

**The Health Care Environment on a Locked
Psychiatric Ward and its Meaning to Patients and
Staff Members**

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ABSTRACT

The overall aim of this thesis was to describe the health care environment on a locked acute psychiatric ward and to elucidate its meaning to patients and staff members.

The study was performed using an ethnographic method on a psychiatric ward, mainly for patients with affective disorders and eating disorders. The ward admitted both voluntary and involuntary patients, and always had the entrance door locked. In papers I and II, participant observations (250 hours), including informal interviews and collection of documents, were made. The focus was on describing the health care environment on a locked psychiatric ward and encounters between patients, staff members and visitors in the common areas of such a ward. In paper III, formal interviews with staff members (N=10) were conducted in order to elucidate the meaning of being a care provider on a locked acute psychiatric ward. In paper IV, formal interviews with patients (N=10) were made to elucidate the meaning care has to patients on a locked acute psychiatric ward.

The findings show a health care environment that was characterized by control and relationships. Staff members (I) were both in control and lacked control; they attempted to master the situation in line with organisational demands and sometimes failed. Patients were controlled by staff; they were the underdogs, and tried to make themselves heard and reacted by developing counter-strategies. The ward (II) provided a space for encounters between people, in a continuum from professional care to private meetings and social events. Both caring and uncaring relationships were seen between staff and patients or their next of kin. The patients' relationships with each other made visible unrecognised relationships that included both supportive and intrusive elements. For staff members (III), being a care provider meant striving for good quality in care; it included a need for security and safety and having to face a demanding work environment. Their sense of responsibility for work to be done and for caring for patients' wellbeing was both a driving force and a burden. The meaning of care to the patients (IV) included both alleviation of suffering and being exposed to stress. The care strengthened patients' integrity and self-determination, they were given support by staff members, next of kin and fellow patients, and the ward offered a place of refuge. Care could also mean being exposed to stress of being dependent due to lack of choice and influence on care, and trapped in a situation where they had to endure surveillance and control and having closeness to fellow patients forced on them.

This thesis shows that the health care environment on a locked psychiatric ward includes a web of relationships between people on the ward and that no relationship can be viewed as insignificant for patients' care. Control and power were parts of the relationships, between patients and staff in particular, pointing to the need to increase patient participation in care. Handling these interrelated relationships with a number of inherent fields of power can explain some of the stress experienced by staff in psychiatric inpatient care.

Keywords: content analysis, ethnography, health care environment, inpatient psychiatric care, patients, staff

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ORIGINAL PAPERS

This thesis is based on the following papers, which will be referred to in the text by their Roman numerals:

- I. Johansson IM, Skärsäter I & Danielson E (2006). The health-care environment on a locked psychiatric ward: an ethnographic study. *International Journal of Mental Health Nursing* 15(4), 242-250.
- II. Johansson IM, Skärsäter I & Danielson E (2007). Encounters in a locked psychiatric ward environment. *Journal of Psychiatric and Mental Health Nursing* 14(4), 366-372.
- III. Johansson IM, Skärsäter I & Danielson E. The meaning of being a care provider on an acute psychiatric ward: staff members' experiences. (*Submitted*).
- IV. Johansson IM, Skärsäter I & Danielson E. The meaning of care on a locked acute psychiatric ward: patients' experiences. (*Resubmitted*).

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INTRODUCTION

In this thesis, the health care environment on a locked psychiatric ward and what it means to patients and staff members are explored. The nature of psychiatric inpatient care has changed in recent decades. In Sweden, it was in an expansive phase until the early 1970s and accounted for the major part of specialized psychiatric care. After a successive change in assignment and scope, inpatient care is now a complement to more open forms and the number of beds has radically decreased. The average time in hospital for people suffering from mental illness has dropped by about two thirds, from 60 days in 1987 to 20 days in 2006 (Socialstyrelsen 2007). The role of inpatient care is now to offer acute care for patients suffering from severe mental illness and care episodes are now much shorter than previously. This has led to a concentration of patients with severe conditions on fewer inpatient wards. This trend of psychiatric care is quite similar to that in other Western countries (Silfverhielm & Kamis-Gould 2000).

