incidents; these were described as controlling, supporting, protecting and using the structured environment. Controlling patients included the practice of establishing boundaries in the context of incidents involving patients' exaggerated behaviours. Controlling was practiced both as a verbal and sometimes a physical intervention. The care was also focused on protecting patients and pre-empting behaviours. The need to protect and pre-empt some behaviour was grounded in a desire to prevent incidents that would have negative effects on the patient's health, for example self-harm. Throughout care, supporting patients in situations was also central. Support in intensive psychiatry was practiced by being physically close at hand and listening to patients, even when they expressed threats and aggressive behaviour. An incident that was retold involved a female patient who was not able to follow the thread in her own story. Despite her confused presentation of her story, the staff felt it was important to be there for her. The structured environment was held to be an important prerequisite for care as it provided small spaces, single rooms, and offered an environment that infused peace and quiet and gave the opportunity to rest and find tranquility. Underlying the care activities that were identified through the inventory that was made, the staff experienced

explicit incidents where they expressed their own personal skills and attributes, such as will, stamina and courage, which had an impact on the care. The staff held that these were important. While these results provided a starting point for describing intensive psychiatry, a more in-depth knowledge of caring in intensive psychiatry was needed. The results from the second and third studies further contributed to describing how and why caring was practiced as they included a consideration of the staff's cultural knowing.

### **The interplay between turbulence and stability**

Caring in intensive psychiatry was conceptualized as a culture of stability (Study II). The overall goal within the culture was to prevent, maintain and restore stability as turbulence occurred. Achieving equilibrium within the culture was accomplished as nursing care intervened with turbulence. In short, stability was a state of tranquillity and peace and was regarded as a baseline for endeavors. However, distortions sometimes led to turbulence. Stability was a complex concept affected by the actions of both the staff and patients and their interactions. Moreover, stability was closely linked to the patients' well-being, and as patients expressed calm or chaos these states reflected the surroundings and the ward environment. A widely accepted position among the staff members was that when patients exhibited turbulent behaviours, these spread easily through the environment, distorting other patients' well-being and could yield exponential effects in the turbulence. From this understanding of the interplay between stability and turbulence, the staff members' cultural knowing as expressed in nursing care was to find an equilibrium by collaborating with the patients in the struggle against turbulence to achieve stability and create a harmonious and peaceful environment. Such struggle involved a professional act of balancing between using restrictive versus less restrictive interventions. Nursing care was expressed in the practices of providing surveillance, soothing, being present, trading information, maintaining security, and reducing in order to cope with the spectrum of stability and turbulence.

### **Providing surveillance**

In intensive psychiatry, surveillance was a central cultural activity in providing care for patients. Surveillance was the overarching concept to observation, which was more of a concrete and individual act. The linguistic differences were important within the culture. An observation was no more than just an observation, without any connection to the context as a whole, while surveillance was about placing specific observations within their context. Surveillance mechanisms were continuously involved in the

care from admission to discharge, although the practice of observation was not conducted at all times. As PICUs in general are small wards that are highly staffed and built to exclude nooks to hide in, the staff members were able to 'see' the patients regularly. 'Seeing the patients' was the folk term used among the culture members and was part of the surveillance mechanism. Seeing might also include alternative ways of observing the patients, and not necessarily visually seeing them. The activity aimed to gather information about the patient's state of being and identify changes in mental state, but was also used to predict and foresee shifts in the spectrum of stability and turbulence. Depending on the specific patient, the focus of observing varied. Some examples of what was observed include the patient's body language and verbal expressions, social skills, level of functioning, ability to concentrate, self-injury behaviours, worries, side effects of medication, and mood (shifting). Based upon the practice of observing, it was possible to assess whether the patient's expressions indicated improvements or deteriorations in their mental health. Providing surveillance was used to direct care and treatment and intervene using other kinds of interventions to prevent turbulence. Just as providing surveillance aimed to prevent turbulence it could also create negative feelings over the feeling of being supervised (Study II).

#### Adopting the latent and manifest approach

In contradiction to the intent behind it, direct observation of the patients may create uncomfortable feelings as the panoptic mechanism violates personal integrity. To be able to conduct the central and highly important task of observing patients and still maintain stability, staff had developed nuanced ways to flexibly use this practice. Different approaches of observing patients were elaborated through the focused analysis. The techniques of observation varied depending on the location, situation and occasion. Also, depending on the patient's willingness to interact, the practice of observation was used differently, sometimes it was preferable to remain close to the patients being observed, while other times remaining at a distance was considered advisable. The act is based on the staff members' skills in terms of expressing sensibility, flexibility and awareness of the practice. Through the staff's ability to be flexible and sensible in relation to keeping a distance and remaining close to the patient, they were able to maintain stability as a means of caring. This implies that being close in the caring relationship could take different forms based on the situation as the staff shifted from being latent observers to more manifest observers. The latent approach involved behaviours that appeared as natural and "invisible" as possible, for example the staff sat in public areas reading a news-

paper or watching TV. This approach was especially useful in situations when patients withdrew themselves from interacting with staff as a demonstration of having been disgraced over an involuntary admission. By adopting the latent approach, the staff was able to observe patients while accepting their resistance as they were not obtrusive. In other situations it was meaningful to adopt a manifest approach. This approach was adopted to confirm a patient's suffering and was used to express that they cared for the patients. However, in some instances there was a need to adopt this approach even though the patient did not appreciate it; for example when a patient was restrained or to signal power when a violent situation appeared (Study III).

### **Being present**

An espoused belief in the care culture of intensive psychiatry was that being present in the unit was highly important to maintain stability as well as for safety and caring reasons. Being present was the abstracted term and referred to the practice of being in attendance, which spanned from directly interacting with a patient to knowingly averting attention away from patients. Staff held that many newly admitted patients avoided contact and denied staff members the opportunity to be present. Staff emphasized that even though patients had a different opinion of care and refused to interact, open up and accept treatment, they were still obligated to observe, report and follow-up with patients. The notion of being present was formed on an individual and situational basis and included a wider cultural knowing than a simple dichotomy of being physically in attendance or not. The term "being present" was used as staff deliberated and swiftly attended to a situation if the patient's demeanor looked to warrant it. Being present included the acts of sitting in chairs or standing in the corridor, having a conversation with a patient, cleaning a table, watering the plants, sitting in the nursing station with the door open, knocking on a patient's door to ask if the person needed anything. Being present was a well-recognised practice within the culture as it was associated with the staff's availability to provide care whenever a patient needed it. As a part of the PICU's espoused beliefs, staff members believed that the patient's wish to be left alone should be respected; otherwise they could destroy a future relationship. Avoiding being intrusive and disrespectful was called "letting be". Letting be included more than absence; it involved patience on the part of the nurses who waited in an inconspicuous manner for the patients to initiate contact, thus implying that the patients governed the degree to which the staff were present. Letting be also included discreet ways of initiating contact, for example asking if the patients needed anything (Study II).

## **Soothing**

Caring in intensive psychiatry involved soothing activities when patients were fearful, confused, irritated, aggressive or violent. When they showed these emotions, soothing was used to re-establish stability, as stability was the baseline endeavour. The purposes of soothing were to make it possible to establish a dialogue, stabilize the patient's welfare, and prevent further turmoil on the ward. Due to cultural knowing in nursing care, soothing was employed by conveying a sense of tranquillity, listening to the patient, providing medications, deflecting, and being at hand in the situation. Soothing involved a constant balancing act between power and resistance. Using power, staff members took advantage of their ability to soothe and applied strict rules that gave no room for negotiation. The use of power also implied taking control of the situation as quickly as possible by exerting superiority over the patient. Methods of exerting power were mainly manifested through the use of physical superiority such as holding, leading away, seclusion and mechanical restraints. As an alternative approach to the use of power, staff could overlook the patients' resistance and tolerate behaviours. This approach accepted the patient's need to vent frustrations and more externalized behaviours by giving time, listening to the patients, and acknowledging criticism. Staff showed tolerance and departed from the strict rules of the ward. Within certain limits, being flexible created a level of harmony, as it prevented unnecessary provocation and maintained stability (Study II).

## **Trading information**

Another ongoing activity in the PICU culture was the constant exchange of information. Trading information was most obvious when new patients arrived who often rejected contact or patients who lacked communicative skills due to their psychosis. Information was shared from one staff member to another using verbal and non-verbal communication or in written reports. Exchanging information could be concretely seen in formal reporting. However, a more abstracted understanding of the activity involved the trading of information that contributed to accumulating knowledge in nursing care strategies. Information that was communicated from one source to another was further distributed to a third-party, by which the receiver became the communicator of the information – a reciprocal activity that can refer to as trading of information. The aim of trading information was to create constant awareness and update one another on the situation in the PICU. During calm periods the staff had the habit of telling stories and sharing anecdotes about particular patients and past events, comparing turbulent and calm situations. The cultural activity of storytelling was

meaningful to the staff as they learned from one another's experiences of encountering patients and shared the techniques they had developed for approaching certain patients and dealing with particular situations. On a daily basis, the staff exchanged information that concerned the patients' mental health in terms of improvements and deterioration, the patients' behaviour and also their subjective feelings about particular patients or situations. The activity was useful as it was a tool for predicting and maintaining control and avoiding turbulence. The information trading enabled the staff to link their individual and collective observations as this could further direct treatment and nursing strategies. From many small observations and trading of information among the working group, bits of information collectively contributed to constructing a more complex understanding of the patients (Study II).

### **Maintaining security**

One of the hallmarks of the PICU culture was the notion of high security. The aim of maintaining security harkened back to the idea of ensuring stability in the unit by means of establishing a safe environment for both the patients and for the staff themselves. The concept of maintaining security was the overarching concept and reflected a united way of thinking and acting within the culture. A basis for maintaining security was the construction of and compliance with rules and guidelines. Among staff members, there was a constant awareness that situations may change rapidly; the calm in the unit could at any time become chaotic and turbulent. The nursing approach enabled the staff a sense of trust and a feeling of security when caring for potentially risky patients. The practice of backing up was conducted in different ways: being there was the most prominent form of backing up as it involved standing up, not disappearing, being available and helping colleagues. Standing by, referred to situations where there was a potential risk, often in situations when patients were about to be given an injection, additional staff stood by outside the door. Attendance referred more to situations when some staff members ended up in a confrontation or altercation and other staff backed them up by being present on the spot (Study II).

### **Reducing**

The last theme is the concept of reducing; overarching to its underlying concepts: limiting, modifying the environment, and minimizing. As most patients were admitted to the PICUs under custodial care they were assessed as temporarily lacking the capacity to provide for their own health and well-being and were therefore restricted from exercising their free will.