One task for specialized psychiatric care is to offer care for individuals who are judged to be in urgent need of inpatient psychiatric care but who do not agree to care, that is, to give care to a person against his/her own will. In Sweden, the most of these patients are admitted to locked wards – wards with locked entrance doors. An investigation was made in Sweden in 2003 of the frequency of having psychiatric wards for children, adolescents and adults locked. It was found that 66% of all wards (n=193) were locked all the time or most of the time (forensic wards were excluded), while only 25% of all patients (n=2073) were in involuntary care. Seventy five per cent of the wards providing general psychiatric care for adults (n=137), were locked on the day of investigation, and 86% of wards for substance misuse (n=21) and 87% of the wards for geropsychiatric care (n=15) were locked (Haglund *et al.* 2007). An inventory of Swedish compulsory psychiatric care for adults carried out in 2008 included 99% of all beds available (n=4 057) and showed that 56% (n=2 285) of the patients were in voluntary care, while 22% (n=904) were in involuntary care, forensic care excluded (Socialstyrelsen 2008). This shows that only about a quarter of the patients on Swedish inpatient wards for adults are committed to care when patients in forensic care are excluded. To summarise, this shows that not only patients in involuntary but also quite a large group of voluntary patients are cared for on locked wards.

The use of locking psychiatric wards seems to vary between countries and settings, even if this kind of information is often neglected in research reports on inpatient care. A trend towards more locked wards is, however, reported in studies from the United Kingdom where legislation regulates the locking of wards (Ashmore 2008, Bowers, Crowhurst *et al.* 2002), which is not the case in Sweden. In Sweden, voluntarily admitted patients are free to leave whenever they wish, while involuntarily admitted patients' freedom to move is restricted by law, but the law does not make explicit by what means (SFS 1991:1128).

Freedom of movement is in practice restricted for all patients on a locked ward, since voluntary patients also need help from the staff to open the door. Research shows that patients are sensitive to the way their freedom is restricted, both in case of direct coercive measures and when exposed to more indirect coercion such as regulations and pressure. Care on locked wards has been experienced by patients as a deprivation of liberty (Haglund & von Essen 2005, Kuosmanen *et al.* 2007) as well as being related to feelings of safety and security (Haglund & von Essen 2005). Such contradictory views are also found in studies of staff members: care on a locked ward was seen as a minor ethical problem (Lind *et al.* 2004), or as including disadvantages for both patients and staff (Haglund, von Knorring & von Essen 2006).

Changes in the nature of inpatient psychiatric care include a change in the work environment for staff members in different professions. The incidence of violence and threats during contact with patients is higher than in most other health care sectors (Lawoko, Soares & Nolan 2004, Nolan *et al.* 2001) and nurses have been found to have the highest exposure among the different professions (Lawoko *et al.* 2004, Wynn & Bratlid 1998). The impact of organisational factors on the work environment of mental health staff and has been identified as a source of fatigue and burnout (Fischer, Kumar & Hatcher 2007, Taylor & Barling 2004, Thomsen *et al.* 1999); organisational factors are also decisive for job satisfaction (Ward & Cowman 2007) and influence exposure to violence (Nolan *et al.* 2001). The conditions that form the health care environment for patients and staff members on a ward include physical aspects as well as psychosocial and cultural aspects. As acute psychiatric inpatient care can be challenging for both patients and staff members, such conditions must be addressed in order to provide a caring environment.

The research question for this thesis is: what meaning does the health care environment on a locked acute psychiatric ward have to patients and staff members? Increased knowledge about the health care environment on a locked acute psychiatric ward can be important for the majority of patients and staff members due to the high frequency of locked wards, patients' freedom to move and to staff members work environment.