However, an espoused belief within the culture was to always strive towards the milder form of limiting. A need to use less restrictive forms of limitation indicated an improvement in the patient's mental health. Modifying the environment was about reducing the environment by means of reducing objects that could be used in a harmful way. Another way of modifying the environment was the modification of impressions in the environment. The staff reduced access to personal possessions. Within the theme of reducing, there was also a subordinated concept called minimizing. A common belief and approach among staff was that they restrained themselves and refrained from expressing religious or political beliefs. Minimizing also included avoiding unnecessary polemics and sensitive topics of conversation with the patients as they mostly ignored name-calling, did not force patients to engage with them, showed respect, and tried to express a non-demanding approach. These minimizing techniques reduced the risk of patients becoming aggressive and maintained stability (Study II).

### **Creating stability through active and passive systems**

As PICU-staff played a central role in the achievement of equilibrium and creation and recreation of stability it was also significant to further theorize upon the basic components of stability and its outcomes (Study IV). In general, stability is the state of something being resistant to change, the ability to resume an original position after shifting and the possibility to recover from perturbations. First, in order to move from a state of turbulence to stability the movement requires some sort of active intervention with the turbulence. Intervention involves adding or using power, making adjustments, supplying energy, some sort of action, implementing an intervention, manoeuvring or parrying. These are all actions and are therefore synthesized in the thesis as active stability systems. Active stability systems are those that are constructed to be implemented in a conscious and directed way and which require additional input. The shift from a state of turbulence may not necessarily require an active stability system given that monitoring, idling, decreasing power and flexibility form the foundation of stability. More abstracted, one could say that these components are incorporated into the basic structure and form a part of the construction itself without the need to exert a specific action to induce a shift towards stability. They are therefore synthesized here as passive stability systems. Both active and passive stability systems are presented in Table 3. Although stability may be established it is only a temporary condition. Contextualized cases and further explanations of active and passive stability systems are presented under the heading 'Model and contrary cases of stability in a PICU'.

Table 3. Components of stability systems

ACTIVE	PASSIVE
APPLICATION OF ENERGY	ENVIRONMENTAL FACTORS
EXTERNAL FORCES	CONSTITUENT MATERIALS
ACTIVE MANEUVERING	
PARRYING	

### Stabilities as caring outcomes

In unpredictable and chaotic environments, for example a PICU, stability is only temporary. A theoretical analysis of stability revealed that it is something that is constructed and reconstructed based upon the idea that stability has different outcomes when exposed to perturbations. Due to these different outcomes, it is more relevant to view the creation of stability as the creation of caring outcomes (Study IV). A visual overview of these caring outcomes is presented in Figure 1.

### Re-gaining as a caring outcome

The first outcome is derived from the notion that stability can be re-gained by implementing active and passive stability systems. Re-gaining as an outcome of stability is based on the principle that turbulence has led to the implementation of actions to control turbulence or distortion. Through these actions, stability will return to its previous state or position. The shifts between stability-turbulence-stability bring to mind the movement of a pendulum with its cyclical movements between two binary positions. For example, a patient acts violently and creates turbulence in a PICU. Mechanical restraint in combination with mediation is used as an intervention. Meanwhile, one staff member must be present and close to the restrained patient to observe. After one hour the patient is no longer aggressive, is calm and can be released. This view implies that the caring outcome of stability is re-gained (Study IV).

### Neo-gaining as a caring outcome

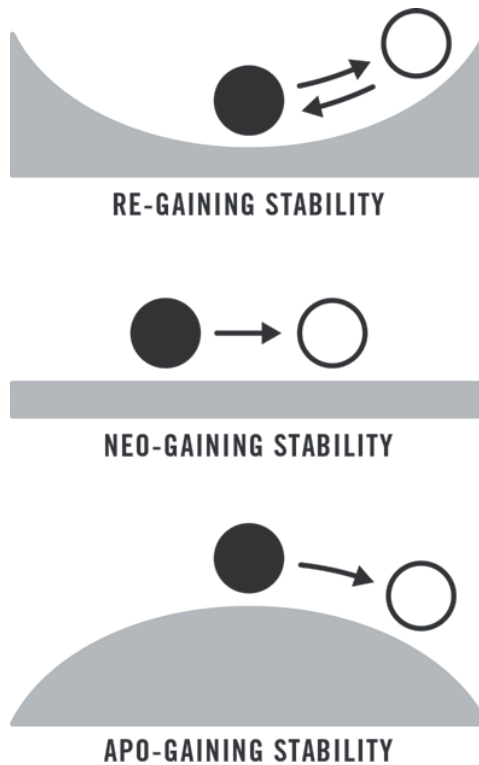
The second outcome of stability is derived from an understanding of stability as a more complex construction. In this case use of passive and active stabilizing systems together results in a neo-gaining outcome. Herein lies an important theoretical difference. While re-gaining stability refers to a re-

turn to a previous state, neo-gaining is based upon the principle that a new kind of stability is constructed and manifested that shapes further possibilities. A patient acts violently and creates turbulence in a PICU. Mechanical restraint together with medication is used as an intervention while one staff member is being present and physically near the restrained patient. The staff member talks to the patient and makes it possible for him to reflect upon his violent act. After one hour the patient is calm and able to verbalize alternative methods for expressing anxiety and can be released. This view implies that the caring outcome of stability is neo-gained because something more has been achieved beyond the restoration of stability (Study IV).

### **Apo-gaining as a caring outcome**

Lastly, apo-gaining as an outcome of stability is closely related to the turbulence itself, as stability is not established *de facto* in this case. The principle underlying apo-gaining stability is that an intervention with active or passive stabilizing systems to influence turbulence does not have the intended effect on the basis of the intervention. The combination of the turbulence itself and the failure of the stabilizing systems that were applied creates a double-negation of turbulence and stability is apo-gained. Turbulence will continue and apo-gaining is to be considered an undesirable outcome. However, this outcome is not a perpetual condition. An analysis of the threats against stability reveals that attitudes, excessive use of resources, lack of resources, the physical position taken, and lack of fit can contribute to an apo-gaining outcome in caring. An example can illustrate this. A patient acts violently and creates turbulence in a PICU. The staff use seclusion as an intervention to achieve stability, however, the patient does not calm down. Instead his aggression escalates and he starts to kick the door over and over. The caring outcome of stability is apo-gained because the intervention did not result in the intended consequences due to the situation (Study IV).

Figure 1. Stabilities as caring outcomes



### Analysis of model and contrary cases of stability

A model case describes a manifestation of stability (Study IV). The model case aims to present an easily recognizable example of what is obvious about stability. Along with the Wilson's (1963) method of concept analysis, it is the aesthetic practice of constructing context-bounded cases that forms the evidence of a concept:

*“It is Monday morning. The clock strikes 06:40 a.m. and the night staff sits around the coffee table in the staff room. All the patients have slept through the night and only Frank is awake as he is up early for a computer tomography. Frank comes up to the staff room and knocks gently on the door and when the staff gives him attention, he politely asks if it is possible*

*to have a shower before the examination even though he knows that it should be handled by the daily contact person after the morning report. Lisa, one of the assistants, maintains her good mood and replies that she will help him as she gets up from her comfortable chair and leaves her hot morning coffee at the table. None of her colleagues make any initiative to assist her and keep on chatting. Wilma is on her way to the kitchen and sees another patient, Fanny, sitting in the sofa reading the newspaper by the TV which is turned off, with a cup of coffee. Wilma stops and says good morning; she asks if Fanny has slept well and if she wants a refill on her coffee. Fanny replies that she has slept well and tells Wilma that she would like another cup.” (Study IV, p. 6).*

Exploring and explaining stability: In this model case, it is apparent that stability harmonizes the situation in the PICU. The occurrence of stability is possible to identify by the relaxed ward atmosphere. The staff members drink their morning coffee and chat with each other in the break room without an actual need to be present, supervise the ward or observe a particular patient. The fact that all patients have slept through the night gives additional witness to a kind of general stability. The staff also depart from regulations and allow a patient to take a shower earlier than what is normally accepted. The nurse assigned to assist the patient went off alone to help. This signals that there is no need to maintain security through backing her up while she engages with the patient. The notion that ‘nothing happens’ is also characteristic for stability, as there are no perturbations that instigate changes. The communication between staff and patients is calm and stable, which also contributes to an equilibrium. Stability is at the moment resolute and solid as a result of the equilibrium and is further maintained through the use of passive stabilizing systems, such as the environmental conditions, based on the original construction of the PICU and its milieu.

A description of a contrary case is an example illustrating the opposite of stability. By contrasting stability with what it is not, the concept itself becomes easier to understand (Study IV):

*“There are four staff members standing in front of a patient who is clearly demonstrating an aggressive behavior; they are trying to calm him down. The patient pushes one of the staff members in the chest and the others approach the patient and lay him on the floor, in the same instant other staff members arrive to help hold the patient. Rita is ordered by one of her colleagues to call the physician and he also directs another of his colleagues to bring the bed with mechanical restraints. As Rita turns around to head to the telephone, another patient stops her for a cigarette; she explains quickly that the patient must wait a few minutes. In reply the patient reprimands*

*her. A third patient also witnessed the situation and insisted that her fellow patient did not do anything on purpose and should be released. The situation as a whole would be best described as a turbulent situation.” (p. 6).*

Exploring and explaining stability: In this case, it is evident that stability does not exist, rather the opposite of stability. The occurrence of instability is conceptualized in this thesis as ‘turbulence’. It is possible to identify the turbulence from the above example: there is an aggressive patient, another patient who is not directly involved in the tumult but who intersects the situation, and a third patient converges with the turbulence and defends his fellow patient against being held down on the floor. In this case, the staff is trying to restore stability by using different actions; the staff is highly present in the situation and able to observe immediately changes in it. They maintain security by being there and backing each other up in order to secure procedures. With these actions in place, they use verbal soothing interventions and calm the patient down. However, when the situation escalates one staff member is attacked. This action triggers the staff to abandon previous strategies. It is no longer possible to balance the dialectic relationship between power and resistance, discretion and minimizing techniques are no longer relevant approaches at this point. Instead, the staff moves further and uses their power to control the turbulence through the use of physical limiting as an intervention. Meanwhile in the background, the turbulence propagates as it involves other patients as well. An analysis of the outcomes (Study IV), further illustrated in Figure 1, shows that the stability has been exposed to the distortion. In this case, the staff succeeded in maintaining stability through the use of active stability components: application of energy, external forces, active manoeuvring and parrying. By intervening with the turbulence and using such power, stability was in this case neo-gained because it moved the stability into a new position (the patient was physically controlled by mechanical restraints). Alternative outcomes would have been possible as well. If the patient had responded to verbal soothing intervention, the stability might have been restored and re-gained, returning to its original position. In yet another possible outcome, the patient’s resistance might have been too strong due to the staff’s power and resources, leading to apo-gaining of the stability - that is, further turbulence until enough power resources were established.

## DISCUSSION

So, how can caring in intensive psychiatry be described? This thesis concludes that the intensive aspect of psychiatric care refers to the structured environment as well as the closeness in care. Caring in intensive psychiatry is conceptualized as a culture of stability with the overall goal to prevent, maintain and restore stability as turbulence occurs. The initial inventory of nursing care activities revealed that controlling, protecting, supporting, and use of the environment constitute care in intensive psychiatry (Study I). More specifically, cultural knowing in nursing care proclaims that providing surveillance, soothing, being present, trading information, maintaining security and reducing are used to intervene when turbulence occurs to create stability (Study II). The focused analysis of the practice of surveillance demonstrates that different approaches are used to observe patients with the flexibility of adopting a latent or a manifest approach (Study III). As a result of intervening with nursing care when turbulence occurs, either through employing passive or active stability systems, stability may be regained, neo-gained, or apo-gained (Study IV). I will expand this discussion and further elaborate my stipulations under separate headings following a presentation of some methodological and ethical considerations.

### Methodological considerations

Critical incident technique (CIT) was originally introduced and outlined by Flanagan (1954) as a systematic process to collect important situations experienced by practitioners in order to classify human behaviour as incidents are managed and the outcomes based on the perceived effects. At the time CIT was developed in the mid-20th century its original epistemological assumptions were grounded in positivism. This is demonstrated in its claim that knowledge is based on objectivity and reliability checks of the analysis (Chell, 2004). This epistemology is not in line with my own view as presented above. However, more recently published CIT studies tend to adopt constructivist assumptions (see for example Pittaway, 2000). Trustworthiness was sought as data was discussed in the research group and we reached agreement on the identification of categories, we discussed the process of analysis and agreed on the consistency of categorizing data (Silverman, 2002). With the help of a head nurse at the ward, five informants were asked to participate in the in-depth interviews. The head nurse was instructed to choose talkative informants and try to mix gender and age. This lack of full control over the selection of participants might have had an impact on the results in my opinion.

Spradley's (1979; 1980) ethnography was used in a variety of forms in several studies (Study II-IV). His ethnography provides a highly structured way of working with ethnographic data as he proscribes a twelve-step sequence that involves the practice of both posing ethnographic questions and analysing data according to structured steps. The initial questions were broad although the focus was narrowed over time. This approach was followed in the three included settings. Spradley himself critically reflects upon his steps and admits that the final step of constructing themes is the least developed step. Further, the structured approach has been criticized by Wolcott (1999) as superficial but it has also been acclaimed for its highly structured approach (Creswell, 2007). In my project, the analysis might have become stunted at a superficial level of analysis if it had included an inventory of nursing care only. However, due to prolonged engagement, memo writing and continuous discussions and reflections I also identified and constructed themes at more abstracted levels of the terms stability and turbulence (cf. Hammersley & Atkinson, 2007). The structured approach was appealing to me as I was a novice to ethnographic scholarship at the start of the project and failed to understand the process of analysis based on reading the work of other anthropologists. Due to my own experience from working as a nurse in psychiatric care, I saw the potential risk to be restricted due to my naïve view. However, I saw the strength of using the Spradley's structured methodology as it in some sense "validated" my choice to allow the data to guide me throughout the analysis rather than my own pre-understanding. The analysis has provided me a whole new way of viewing caring in intensive psychiatry as I had never considered the calm periods as something of interest in care. Yet, this had a special meaning for the projection of the culture and became the primary point of departure.

Achieving trustworthiness in qualitative studies has been debated in literature (see for example Creswell, 2007; Lincoln & Guba, 1985; Rolfe, 2006) and more specifically in the ethnographic work of Spindler and Spindler (1987) and Hammersley and Atkinson (2007). A commonly used method for validating ethnographies is the use of member check (Creswell, 2007). This strategy was not used as I find it to be contradictory to my epistemological assumption (cf. Mishler, 1990; Rolfe, 2006). This was further elaborated in an article detailing my method:

"Seeking validation from the cultural members would imply that the cultural members express a greater truth, or an absolute truth that the researcher can validate independently. This kind of validation tends to mirror the findings toward the cultural member's own self picture rather than lending trustworthiness to the researcher's interpretation." (Salzmann-Erikson & Eriksson, 2012, p. 14).

In accordance with Schein's (2010) descriptions of different layers in cultures, the inner level of a culture relates to the unconscious values and beliefs of the culture, it would be beyond the cultural members' ability to validate such notions. Rather, due to my ethnographic seeing I was inspired by Spindler and Spindler's (1987) criteria for conducting a 'good ethnography'. These criteria were followed in the sense that observations were contextualized, hypotheses emerged in situ throughout the study, systematic and prolonged observations were made, the natives' views of reality were projected through their use of language. Spradley (1979) advocates for the use of 'folk terms' in the early analysis but accepts a sort of transcendence towards 'analytic terms' as data are abstracted during analysis. Further, in accordance with Spindler and Spindler (1987), the schedules, questionnaire and an agenda for observing and interviewing was used.

Throughout this project credibility was established through the use of peer debriefing; I exposed and made myself transparent in discussions with my supervisors regarding the process of data gathering and analysis, my hypothesis and premature analysis. Credibility was also established through the use of triangulation, as multiple sources were used for gathering data. My view of triangulation is that it does not seek consensus but rather to understand caring in intensive psychiatry from multiple approaches to seeing data (cf. Lincoln & Guba, 1985). Triangulation was used in the sense of using different methods to gather data, interviewing, observations, etc. In addition, the strategy of triangulation of sources was also applied in terms of the four PICUs that were included and through prolonged engagement (Creswell, 2007). Yet another way of using triangulation is what Patton (1999) calls theory triangulation; that is, the use of multiple theoretical perspectives to interpret and examine data. This was mostly practiced in the concept analysis (Study IV). Throughout this project I have also used external audits in the form of research seminars as a strategy for discussing the research designs, how to conduct data gathering and analysis and evaluating my inquiry process. These strategies were used to establish confirmability (Lincoln & Guba, 1985). Yet another aspect of trustworthiness is the notion of fittingness; that is, when the findings can fit into other contexts outside the study settings and can be meaningful and applicable to a wider audience (Sandelowski, 1986). Achieving fittingness or transferability by being able to visualize the settings to identify similarities among settings was proposed by Chiovitti and Piran (2003). In contrast, Morse and Singleton (2001) hold that it is the transferability of the theory that is central in the achievement of transferability. In this thesis, provide contextualized examples and describe the settings as far as possible without disclosing the identities of the informants. During the time of this

project I lectured for staff in settings that were not included in the data collection, both for audiences working in intensive psychiatry and acute wards and for research colleagues at international conferences. This activity was not a methodological step due to transferability and therefore the feedback was not systematically collected. However feedback was generally positive and the audiences recognized my characterization of the settings and understood how I treated them theoretically.

### **Reflecting on my own presence and impact on the field**

In the introduction I presented my vision of knowledge as a projected product and stated that it is not possible to separate me as a researcher from this product as I actively intersected with the fields and interacted with the informants. Following from this, it is also necessary to reflect upon my own impact on the field and the issues that arose during fieldwork to understand how these later had an impact on the final product.

During fieldwork, I had at least two roles, the expert and the novice. On one hand, the staff members viewed me as an expert as I was a psychiatric nurse and at the time was writing a doctoral thesis on the topic of caring in intensive psychiatry. I tried to minimize my education and my experience from working in a PICU with the main argument that I was interested in *their* way of providing care in *their* specific PICU. In this sense, I tried to project myself as a novice. At the introductory meetings, I asked to be treated as a novice, which was sometimes successful and in other cases was not. Sometimes staff members stated “...but I’m sure you know how that works since you are a psychiatric nurse yourself, I don’t have to explain that to you.” Adopting the role of the novice was at times difficult as I sometimes dreaded asking some of the most naive and fundamental questions, for example how and when the alarm was used, or why it was desirable to soothe patients who expressed irritation and anxiety. Even though I thought I knew the answers to these questions, I tried to be open-minded to the participant’s way of presenting their view. I dreaded asking the most fundamental questions but in retrospect this constitutive way of working yielded a great deal of information and a hearty basis for my further analysis. For example, I was able to ask the data ‘What are all the reasons for soothing patients?’, and could then operationalize all the reasons through a taxonomy without risk of mixing this with my pre-understandings. According to Patton (1990), a main concern is that the researcher will go native and lose the researcher’s perspective. Throughout the project I have worked hard to maintain my perspective as a researcher. I discussed my strategies with my supervisors throughout the project, I kept a reflexive diary and detailed fieldnotes, and applied Spradley’s analytic steps. Yet, my

strategy of positioning myself as a novice was used both to parenthesize my own pre-understanding and to maintain my role as a researcher. Since I did not actually work as a nurse, it was also helpful to maintain my critical perspective.

During the fieldwork, I became more familiar with the culture as I moved along the continuum between being the outsider (etic) and the insider (emic) (cf. Holloway & Todres, 2006). I felt like an outsider at times when I was unsure and needed to ask for permission or waited for a request to participate when reports, rounds, social meals and coffee breaks were taking place. In other instances, I felt like an insider when I initiated coffee breaks comfortably. One evening when I loaded the coffee machine, one informant expressed “Now, you are definitely familiar with this place”. I also felt like an insider when I wore a nursing uniform. After I had changed clothes one staff member stated, “Now you look like a real PICU staff member with that short hair and big arms.” I had keys and a parking card so I was able to come and leave as I pleased. I also felt like an insider when the staff used their culturally specific language without translating it for me and I was able to follow the medical jargon, looks, timely smiles and small comments (cf. Allen, 2004).