BACKGROUND

Health care environment

Health care environment, in Swedish “*vårdmiljö*”, has no consensus about content. In the MESH database (the U.S. National Library of Medicine’s controlled vocabulary), the closest concept is Health Facility Environment, defined as “physical surroundings or conditions of a hospital or other health facility and influence of these factors on patients and staff”. In this thesis, the concept environment includes both the material world and the world that is socially constructed by humans. The concept health care environment is accordingly used to include not only physical but also psychosocial and cultural aspects of the environment in a care setting. The concept atmosphere is often in research synonymous with health care environment and also suffers from the same lack of consensus about its definition (Edvardsson 2005). When measuring psychosocial environment and atmosphere in inpatient care and in residences for the mentally ill various scales are used that include dimensions of relationships, personal growth and system maintenance (Brunt & Hansson 2002). In this thesis, psychosocial refers to relational and emotional aspects of care and environment. Culture is used in the sense of ‘culture in a care organisation’ comprising a set of basic assumptions, values and rules, which underlie caring actions and influence the interpretation of actions and the way people act (Sandelin Benkö & Sarvimäki 1999). The groups of people included in the health care environment in this thesis are the patients and their next of kin, who include family members and other significant persons for the patient, and the patient’s friends, other visitors and staff members.

Inpatient psychiatric care

Environment

The physical environment has been seen as part of the care tradition in psychiatric hospitals since the middle of the 19th century. In Sweden, following a development that started in France about a century earlier, regulations for the new mental hospitals stated that they should be placed in fresh and wholesome environments, separated from somatic hospitals, providing enough space for patients and a suitable occupation (Danielson 1983). They became small isolated societies in the society where food, activity and a wholesome environment were a part of the care. People from all social classes were, however, reluctant to send their next of kin to these hospitals, for one thing because it was seen as humiliating (Björkman 2001), and most of the mentally ill were taken care of at home by next of kin until the late 19th century (Eriksson & Qvarsell 1997). During the first half of the 20th century, care in psychiatric hospitals expanded five hundred per cent in Sweden when new psychiatric hospitals were built (Qvarsell 1991). Growing criticism in the Western world of large and closed institutions exposing patients to violation (Goffman 1991/1961, Jönsson 1998), resulted in a change towards more open care settings. A great variety of milieu treatment models were then developed (Al-

mond 1983), but in the late twentieth century these played a minor role, after increasing biomedical influence in psychiatric care and a large focus on open forms of care. Instead, there has been growing concern about a return to custodial care in 'secure units' and the preoccupation with issues of risk management and security technologies (Morrall & Hazelton 2000).

Recent studies of psychiatric inpatient settings have shown that patients consider the environment important for quality of care and satisfaction with care. Aspects mentioned as important were a good organisation and support (Eklund & Hansson 2001, Middelboe *et al.* 2001), calmness and security (Howard *et al.* 2001, Schröder, Ahlström & Larsson 2006) and personal space (Howard *et al.* 2001, Schröder *et al.* 2006, Wallace *et al.* 1999). Andes and Shattell (2006) argue in a review that patients have limited control over space in acute inpatient care, that their privacy is often invaded by staff members, something necessary in order to maintain safety for the patient. A study in an open psychiatric clinic for planned 24-hour care, where emphasis on beauty and pleasure was shown in buildings and surroundings, it was found that a pleasant physical environment contributed to positive energy, increased courage to live, and motivation for treatment in patients (Borge & Fagermoen 2008).

Care and relationships

When describing the care on inpatient wards, firstly an overall organisational perspective will be used. A report (SOU 2006:100) from the Swedish government concluded that there were deficiencies in psychiatric care concerning access to competent staff, evidence-based methods, way of working, and organisation. Evidence-based methods were not used to the extent expected and the directives for care were vaguely formulated at all levels in the organisation. It also pointed out that the wards for inpatient care were often too big and noisy, that wards differentiated for groups of patients with special needs were lacking and that more beds were needed. Several of these problems are not unique but reflect how psychiatric inpatient care in other countries is described (Bowers 2005, Cleary 2003, Hanrahan & Aiken 2008). Psychiatric care is not only intended to care for people with mental illness but also, particularly in the case of forensic care, to protect the society. This also implies an exercise of power by society towards individuals, which makes the quality of psychiatric care of importance for the whole of society.