My presence in the fields also raises ethical considerations that are relevant to discuss. During my presence, I was guided by a set of general ethical principles similar to those suggested by Hummelvoll and Severinsson (2005) when participating as a researcher in a psychiatric setting. All participants were fully informed and consent was collected. During my fieldwork, I put up a notice on the ward’s bulletin board and at the front door to inform the staff and others about the ongoing study. Respect for the participants’ personal integrity was also important as no personal records were created. Together with the staff I discussed how to act if patients approached me. As it turned out, we had anticipated more problematic situations than those that actually occurred, as only a few patients initiated contact and asked about my role on the wards. I briefly explained that I was a research student who was present to study the staff and their work. None of the patients continued this conversation, but some expressed a short positive comment that the project was important. As I participated in the fields to study the staff, it was not always easy to fully exclude patients from the data as I took notes ‘as it happens in situ’. However, this was practiced to the extent possible. Where reference to a patient was necessary, he or she was anonymously referred to as ‘the patient’. Further, since all my fieldnotes were reviewed and rewritten on the computer, the notes were reviewed to ensure that no patient was described individually or described from the perspective of the patients. Even though the project was

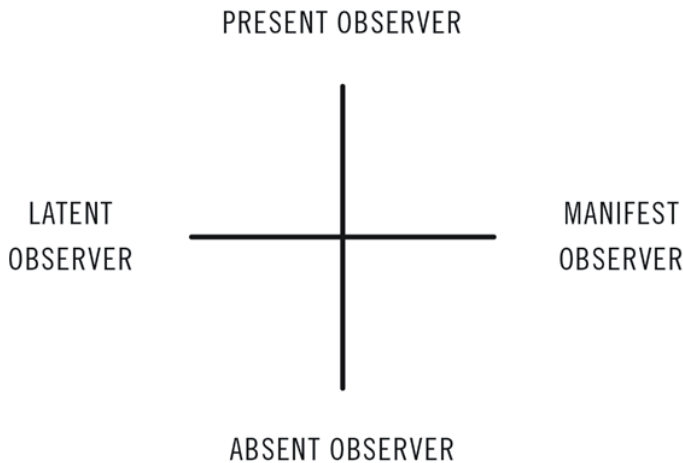
welcomed by both staff and the administrative heads, I tried as far as possible to avoid exploiting the participants and the ward.

### **Conceptualization of caring in intensive psychiatry**

Earlier conceptualizations of caring and nursing focused on the nurse-client relationship. One good example is Peplau's (1992) nursing theory of interpersonal relationships. Just as Dziopa and Ahern (2009) identify different domains in the therapeutic relationship that characterize mental health nursing, such as expressing understanding and empathy, ability to see the individuality in patients, and providing support, Løkensgard (1997) stresses the importance of the ability to listen, accept, give feedback and be clear when psychiatric nurses communicate with patients. Finfgeld-Connett (2006) synthesizes caring in terms of an interpersonal process involving interpersonal sensitivity and intimate relationships. Further, predominant ideas in psychiatric care refer to curing and restoring the patient's health condition to a previous state before the illness struck and to help the patient to return to a previous life (Liebermann & Kopelowicz, 2002). Opponents argue that recovery in mental illness involves more than returning to a previous state of mind. For example, Aston and Coffey (2012) describe recovery as a 'long and winding road' (p. 262). Both these views refer to curing as well as caring in relation to the absence of illness and presence of health as the final goal. Due to the short-term perspective of care in intensive psychiatry it is doubtful whether it is useful to discuss recovery as an achievable goal. Traditionally nursing in psychiatric intensive care has been grounded in theories that present the patient dichotomously as healthy/sick, well/suffering, with/without disease, etc. In turn, care and treatment methods focus on pharmacologic interventions, psychotherapy, and social support to provide caring in terms of interactions, establishing trustful relationships through good communication skills, containing the patient's frustrations, educating and in some sense disciplining the patient into health and healthy lifestyles on the basis of social norms. I argue that caring in intensive psychiatry stipulates a construction of care that moves beyond this dichotomized thinking. Further, I do not view caring in intensive psychiatry primarily in terms of the nurse-client relationship nor the individual experiences as directed by a lifeworld perspective. Instead, I stress that caring in intensive psychiatry is the overarching term for the projection of rhythm and movements. The conceptualization of caring in these terms presupposes caring as constituted by balancing entities in the achievement of equilibrium within the culture of stability. Stability is here projected as a non-fixed position; it is a highly temporary condition that fluctuates in spacetime. I stress that physical boundaries and incorporated

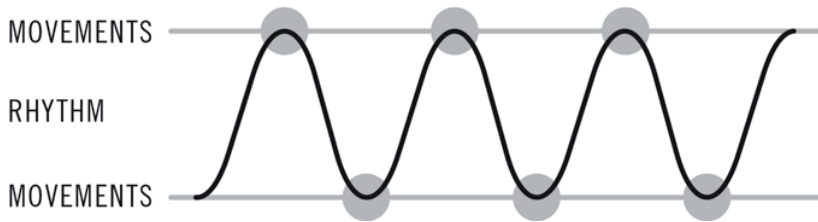
control along with tactful sensibility entail rhythm and movements within the limited structures of the PICU and the closeness in care that exists there. The important contribution of this thesis is the identification of rhythm and movements, which have been overlooked earlier. Movement is the exertion of cultural knowing in a tactful way in nursing care in specific situations. For example, PICU staff use their cultural knowing of how to approach patients in order to observe them with the overall intention to avoid provoking or arousing negative feelings around the activity of observing. As they do so, they cross a vertical axis along which degrees of physical presence are plotted, and along a horizontal axis marking degrees of distance between latent versus manifest approaches (see Figure 2).

Figure 2. *The Powerful Scheme of Observation and Surveillance*



Another example is the cultural knowing of nursing care on soothing patients, which entails constantly balancing between power and resistance. This situationally bounded and flexible use of nursing care comprises movements that establish a rhythm of caring. Figure 3 illustrates how movements create fluctuations in stability. Movements establish parameters around a space within which a rhythm of caring in intensive psychiatry is established. As movements change, this creates fluctuations as the rhythm is altered.

Figure 3. *Caring in intensive psychiatry*



### **Movements as limited structures and closeness in care**

The intensive aspect in psychiatric care is twofold – it includes limited structures and closeness in care. First, the term ‘limited structures’ refers to the manifestation of care in concrete acts of nursing that limit patients on the basis of restrictions that are created through setting physical boundaries (Study I). The notion of limiting patients in PICUs by restricting them has previously been addressed as a prerequisite for PICU care (Frampton, Wijveld & Porter, 2007; O’Malley; Rachlin, 1973). The therapeutic intentions of the PICU are to limit and restrict patients by using physical boundaries that ‘keep the patients in place’ as they create a safe place for the patients and the staff. However, the drawbacks of restricting patients with locked doors were studied by Haglund, von Knorring & von Essen (2006). They hold that locked doors create negative feelings among patients and this contraindicates this activity as a therapeutic strategy. The limited structures have an impact on care as patients have restricted access to their belongings for security and strategic care reasons (Study I, II). These descriptions of limited structures in PICU care are supported by Cohen and Khan (1990) who address the term ‘intensive’ as implying a lack of activities, also called in-house therapy. More recently, Vaaler et al. (2011) reported that stimuli reduction and control of behaviour were central to care in a Norwegian PICU although this was not elaborated.

Caring in intensive psychiatry also involves limited structures in terms of the set of ward rules that are to be followed. Ward rules have a long tradition in psychiatric care. Goffman (1968) presents asylums as a total institution in light of the centrality of adapting to rules, regimens, and demands. More recent research indicates that there is a link between ward rules and patient violence although it cannot easily be determined whether the use of rigid or flexible environments are the best practice (Alexander & Bowers,

2004). These corporeal examples are compiled to demonstrate limited structures as they are the prerequisite for creating and maintaining stability. My thesis demonstrates that the limited structures can be found in even more fundamental entities that are presented here as passive stability systems involving environmental factors and other constituent elements of the PICU (Study IV). The stability systems serve as boundaries for the rhythm of care and can fluctuate within an acceptable range. Although the limited structures may contribute to negatively associated feelings for patients, such as being imprisoned and confined (Shattell, Andes & Thomas, 2008), and feelings of deprivation of liberty (Kuosmanen, Hätönen, Malkavaara, Kylmä, & Välimäki, 2007), it is important to fully understand the possible advantages of them; namely, closeness in care.

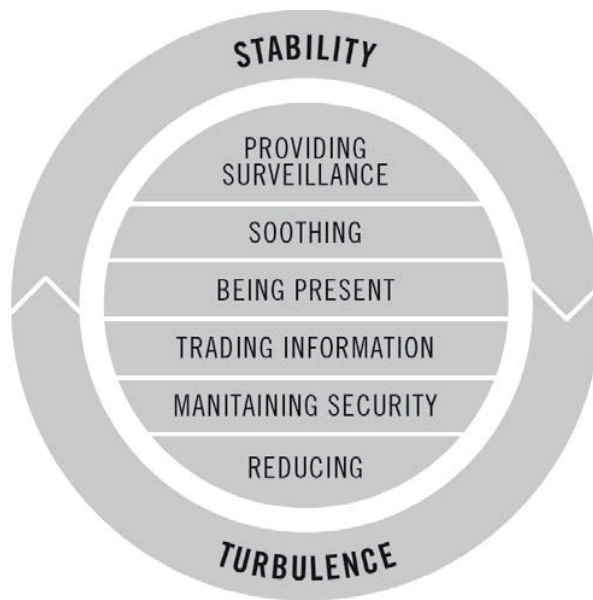
Closeness in care comprises the second basis of caring in intensive psychiatry and involves the ward design and the staff-patient ratio, a prerequisite for closeness in care (Study I, II). Gaskin, Elsom & Happell (2007) emphasize that increased staff to patient ratio was one of the core components in effective PICU care in their study. Similarly, Rachlin (1973) holds that patients experience a whole new therapeutic experience with a high staff-patient ratio. Further, closeness in care also incorporates the nurses' will, stamina and courage as they control and establish boundaries, protect and ward off, and support and provide intensive assistance (Study I). Closeness in care does not explicitly or necessarily implicate being in close proximity, but rather, and even more importantly, it relates to cultural knowing of the act of balancing between being close and keeping a distance (Study III). Finfgeld-Connett (2006) holds that close physical proximity and the notion of being intimate is the normative attribute of presence in nursing science but she also emphasizes that presence is not possible when willingness is absent or if the patient lacks the capacity. Closeness in care is here envisioned in a wider perspective that includes staff continuously moving along theoretical axes of present-absent and latent-manifest. Staff may be physically present and exposed in different areas in the unit while making their observations, although in other instances they may adopt a more absent role as observers (Study III). Acting flexibly to gain stability makes it possible to avoid provoking or arousing negative feelings around the central nursing practice of observing. Such flexibility in caring in intensive psychiatry is the manifestation of cultural knowing in nursing care. Being discreet while observing patients in order to avoid provoking is addressed by Hamilton and Manias (2007). Approaching patients through shifting between present-absent and latent-manifest, stems from the flexible use of active and passive stability systems as it involves the application of energy, acting, parrying as well as the use environmental factor (Study III,

IV). In the next section I will discuss how rhythm and movements encompass caring in intensive psychiatry.