In this thesis, the concept relationship refers to a human-to-human relationship based on staff members' and patients' experiences in psychiatric care. Relationships in care can be of great value for the patient but there are also relationships that suffer from great deficiencies or never even begin. Research shows the importance of a good relationship from a patient perspective; it was to be found essential for the patient's experience of coercion in care (Olofsson & Norberg 2001), quality of care (Johansson & Eklund 2003, Längle *et al.* 2003), feelings of safety (Gallop *et al.* 1999) and for their attitude towards treatment (Day *et al.* 2005). Staff members likewise have been found to consider the relationship with patients as central in care, i.e. central to quality in

care (Schröder & Ahlström 2004). Trust, respect and dignity are important and interrelated concepts when describing relationships in psychiatric care. Patients' trust in staff members is shown to be needed for a good relationship between patients and staff members (Talseth, Jacobsson & Norberg 2001) and for patients to feel safe in inpatient care (Gallop *et al.* 1999). Both respect and trust were needed to preserve the patients' dignity in order to promote health processes in psychiatric care (Svedberg, Jormfeldt & Arvidsson 2003) and, further, respecting patients' dignity was shown as a condition for quality in care both for patients and staff members (Schröder & Ahlström 2004, Schröder *et al.* 2006). A good relationship can also be an example of a caring relationship. The philosopher Milton Mayeroff (1990/1971) explains caring as helping another person to grow and actualize himself, then experiencing him/her as an extension of myself and at the same time something separate, that I respect in his/her own right. Caring in nursing is described as a dynamic interpersonal process based on encounters that are intimate and holistic in nature and rely on the expert practice of nurses (Finfgeld-Connett 2007). Berg and Danielson (2007) shows that not only nurses but also patients used their specific competence to achieve a caring relationship, which implied balancing between vulnerability and dignity in daily encounters.

Research shows the difficulties in upholding or even establishing relationships in psychiatric inpatient care. User-led participatory research showed that hindrances to positive relationships between patients and staff from the patients' perspective were insufficient communication, lack of trust and safety and use of coercion (Gilburt, Rose & Slade 2008). Nurses behaviour as a group, shaping an atmosphere of 'them and us', was exemplified by patients as having a negative impact on their relations (Beech & Norman 1995) and, on a individual level, nurses' impersonal professional routine where the relationship is not defined as a personal encounter made patients feel rejected (Hem & Heggen 2004). Additionally, the use of various degrees of control over patients was shown to create distrust (Hem, Heggen & Ruyter 2008, Hoekstra, Lendemeijer & Jansen 2004) and patients associated violent encounters with situations that lack respect and dignity (Carlsson *et al.* 2004).

Coercion in inpatient care

The use of coercion in psychiatric care is strictly regulated by law, although there are some variations between countries (Wallsten 2008). Swedish legislation of health and medical care stipulates that all care shall be of good quality, be built on respect for the patient's self-determination and integrity, it shall support good contact between patient and staff, and as much as possible be planned and performed in cooperation with the patient (SFS 1982:763). The additional Compulsory Psychiatric Care Act (SFS 1991:1128) states that a person can be admitted to psychiatric inpatient care against his/her own will if: he/she is suffering from a serious mental illness, is in absolute need of specialized inpatient care, and is opposed to the care needed or cannot give his/her consent to care due to his/her mental condition. Involuntary care includes, among other things, that the patient can be prevented from leaving the care

setting, but the law does not specify by what means. The law regulating forensic care states that a court can sentence a person who has committed a crime to forensic care if he/she is suffering from a serious mental disorder. The commitment to forensic care can include that a special court decision is needed when it comes to leave and discharge, since The Forensic Psychiatric Care Act (SFS 1991:1129) places greater emphasis on the protection of society than does the Compulsory Psychiatric Care Act. Patients sentenced to forensic care are usually cared for in specialized units, but in the case of forensic care without the earlier mentioned special restrictions they can also be cared for on general locked wards (Haglund *et al.* 2007). The use of coercion in psychiatric care is then intended to protect not only the patient him/herself but also society. Additionally, coercion is also needed to protect those who perform the care and other patients from the risk of harm.