### **Stability as the rhythm of caring in intensive psychiatry**

Movements was explained above as an abstracted term to refer to nursing care based on the use of passive and active stability systems. These movements set in motion the rhythm of caring, which is an overarching concept. Within the culture of stability, the overall goals are to prevent, maintain and restore stability as turbulence occurs (Study II). However, these goals are not achieved spontaneously but are the result of cultural knowing in nursing care, namely, movements. Figure 4 demonstrates an abstracted description of the interplay and circularity of stability and turbulence and use of nursing care in order to prevent, maintain and restore stability when turbulence occurs.

*Figure 4. The circularity of stability and turbulence*



(Modified figure from Study II, p.264)

Within the scope of preventing and maintaining stability, there are certain variations because the energy exerted through the movements creates waves. These waves constantly fluctuate through spacetime and shape, over time, repeated patterns that manifest as a rhythm of stability in care. Turbulence may occur when a gigantic fluctuation occurs that disrupts the rhythm. During such periods of disorganization, unpredictability and uncertainty all the energy of movements is used to generate the rhythm of stability (cf. Newman, 1994). The acceptable range of fluctuations enables the rhythm as the movements involve regaining stability. For example, if a patient expresses irritability it is possible to accept the patient's resistance by avoiding confrontation in the interest of maintaining stability by using passive stability systems. However, if the patient's resistance exceeds what is considered an acceptable or normal fluctuation, the staff must use more active stability systems to regain the rhythm. Regaining stability implies returning to an original position as larger fluctuations do not occur, but during turbulent events other outcomes of stability may be useful to recognize. As demonstrated in the results (Study IV), projecting the neo-gaining stability as a possible outcome is important for the progress of the patient's care as it involves the notion of something more than simply taking control of turbulence. It is also important to be aware of apo-gaining in stability as it is an outcome associated with ongoing turbulence. During apo-gaining, the way the nurses approach patients in the situation is crucial. This is demonstrated in Carlsson's (2003) dissertation that emphasizes the nurses' ability to be in the moment of a potential violent situation as this influences the experience of the encounter as positive or negative. Carlsson stresses that it is the nurse's desire to do good, ability to be present in the situation and earnest attempt to understand what the situation means for the patient that leads them to have the courage to be present in the moment and bring about a positive encounter, even in incidents involving potential threats of violence. The strength in these positive encounters is that they might avoid threats and violence. As demonstrated in the results (Study I), will, stamina and courage are highly valuable qualities among those who care for patients in intensive psychiatry.

## IMPLICATIONS

Although PICU staff members are obligated to provide advanced nursing care, in many ways they have lacked context specific concepts to guide their practice. It is also reasonable to argue that this shortcoming and description of nursing care have contributed to the pessimistic clinical view of PICUs. This thesis contributes important insights and knowledge for practitioners through an in-depth analysis and description of the most central concepts in relation to caring in intensive psychiatry.

Nurses and enrolled nurses in PICUs are positioned at the center of care - they interact with patients more frequently than other professionals and the care and treatment they provide is often 'on the spot'. Due to this central position in care, it is of utter importance that PICU staff are aware of the goals and the centrality of achieving stability in the unit, as well as their own roles as stabilizers and the many forms of nursing care that can be used when approaching patients in the worst phase of mental illness. As shown in the results, alongside the techniques in nursing care and use of both active and passive stability systems, rhythm and movements in the culture of stability project caring in PICUs. These arguments draw attention to the specifics of intensive psychiatry and have implications for practitioners. In a more concrete way, the knowledge offered here might be implemented in the following three areas: language, policies and education.

*Continuous cultural and self-critical reflection and language development.* The results may contribute to theoretical development within psychiatric nursing by clarifying concepts in practice and the relationship between practice and theory. Given this, it is possible for nurses to be self-reflective and critically view their own practice on an ongoing basis.

*Policy development on regional and national levels.* The results may not only direct day-to-day nursing care but can also be one source, among others, to inform policy developments on regional and national levels. PICUs have been a level of psychiatric care for more than twenty years in Sweden but there is still uncertainty over what distinguishes acute and intensive care. Efforts to differentiate these intensive forms of care and to address the specifics of PICU care in policies would perhaps benefit nursing assessments and nursing interventions in intensive psychiatry.

*Structured educational measures.* The results may help to incorporate the theoretical conceptualization of nursing care into clinically-related education and degree programs through structured measures that include a better understanding of the rhythm and movements.

## **FUTURE RESEARCH**

This thesis focuses in large part upon the culture of stability and on expanding an understanding of the concept of stability and its relation to caring in intensive psychiatry. The theoretical body of knowledge on turbulence is underdeveloped and should be further explored and described in order to develop psychiatric nursing both theoretically and in practice. As discussed in this thesis, the PICU is complex – it is a highly volatile and fluctuating setting. Within PICUs, dynamic interactions between patients and staff, involving all sorts of constellations, are present at all times. In future studies it would be interesting to study and theorize upon PICUs as complex adaptive systems through the perspective of chaos- and complexity theories. Another domain of future research that is important to study is the patients' experiences of being cared for in PICUs and their views of what factors contribute to improvements in mental health in such restrictive environments.

## CONCLUSIONS

- The PICU is a culture of stability that is directed at preventing, maintaining and restoring stability as turbulence occurs.
- The cultural knowing that is embedded in nursing care encompasses providing surveillance, soothing, being present, trading information, maintaining security and reducing. By intervening with nursing care when turbulence occurs, the PICU becomes a sanctuary that offers tranquility, peace and rest.
- Nursing care in terms of movements creates fluctuations in the stability as it shapes the rhythm of caring in intensive psychiatry.
- Stability is a highly temporary condition and not a fixed position in care. When striving for stability, active and passive stability systems may be used that involve physical boundaries and incorporated control along with tactful sensibility.
- Different outcomes of stability are possible. Stability may be re-gained, neo-gained and apo-gained. It is important for staff to be aware of these different outcomes in their roles as stabilizers.
- PICUs provide possibilities to be intensively cared for in a safe manner because of the specific environment and closeness in care.
- Two dichotomous approaches to observing patients were identified - the latent and the manifest approach.

# SVENSK SAMMANFATTNING

Intensivpsykiatrisk omvårdnad - rytmer och rörelser i en stabilitetskultur

## Inledning

Jag heter Martin Salzmänn-Erikson och det här är min doktorsavhandling: "Intensivpsykiatrisk vård - rytmer och rörelser i en stabilitetskultur". För att förstå utformningen i denna avhandling vill jag först klargöra min syn på världen och hur jag tänker kring produktion av kunskap. Mina ontologiska antaganden härrör sig till tanken om att världen inte går att reduceras till ett epicentrum i likhet deterministiska principer och därmed förkastar jag också ideén om en absolut sanning som kan studeras objektivt. Jag hävdar att världen är alltför komplex och föränderlig och det vi kallar för verkligheten är något vi skapar och omskapar på basis av temporära referenspunkter. Med hjälp av medierande redskap, exempelvis språket, kan vi kommunicera våra referenspunkter och därmed skapa en gemensam förståelse för vår uppfattning av världen. Språket är det redskap vi har för att kommunicera och ordna våra tankar och tolka världen vilket sedermera manifesteras i hur vi agerar tillsammans med andra. På detta sätt kan vi utforska världen och enas hur den kan beskrivas, exempelvis sociala fenomen och händelser. En viktig utgångspunkt i detta seende på världen måste dock understrykas, dvs. vi kan inte göra anspråk på att någon referenspunkt är mer sann än en annan. När vi förenas kring liknande referenspunkter i relation till ord eller begrepp är det vår framskrivning av en gemensam förståelse av världen - vilket jag menar är kultur. På basen av mina ontologiska antaganden är min uppfattning att en kultur inte kan studeras isolerat från sitt sammanhang och isolerat från dess medlemmar eftersom medlemmarna är de som är medskapare av kulturen vilken också med hjälp av språket kommer att förändras och nyanseras över tid.

I den här avhandlingen har jag som forskare engagerat mig i den psykiatriska intensivvårdskulturen, dvs. den plats inom den offentliga sjukvården som vårdar patienter i det mest akuta skedet av psykisk ohälsa. Mina anspråk med denna avhandling var att utforska och beskriva det som kulturens medlemmar betraktar som omvårdnad. För att göra det har flera forskningsmetoder använts men i huvudsak har etnografiska metoder och kunskapsanspråk varit vägledande. I etnografiska studier finns forskaren med i den kultur som avses att studeras och jag har engagerat mig genom att närvara på flera psykiatriska intensivvårdsavdelningar (PIVA). Genom mitt deltagande har jag förvärvat goda insikter i kulturen och medlemmarnas referenspunkter till omvårdnad. Jag har genom deltagande observationer, intervjuer och fältanteckningar tagit del av medlemmarnas (persona-

lens) värderingar, attityder, normer, agerande och deras sätt att prata om sitt arbete. I likhet med den 'kroppsliga' sjukvårdens intensivvårdsavdelningar är den psykiatriska intensivvården en av sjukvårdens mest specialiserade inrättningar, ändå känner få människor till att dessa avdelningar existerar än mindre vad som sker i dessa slutna och svåråtkomliga rum.

Mina antaganden om epistemologi, dvs hur jag menar att kunskap införskaffas och skapas, omfattar idén att jag som forskare omöjligt kan friskriva mig själv från den kunskap som har producerats i och med mitt eget engagemang i kulturen. Detta synsätt skiljer emot det objektiva förhållningssätt där data samlas av forskare vars roll i stort sett är utbytbar mot det subjektiva förhållningssätt som jag har anammat i vilken jag har varit medskapare av data. Detta betyder att om någon annan hade gjort samma studie hade resultaten sett annorlunda ut.

I den här avhandlingen studeras psykiatrisk intensivvård i en vårdvetenskaplig kontext. För att inledningsvis förstå vad jag avser att studera ska jag kort introducera detta område av vården. Psykiatrisk heldygnsvård eller slutenvård finns i samtliga landsting och regioner i Sverige. De flesta avdelningar kallas för akutavdelningar, men majoriteten av de psykiatriska klinikerna har också valt att använda sig av så kallade psykiatrisk intensivvårdsavdelningar. Ofta är akutavdelningarna inriktade på vård och behandling av patienter utifrån specifika diagnoser, t.ex. psykossjukdomar eller depressiva tillstånd. Ibland uppvisar patienter så allvarliga symptom att de resurser som finns på akutavdelningarna inte är tillräckliga varpå patienterna skrivs in direkt alternativt flyttas till PIVA, oavsett diagnos. Patienterna är oftast inlagda enligt lagen om psykiatrisk tvångsvård (LPT), majoriteten har någon form av schizofrenidiagnos, bipolär sjukdom ofta i manisk fas och patienter som diagnostiserats med personlighetsstörning där det föreligger överhängande risk för aggressivitet och våld, mot andra eller sig själv. Att vårda de patienter inom psykiatrin som kräver så omfattande resurser att det behövs en vårdnivå utöver den akuta ställer höga krav på verksamheten, inte minst på personalens expertis och kunnande.

Inom den kroppsliga intensivvården (IVA) finns riktlinjer för vilka diagnoser som betraktas som IVA-diagnoser, dvs. vid vilka sjukdomstillstånd som ska ligga till grund för den specialiserade vården. Liknande nationella förteckningar saknas inom den psykiatriska vården vilket skapar förvirring inom vilka gränser som vård och behandling ska bedrivas på PIVA respektive akutspsykiatriska avdelningar. Bristen på ramar skapar oegentligheter var patienterna ska vårdas och förvirring kring vad uppdraget går ut på. På klinikerna aktualiseras frågor om vilka patienter som är "riktiga" PIVA-patienter. Bedömningarna beskrivs ofta i termer av att vara godtyckliga och ytterst subjektiva och inte sällan uppstår konflikter mellan intensiv och

akutavdelningarna. Vad beträffande vårdpersonalens dagliga arbete saknas i stor utsträckning forskning som beskriver den specifika och avancerade omvårdnad som patienterna kräver under denna intensiva fas av psykisk ohälsa.

Traditionellt finns en vårdideologi om att de mest resurskrävande patienterna ska kontrolleras, disciplineras och korregeras avseende avvikande beteenden med hjälp av olika rigida maktmedel i form av tvångsvård och avdelningsregler. Sådana ideologier härstammar från en vårdkultur inom psykiatri sedan århundraden tillbaka och blev synligt inte minst på de gamla mentalsjukhusen. Som utmanade till de traditionella uppfattningar och ideologier har det på senare år börjat växa fram alternativa sätt att se på psykiatrisk vård. En trend är att vården i större utsträckning bör utgå från patienternas behov och man pratar om patientcenterad vård. Dessa ideologier får en alltmer framträdande position i dagens psykiatriska vård och innefattar även ett förändrat förhållningssätt som är mer flexibelt i förhållande till rigida och disciplinerande ideologier. Vårdpersonal på PIVA förlitar sig i stor utsträckning på traditionell medicinsk- och omvårdnadskunskap vilket inkluderar medicinering, restriktioner och samtalsstöd men samtidigt finns det en uppfattning bland PIVA personal att “vi kan inte göra så mycket än att vänta på att patienterna ska landa” eller att “patienterna är här i väntan på att medicinen ska verka”. Genom att betrakta PIVA i likhet med ett “väntrum” ger det upphov till det som jag kallar för en klinisk pessimism som underminerar den specialiserade omvårdnaden och personalens kompetens. Mina ambitioner med denna avhandling var att utforska strukturer i vårdkulturen på PIVA och beskriva hur vårdpersonalen skapar något som kan refereras till omvårdnad i detta “väntrum”. Min avhandling har inte för avsikt att besvara alla frågor som rör vård i den intensiva psykiatri men min utgångspunkt som sjuksköterska och vårdvetare är att söka besvara de mest grundläggande frågorna beträffande intensivpsykiatrisk omvårdnad.

## **Bakgrund**

Begreppet psykiatrisk intensivvård härstammar från tidigt 1970-tal i USA där det myntades för att vårda de patienter som inte kunde tillgodogöra sig behandling på öppna psykiatriska avdelningar (Rachlin, 1973). Begreppet har sedan kommit att anammas i Australien, Canada, Storbritanien, Nederländerna, Japan och Slovakien för att nämna några (Basson & Woodside, 1981; Dernovsek, et al., 1999; Georgieva et al., 2009; Goldney et al., 1985; Hatta et al., 1998; Mounsey, 1979; Warneke, 1986). I Sverige finns inga dokument som styrker exakt när den första PIVA öppnades eller varför man anammade begreppet. Det finns dock anledning att knyta infö-

randet till tidigt 1990-tal baserat på en studie som publicerades i början på 1990-talet vilken studerade korrelationen mellan trängsel och aggressivt beteende på en psykiatrisk intensivvårdsavdelning (Palmstierna, Huitfeldt & Wistedt, 1991).

Eftersom hälso- och sjukvårdssystemen är uppbyggda på olika sätt i olika länder är det svårt att veta om det enbart är begreppet PIVA som har direktöversatts och anammats eller om det är hela vårdidén. Beskrivningar av PIVA som ingår i studier världen över tyder på att flera aspekter är liknande beträffande antal sängplatser, vårdtider och vårdinnehåll. I grannländerna Norge och Danmark har däremot inte begreppet intensivvård blivit vedertaget, istället används 'skjerming' och fungerar i praktiken som en avgränsad yta för ett fåtal rum på akutavdelningar där de mest vårdkrävande patienterna är tillsammans med personal och avskärmade från övriga patienter på avdelningen (Norvoll, 2008; Vaaler, 2007). I Storbritannien har PIVA varit föremål för forskning och utveckling under flera år. PIVA beskrivs i termer av de enheter som äsyftar korttidsvård för patienter som visar utmanande beteenden och som inte kan vårdas på akutavdelningar och i behov av tät uppföljning på grund av risk att skada sig själv eller andra (Bowers et al., 2008; Brown & Langrish, 2007b; Stewart & Bowers, 2011). Brittiska myndigheter har också utarbetat nationella riktlinjer för PIVA vård avseende inskrivningskriterier, innehåll i vård och behandling samt kriterier för utskrivning. Även om dessa riktlinjer ger en ett ramverk för utformning och struktur saknas beskrivningar över det specifika och mångfacetterade omvårdnadsarbetet.

Populationen på PIVA inte ingalunda en homogen grupp patienter utan varierar i avseende på psykiatriska diagnoser. En central problematik på PIVA är förekomsten av hot- och våld vilket också blir tydligt då en stor del av de forskningartiklar som publicerats i fältet fokuserar på denna typ av problemställningar. Långt från alla PIVA patienter är aggressiva och hotfulla och överaktiva beteenden och självskadeproblematik finns också närvarande (Bowers et al. 2008). En studie visade att våld på PIVA är tre gånger så vanligt som på akutavdelningar (Brown & Bass, 2004). Några faktorer som bidrar till våld och aggressioner är tillfällig personal, trängsel, och avdelningens utformning (Hyde & Harrower-Wilson, 1994), och personalens bristande förmåga att kommunicera med patienterna (Duxbury och Whittington, 2005). Björkdahl, Hansebo och Palmstierna (2013) visade att faktorer som innefattar tydliga och relevanta avdelningsregler, att bemöta patienter med lugn, förmåga att sätta sig in och förstå varför patienten är aggressiv samt personalens förmåga att snabbt identifiera tecken på aggressivitet var faktorer som bidrog till att förhindra och hantera våld och aggressioner. Forskning som berör PIVA har i huvudsak kretsat kring ett

fåtal områden när det gäller vård och behandling. Ett centralt område är vårdpersonalens förmåga att förutsäga aggressioner och våld för att skapa en säker miljö där Bröset Violence Checklist (BVC) har fått ett stort genomslag då det förutser risken för våld och aggression det närmaste dygnet. BVC utgår från att man skattar patienternas beteenden på sex variabler, förvirring, irritabilitet, störande beteende, verbala hot, fysiska hot, och attack på objekt. Instrumentet är väl anpassat för PIVA miljöer eftersom det till skillnad från andra instrument predicerar risker på kort tid medan andra instrument har betydligt längre perspektiv.

Den forskning som har fokuserat på PIVA innefattar också den farmakologiska behandlingen. En princip som fått fäste är att snabbast möjligt reducera symptom och att bygga upp en allians med patienten för behandling på längre sikt. I det mest akuta skeendet handlar denna behandlingsform till att snabbt lugna ner patienterna genom stora doser av neuroleptika och kontrollera agitation och utagerande beteenden (Holmes & Simmons, 2008; Okocha, 2008; Parker & Khwaja, 2011). En annan behandlingsstrategi på PIVA är användandet av isolering och fastspänning som ett alternativ och ibland ett komplement till den farmakologiska behandlingen. Vanligen används denna strategi när patienter är våldsamma och förstör inredning. Den terapeutiska ideologin med isolering enligt Norvoll (2008) och Vaaler (2007) är att använda sig av stimulansfattiga miljöer för att minska risken för våld. Forskning bekräftar att isolering och fastspänning är vanligt förekommande på PIVA (Brown & Bass, 2004; Cohen, et al., 2008; Dye, Brown & Chhina, 2009; O'Brien & Cole, 2004; Pereira et al., 2006; Tunde-Ayinmode & Little, 2004). Ett par studier har även tagit fasta på att det är mer vanligt förekommande på PIVA än på akutavdelningar (Cohen & Khan, 1990; Wynaden et al., 2001). Kritiska röster ifrågasätter användandet av isolering och fastspänning som en strategi för att behandla patienter inom psykiatrin. Studier har påvisat att patienter upplevt metoderna som traumatiska och associerades med ilska, förnedring, ensamhet (Hoekstra et al., 2004). Två studier pekar dessutom på att det inte finns evidens för utvärdera effektiviteten av inlåsning och fastspänning (Nelstrop et al., 2006; Salias & Fenton, 2000). Klinisk erfarenhet visar att metoderna i det akuta skedet (för)hindrar skada vilket speglas i attityder hos vårdpersonal. Hoekstra et al. (2004) menar att metoderna rättfärdigas av vårdpersonal då det inte finns alternativa metoder som ersätter som fungerar som ersättning. Resultaten från Hoekstras m.fl. studie är dock inte överensstämmande med andra studier som istället argumenterar för och framhåller ett antal alternativa strategier och metoder som reducerar användandet av isolering och fastspänning på PIVA. En studie från Nederländerna visade ett flertal faktorer som bidrog till en positiv utveck-

ing beträffande att reducera isolering till ett minimum (Georgieva, de Haan, Smith & Mulder, 2009). Åtgärderna som beskrevs i studien berörde personalens kunskaper i att de-eskalera patienter vebalt, miljömässiga faktorer, nära involverade med patienter, attitydförändringar i avdelningskulturen från kontroll till förhandling, att ha ett kompetent ledarskap, implementera krisplaner på individbasis. I likhet visade en annan studie från Australien att implementering av en patient-centrerad vårdmodell samt förändringar i ledarskapet reducerade antalet inlåsningar (Mullen & Drinkwater, 2011). En vårdmodell för att reducera våld och aggresioner är TERMA (även kallad Bergen-modellen i Sverige) utvecklades i Norge vid Haukelands Universitetsjukhus. Modellen går ut på tre nivåer. Första nivån är att bygga upp goda relationer med patienterna och bibehålla dessa relationer på daglig basis för att undgå och förebygga våld och aggressioner. Den andra nivån handlar om att sätta gränser och lugna ner patienter när det börjar bli oroligt och förhindra ytterligare eskalering. Den tredje nivån handlar om att ta kontroll över våldet och aggressiviteten när den uppstått och fysiskt ta kontroll över patienten samt efterarbetet med post-debriefing sessioner.