Coercion in psychiatric care has been the subject of debate and research for many years, with most research being conducted in Europe and North America. Defining coercion of patients is problematic since there is both formal coercion regulated by law and the practice in which there exists a continuum of measures from persuasion and manipulation to seclusion and restraint (Ryan & Bowers 2005, Sjöström 2006, Sørgaard 2007). When scrutinizing this problem area, research has a number of main foci that often overlap each other. These are coercion, the use of seclusion (isolating a patient in a room) and restraint (physical measures that restrict a patient's freedom) and violence in care. European research on coercion in care, of which several studies are Swedish, emphasises the experiences of those involved in the use of coercion, i.e. patients, staff members, and next of kin (Iversen *et al.* 2002, Kjellin *et al.* 2004, Olofsson & Norberg 2001). It also deals with ethical problems (Kjellin *et al.* 1997, Lind *et al.* 2004) and legal issues (Sjöström 1997). Research on violence and the use of seclusion and restraint focuses more on staff members than patients (Carlsson, Dahlberg & Drew 2000, Lawoko *et al.* 2004), on managing aggression (Björkdahl *et al.* 2007, Duxbury & Whittington 2005), and how to measure incidents (Bowers, Nijman *et al.* 2002). The research from North America is not as extensive as the European. In the case of coercion, it concentrates on the process of admission to hospital including experiences of patients, staff members, and next of kin, ethical issues and sources of coercion (Monahan *et al.* 1999). Examples of research on violence and use of seclusion and restraint are studies of patient (Robins *et al.* 2005) and staff experiences (Marangos-Frost & Wells 2000) and intervention to reduce aggression and control (Hunter *et al.* 2008).

In the following section, findings from research with a focus on coercion in care will be presented in greater detail. Key findings in studies from the USA were that perceived coercion by the patient was negatively affected by pressure and positively affected by being involved in the decision about admission (Monahan *et al.* 1999), and that patients perceived less procedural justice in the admission process than did the staff members and next of kin involved (Hoge *et al.* 1998). Such differing experiences were also found in a Swedish nursing study of coercion in inpatient care. One example is how coercion was

described: when staff members said 'not being allowed to go out', patients said 'being locked up'. However, both patients and staff members emphasised the importance of human contact and a mutual relationship, although they experienced it differently when coercive incidents occurred (Olofsson & Norberg 2001). The use of coercion is also closely associated with having control. When studying control as a part of the ward atmosphere in psychiatric inpatient care, one consistent finding in several studies from the USA and Denmark was that patients rate staff's use of control in care higher than do staff members (Lanza *et al.* 1994, Main, McBride & Austin 1991, Schødt *et al.* 2003) and in a Norwegian study, staff control was found to be strongly correlated to patients' satisfaction with care (Rossberg *et al.* 2006).

Other examples of the complicated nature of the experience of coercion in care are how patients' legal status in care is related to the experience of coercion and how patients report coercive incidents. Studies from both the USA and Europe show that the patient's legal status (i.e. voluntary or involuntary care) cannot predict the experience of coercion in care (Monahan *et al.* 1999) and that patients in voluntary care to a fairly high degree experience coercion (Hoge *et al.* 1997, Iversen *et al.* 2002, Poulsen 1999, Wallsten & Kjellin 2004). One explanation may be the practice by staff of invoking the coercion context in compliance communication even with voluntarily admitted patients, as shown in a Swedish study by Sjöström (2006). Here, having the ward locked all the time was a primary resource for staff who thus can be evasive when voluntary patients wanted to leave. However, it has also been found that coercive incidents reported by patients can be both false positive and false negative; in another Swedish study, patients reported that mechanical restraints had been used on them when reliable documentation showed that it had not occurred and, respectively, patients reported no use of mechanical restraints when they actually had been restrained (Wallsten, Kjellin & Sjöberg 2008). The use of coercion and control seem to have different meanings for patients and staff members, and cannot be limited to the patients' legal status in care, which is important to consider when studying phenomena that can be perceived as coercive.

Staff members face ethical problems different types of when using coercion on patients in psychiatric care. Studies have shown that it is difficult to handle the difference between what is formally coercive (i.e. involuntary admission, restriction on leaving the ward, seclusion, restraint) and the use of coercion in practice, which also includes more informal measures such as persuasion, manipulation, and threats (Ryan & Bowers 2005, Sjöström 2006). British nurses used subtle coercion when dealing with problematic incidents (Lütznén 1998) and an Australian study showed how the failure to make distinctions between what counts as coercive practice and what justifies it resulted in the use of unjustified coercion (O'Brien & Golding 2003). In two Swedish studies, the use of coercion was experienced as an ethical conflict by physicians who, when protecting patients from physical injury, felt they were causing psychological injury (Olofsson *et al.* 1999) and by nurses who did not want to use coercion but had difficulties in finding alternatives (Olofsson *et al.* 1998). In a Finnish

study, coercion in care was not considered an ethical problem by the majority of nurses, and very few (6% of n=170) considered treatment on a locked ward to be ethically problematic (Lind *et al.* 2004). The research above shows that coercion is sometimes seen as an ethical problem in psychiatric care, and that there exists grey zones when it comes to coercion in care. Caring for patients on locked wards can be one such grey zone that may pass unnoticed by staff members as being coercive, especially in the case of patients in voluntary care who are supposed to be free to leave.