Prevention och hantering av aggresioner och våld får ofta en dominerande position i forskning om PIVA som redogjorts för ovan men jag menar att det utöver dessa aspekter även finns också andra aspekter och komponenter i den dagliga omvårdnaden som inte beaktas och som också viktig omvårdnad. Som en konklusion av den genomlästa litteraturen ser jag att frågor som berör vad vårdpersonalen gör är den mest omfattande beskrivna frågan följt av, än mindre utsträckning, hur vårdpersonalen arbetar. Den fråga som kanske allra minst berörts är varför. Jag uppfattar att frågan ses som självklar då vårdandet ofta beskrivs som något naturligt att den sällan ifrågasätts eller artikuleras utanför ramarna att nå hälsa och lindra lidande. I den här avhandlingen avser jag att utforska och beskriva omvårdnad i den psykiatriska vårdens mest slutna rum.

## Syften

Det övergripande syftet med avhandlingen var att utforska och beskriva intensivpsykiatrisk omvårdnad. Avhandlingens specifika delsyften var att beskriva vilka vårdaktiviteter som erbjuds patienterna. Ett annat syfte var att beskriva vårdpersonalens kulturella kunskaper i omvårdnad och dess uttrycksformer på PIVA. Vidare var syftet att beskriva hur vårdpersonalens använder olika förhållningssätt för att observera patienter i relation till övervakningsmekanismer i den psykiatriska vården. Det sista specifika syftet var att beskriva, utforska och förklara stabilitet som ett begrepp i omvårdnad i intensivpsykiatri.

## Metoder

Alla fyra delstudierna använde kvalitativa forskningsmetoder men utifrån de olika forskningsfrågorna i de specifika studierna valdes olika metodologier och metoder.

I delstudie I användes Critical Incident Technique (Flanagan, 1954) där personal på en PIVA fick svara på öppna enkäter samt att några i personalen intervjuades om sina erfarenheter av att vårda patienter på PIVA. Datamaterialet analyserades genom att incidenter/situationer identifierades i datamaterialet. Därefter sorterades dessa i olika kategorier baserat på dess likheter och olikheter. För att ge stöd åt kategorierna tydliggjordes det med citat från det som informanterna sagt. Under analysen diskuterades de kategorier som konstruerats för att nå en samstämmighet med stöd av handledargruppen över vad som framträdde under analysen.

I delstudie II användes etnografiska metoder, med hjälp av deltagande observationer, strukturerade och ostrukturerade intervjuer och fältanteckningar och memos konstruerades ett omfattande datamaterial. Observationerna gjordes vid tre PIVA och omfattade drygt 200 timmars fältarbete under en 15 månaders period. Totalt omfattade data nästan 500 sidor text. Under de deltagande observationerna fanns jag med i verksamheterna och studerade hur personalen jobbade för att förstå det kulturella kunnandet i intensivpsykiatrisk omvårdnad. Data analyserades med Spradley's (1979, 1980) etnografiska 12 steps metod, Developmental Research Sequence. I korthet samlades och analyserades data växelvis. Inledningsvis ställdes öppna och breda frågor som sedan analyserades. Vartefter frågornas fokus blev allt snävare kunde min förståelse för det kulturella kunnandet fördjupas. I enlighet med Spradleys metodologi studerades begreppen på basis av deras likheter och olikheter samt deras attribut genom så kallade domän-, taxonomi-, komponent- och temaanalys.

I delstudie III användes den data som samlats under fältarbetet men analyserades ännu mer fokuserat utifrån en specifik frågeställning som berörde vårdpersonalens kunnande i att observera och övervaka. Även i denna studie följdes Spradleys analyssteg för att strukturerat och systematiskt kategorisera och beskriva denna specifika omvårdnad. För att ge trovärdighet till analyserna exemplifieras kategorierna med citat och fältanteckningar i presentationen.

I delstudie IV användes Wilsons (1963) metodologi för att göra en begreppsanalys på begreppet "stabilitet" mot bakgrund av att det i delstudie II framkom att den psykiatriska intensivvårdskulturen beskrevs som en stabilitetskultur. I denna studie gick jag bortom de kliniska data som samlats i tidigare delstudier för att förstå begreppet mer kontextlöst och därefter återkontextualisera genom exempel från den intensivpsykiatriska vår-

den. Data samlades med hjälp av nätbaserade ordböcker, Wikipedia, YouTube, traditionell litteratursökning samt egna erfarenheter. Data analyserades med Spradley's (1979) domän-, taxonomi- och komponentanalyser på samma sätt som beskivet för delstudierna II och III.

## **Etiska överväganden**

I avhandlingen gjordes två datainsamlingar som båda underställdes etisk granskning. Den första vid Mälardalens Högskola (dnr. CF33-522/06) och den andra vid Etikprövningsnämnden (dnr. 2008/105). En etisk princip som löpt genom hela avhandlingsarbetet var att "etiken föregår ontologin" (Eriksson, 2001). Denna princip har väglett mig i både designen av delstudierna samt i specifika situationer under datainsamlingen. När de enskilda delstudierna har designats har jag ständigt diskuterat mina val med handledare och i seminarier för att överväga de eventuella riskerna att involvera dessa människor mot den eventuella nyttan i kunskapsvinsterna. Under fältarbetet har jag reflekterat över på vilket sätt min egen roll påverkar människorna som jag har involverat. I förväg träffade jag personalen vid respektive avdelning för att diskutera min närvaro och eventuella problem som kunde uppstå. I mötet med informanterna har jag hela tiden haft inställningen att jag är novisen och personalen är experterna vilket också ligger i linje med mina ontologiska antaganden att min sanning inte är mer sann än den kulturella kunskap de företräder. Att anta ett ödmjukt förhållningssätt var viktigt i enlighet med mina etiska principer, dessutom ett sätt att inte riskera att kontaminera fältet för kommande forskare. I enlighet med Helsingforsdeklarationen (WMA, 2008) har samtliga informanter varit fullt informerade om deltagandet, samtyckt och fått information om rätten att avböja medverkan utan påföljd. För att informera om den pågående studien satte jag upp ett anslag dels på anslagstavlan vid respektive avdelning samt ett anslag vid entredörren. En annan etisk aspekt som var viktig var att behålla konfidentialiteten så långt det varit möjligt.

## **Resultat**

Den intensivpsykiatriska vårdkulturen beskrevs i termer av att vara en stabilitetskultur där det övergripande målet var att förhindra, behålla och åter skapa stabilitet när turbulens uppstod. Genom att praktisera intensivpsykiatrisk omvårdnad kunde turbulensen intervenseras för att nå en balans. Stabiliteten var ett modus som kännetecknades av lugn och ro och uttrycktes som ett utgångsläge att sträva efter men ibland uppstod störningar som ledde till turbulens. Stabilitet var ett komplext begrepp som förändrades och påverkades som en följd av personalens och patienters interaktioner, ibland mindre

fluktationer i lugnet och i andra tillfällen fullskalig kaos. Stabiliteten var nära kopplat till patienternas välmående och beroende på om de uttryckte turbulens eller stabilitet kom det också att inverka på hela vårdmiljön. Ett allmänt accepterat antagande i stabilitetskulturen var att om en patient uttryckte oroligt beteende var det också troligt att turbulensen och oron skulle komma att spridas till andra patienter, därför var det viktigt att allokera resurserna och försöka stävja en begynnande turbulens, bland annat genom att hitta en balans och ett sätt att samarbeta med patienterna. Strävandet mot stabilitet innebar ett involverade och ett balanserande mellan att använda mer eller mindre restriktiva omvårdnadsstrategier. Omvårdnaden beskrevs i termer av att observera och övervaka patienterna, deras förmåga att de-eskalera och lugna ner, finnas närvarande utan att vara påträngande, att utbyta information mellan varandra i personalgruppen för att ständigt vara uppdaterad, bibehålla ett säkerhetstänk, och reducera och minimera. Med utgångspunkt att PIVA i mina resultat framskrevs som en stabilitetskultur analyserades begreppet stabilitet.

Analysen visar att stabilitet inte är något som uppstod av sig självt utan med hjälp av komponenter i form av aktiva respektive passiva stabilitetssystem kunde stabilitet skapas och bevaras. För att stävja turbulens interverades den med tillförsel av energi eller en kraft, att göra en förändring, implementering, manövrerande eller parrerande åtgärder. Samtliga komponenter i dessa aktiva stabilitetssystem förutsätter någon form av görande eller agerande vilket gjorde dem till aktiva. Exempelvis skulle en sådan aktiv interverering vara att avleda en orolig patient genom en promenad eller att fysiskt hålla fast någon som är våldsam. Transitionen från turbulens till stabilitet kunde också vara ett resultat av andra komponenter som inte förutsatte ett agerande i samma mening. De passiva stabilitetssystemen omfattade komponenter som monitorering, stillastående, minskad användning av kraft och flexibilitet. Exempelvis skulle sådana passiva stabilitetssystem konkretiseras i att själva PIVA miljön är begränsande och att ett etablerat säkerhetstänk bidrar till att förhindra och skapa stabilitet. Än mer abstrakt betydde det att komponenterna var inkorporerade i själva grundstrukturen i materialet och en del av konstruktionen själv utan aktiv påverkan.

Det som var centralt för skapandet av stabilitet var att den endast var temporär då yttre påverkningar ständigt utmanade dess position. Vid sådana yttre påverkningar kom stabiliteten att ompositioneras, tre utfall identifierades. Stabiliteten kunde antingen återgå till stabilitet och till sitt ursprungsläge men den kunde också ny-positioneras och få en ny innebörd alternativt fortsätta att röra sig från stabiliteten tills att kraft har etablerats för att stagnera turbulensen.

## Diskussion

Fokus för den psykiatriska vårdens omtalas ofta i termer av att behandla och vårda patienter i syfte att bota och lindra lidande. Vård och behandling utgör en kombination av olika strategier såväl medicinska som paramedicinska behandlingsmetoder, samtalsterapier i sociala stödåtgärder och samtalsstöd, psykoedukativa insatser m.m. Målet är att individen ska bli frisk, återfå hälsa och öka livskvalitet och komma tillbaka till ett bra liv. I den här avhandlingen stipuleras nya teoretiska konstruktioner som specifikt rör den intensivpsykiatriska vården där den enskilda individens hälsa och lidande ur ett livsvärldsperspektiv inte är det primära. Istället stipuleras intensivpsykiatrisk vård som en framskrivning av den underliggande konstruktionen av rytmer och rörelser för att skapa stabilitet. Omvårdnad i denna kontext förutsätter ett kontinuerligt balanserande för att uppnå jämvikt i stabilitetskulturen. Omvårdanden är de rörelser som ger energi och riktning åt rytmen. Stabiliteten ska dock inte förstås som något slutgiltigt och permanent när den väl etablerats utan snarare betraktas som ett ytterst temporärt tillstånd. Rytmens vågor gör avtryck i tidsrymden genom sina fluktationer och skapar över tid ett visst mönster och skapar stabilitetsrytmen. Att stabiliteten fluktuerar inom ett visst utrymme ska betraktas som ett normaltillstånd och accepteras inom vissa gränser. Ibland kommer stora fluktationer och sätter rytmen ur spel som överträder de acceptabla gränser för vad som kan anses vara stabilitet. Fluktationerna skapar turbulens och disharmoniserar rytmen. Under sådana förhållanden är läget osäkert, oförutsigbart, och all energi går åt att återställa stabilitetsrytmen. På så sätt pågår en kontinuerlig och växelverkan mellan turbulensen och stabiliteten. Dessa rytmer och rörelser har tidigare inte uppmärksammats inom psykiatrisk omvårdnad vilket är ett viktigt bidrag i avhandlingen.

## Konklusioner

- PIVA är en stabilitetskultur med det övergripande målet att förhindra, bevara och återställa stabilitet när turbulens uppstår.
- Det kulturella kunnandet i omvårdnad på PIVA beskrivs i termer av att erbjuda övervakning, lugna ner, vara närvarande, utbyta information, bibehålla säkerhetstänk och att reducera. Genom att intervensera turbulensen med omvårdnad kan PIVA bli en fristad som erbjuder lugn, ro och vila.

- Konceptualiseringen av vård inom intensivpsykiatri förutsätter balanserande entiteter i strävan efter jämvikten i stabilitetskulturen. Omvårdnad beskrivs i termer av rörelser och sätter igång och skapar fluktuationer i stabiliteten vilket bidrar till rytmen. Rytmen och rörelserna presenteras här som vård i intensivpsykiatri.
- Begreppet stabilitet är ett högst temporärt tillstånd och ingalunda en fixerad position. Stabilitet formeras på basis av användandet av aktiva och passiva stabilitetssystem.
- På basis av de olika stabilitetssystemen har olika stabiliteter identifierats vid fluktuationer. Stabiliteten kan återgå till stabilitetsrytmen och sitt ursprungliga läge, men den kan också ny-positioneras och få en ny innebörd eller fortsätta röra sig från stabiliteten tills dessa att tillräcklig kraft etablerats.
- PIVA erbjuder en intensiv miljö för vård på grund av den specifika vårdmiljön och vårdarnas närhet.
- Två dikotomiserade förhållningssätt framskrivs för att observera patienter – den latent och den manifesta.

## TACK

Det finns många personer som jag vill rikta tack till därför att de på sitt sätt har bidragit och stöttat mig under min skrivprocess. Först och främst vill jag tacka all personal på de fyra psykiatriska intensivvårdsavdelningar som engagerat sig. Tack för att ni har ställt upp och låtit mig ta del av er kunskap och kultur. Utan er hade denna avhandling aldrig varit möjlig att skriva. Jag kände mig mycket välkommen under mitt fältarbete och blev snabbt accepterad i respektive grupp och ni lät mig ställa de mest naiva frågorna som ni omsorgsfullt och tålmodigt svarade på. Ni såg till att jag blev omhändertagen, allt från välkomnande leenden till mer praktisk hjälp i form av övernattningsmöjligheter. Ovärderligt! Vidare vill jag tacka...

**Henrik Eriksson** - min huvudhandledare för din tillgänglighet och snabba respons och ditt outtröttliga engagemang - natt som dag, online som offline. Det har varit fantastiskt roliga, allvarliga och ibland oerhört invecklade teoretiska diskussioner. Du har bistått mig på ett sätt som har varit över förväntan med ditt skarpa öga för såväl detaljer som det övergripande. Du har dessutom bidragit till en självständighet hos mig som forskare just därför att du inte krävt kontroll.

**Kim Lützn** - min biträdande handledare. Du gjorde det möjligt för mig att påbörja forskarutbildningen genom att ordna en halvtidstjänst som doktorand vid Högskolan Dalarna hösten 2006 och var de första åren min huvudhandledare. Du har bidragit med viktiga inlägg med ditt stora kunskapsområde i psykiatrisk vårdforskning. Du har haft ett skarpt öga för de etiska aspekterna och fått mig att reflektera vilket bidragit till min utveckling.

**Ann-Britt Ivarsson** - min biträdande handledare för att du bidragit med kloka och insiktsfulla synpunkter vid handledningsträffarna. Du har också bistått och varit behjälplig med rutiner kring forskarutbildningen. Du har bidragit med viktig kunskap i både vetenskaplig metod och gett råd vid viktiga strategiska avgöranden under avhandlingsarbetet.

**Maria Salzmänn** - min kära fru! Bara en äkta hälft förstår vad det innebär att leva ihop med en doktorand. Jag tackar för ditt fulla stöd och tålamod som du har visat mig under forskarutbildningen. Vi har också haft många berikande diskussioner om akut och intensivpsykiatrisk vård. Jag har ofta bollat mina teoretiska idéer med dig vilket har varit viktigt för mig i skrivandet. Det har varit tryggt att ha dig vid min sida.

**Perla och Isidor** - mina barn som hunnit bli tre respektive ett år!

**Christer och Maria Erikson** - Min pappa med fru som ställt upp och varit behjälpliga med allt från barnpassning till renovering när jag i perioder rest runt och varit frånvarande.

**Solveig Salzmans och Reggie Brock** - Min mamma med sambo som stöttat mig och trott på mig under hela projektets gång, bidragit till diskussioner och även följt med på en internationell konferens som barnvakter.

**Rickard Salzmans** med familj - min bror som energiskt frågat gång på gång vad jag egentligen gör när jag forskar. Du undrar fortfarande.

**Britt och Manne Erikson** - Min farmor och farfar som under många år idogt försökt förstå vad jag "går och läser" samt ert stöd med familjelivet när jag varit frånvarande.

**Mats Ewertzon** - Du var en mentor för mig när vi samtidigt började på Högskolan Dalarna som doktorander. Jag hade inga kunskaper om den akademiska världen men du introducerade mig omsorgsfullt. Tack för alla konferensresor och långa samtal som vi har haft.

**Jessica Holmgren med familj** - för många och roliga middagar med diskussioner om vårdvetenskap, etnografi, fältarbete och postmodernitet. Du har stöttat mig på ett fantastiskt sätt.

**Christina "Kicki" Ulvede** - Tack för att du trodde på mig och mina idéer att forska om psykiatrisk intensivvård.

**Paul Stronegger** - min närmaste chef vid Oslo Universitetssykehus, Ullevål för att du stöttat mig och bidragit till konferensresor och ledighet när jag behövt det i samband med forskarutbildningen.

**Caroline Sutton** - för din skicklighet och hjälp med språkgranskningen.

**Nina Nilsson och Jill Widén** - för er hjälp med administration under forskarutbildningen.

**Åsa Johansson** - bibliotekarie på Högskolan Dalarna, tack för din hjälp att ta fram gamla artiklar och litteratur som du skickat hem till mig i tid och otid.

**Agneta Schröder och Birgitta Hedelin** - tack för ert bidrag som granskare vid slutseminariet vid Örebro Universitet. Den akademiska diskussionen var viktig för mig och gav mig möjlighet att argumentera för mina ståndpunkter.

**Maria Forsner, Ulla-Karin Schön och Susanna Nordin** - tack för ert bidrag som granskare vid det lokala slutseminariet vid Högskolan Dalarna.

**Margareta Ehnefors och Margareth "Peggy" Wilson** – tack för er insats som kursansvariga för "Concept Development" vid Örebro Universitet.

**Torhild Johansen** - för intressanta diskussioner under alla arbetspass som vi jobbat tillsammans och spännande tillsynsrundor på avdelningen.

**Andreas Carlson** - för hjälpen med att designa och rita om mina kråkfötter till figurer i avhandlingen.

Mina kollegor på akutpsykiatriska avdelningen "post-4" vid Oslo Universitetssykehus, Ullevål.

Mina kollegor vid Högskolan Dalarna.

Mina doktorandkollegor vid Örebro Universitet.

Mina före detta kollegor på avdelning 93 vid psykiatriska kliniken i Västerås.

Tack också till övriga av mina närmaste vänner samt samarbetspartners i diverse forskningsprojekt som funnits med under resans gång: **Tomas och Lena Karlsson med familj, Claes Heldemar, Magnus Anegrund, Tom Johansson, Johan Lönneborg med familj, Ulf Johag, David Hamberg, Johan Melin, Tommi Varoma, Linda Hammarström, Lennart Törnkvist, Mikael "Mike da Spike" Karlsson, Susann Norgren, Cecilia Rydlo, Lena Wiklund Gustin, Lena Marmstål, Charlotta Thunborg, Mats Christiansen, Annica Engström, Jonas Sandberg, Esa Kumpala, Lena Marmstål, samt "VUB-gruppen"** bestående av **Marco Pilaja, Oona Lassenius, Anders Larsson och Linda Sellin.**

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