The ways of managing the care of patients, who are involuntary admitted and restricted from leaving the ward, seem to vary considerably. The establishing of locked psychiatric intensive care units as an alternative to acute wards has been a way to manage care of patients who risk harming themselves or others if they abscond. This often includes patients with psychotic symptoms, drug misuse, and violent behaviour who are difficult to manage on general acute wards (Crowhurst & Bowers 2002, Salzmänn-Erikson *et al.* 2008). A study from the UK shows that even on acute wards not referred to as psychiatric intensive care units, the control of patients were accomplished by having the ward locked, while on open wards, methods used for surveillance were: staff members placed at the entrance, access to security guards and/or technical equipment, and regulations that patients were supposed to follow (Bowers, Crowhurst *et al.* 2002). An Australian study shows how having a 'least restrictive treatment' policy gave rise to yet other solutions to managing involuntary patients on open wards. This was done by combining regulations for patients with nurses doing regular rounds several times a day checking patients' presence, and by having a small enclosed area as part of the open ward for patients for whom these measures were insufficient (Hamilton & Manias 2008). This shows that in caring for involuntary patients who might leave the ward, psychiatric intensive care units and a number of methods for controlling people coming and going on open wards have been developed as alternatives to locking general psychiatric wards.

Care environment on locked psychiatric wards

Research with a focus on the health care environment on locked acute psychiatric wards is hard to find, which may be due to the fact that what kind of ward is studied, locked or open, is seldom mentioned. One may assume that studies of involuntarily admitted patients involve locked wards, but that is risky since, as mentioned above, the ways of running wards for these patients differ between countries and settings (Bowers *et al.* 1999, Haglund 2005, Hamilton & Manias 2008). This does not include forensic care, where wards are generally locked. A few studies have concentrated on patients' and staff members' opinions about the ward being locked, while the issue is more often only a small part of studies with another focus. In a number of Swedish studies, the advantages and disadvantages of locked wards have been studied, from the perspective of both patients and staff members, showing the duality in how this is perceived (Haglund & von Essen 2005, Haglund *et al.* 2006). It is, however, evident that being locked in can lead to feelings of confinement and

impaired autonomy (Alexander 2006, Haglund & von Essen 2005), but also to lower satisfaction with care (Müller *et al.* 2002), less improvement by care (Kjellin *et al.* 2004), and to precipitating aggressive incidents (Johnson *et al.* 1997). In contrast, the locked door can also be related to feelings of safety and security in both patients (Haglund & von Essen 2005, Hummelvoll & Severinsson 2001b) and nurses (Ashmore 2008, Haglund *et al.* 2006).

RATIONALE

The environment as a general component of psychiatric inpatient care has a long history, for more than a century represented by large, closed institutions separated from the rest of society. Research on the health care environment in inpatient settings today reveals that there are a number of qualities that are important for patients and staff members, but also that several problems exist. Being on a locked ward affects patients' freedom of movement and restrictions may be experienced as coercive even if a patient is in voluntary care. Research shows that the patients' legal status cannot predict the experience of coercion in care. Sensitivity to patients' experience of coercion and control even when no obvious coercive measures are taken is thus needed as well as being observant of the way coercion is applied and justified by staff members. Studies show that being on a locked ward influences both patients' care and staff members' work environments. Due to the inherent exercise of power when using coercion in care and to the paucity of studies, a deeper knowledge of the meaning of the health care environment on a locked ward is needed. This knowledge should be acquired by using a method with a holistic approach, capturing both patients' and staff members' experiences and the context in which care is performed.

AIMS

The overall aim of this thesis was to obtain an understanding of the health care environment on a locked acute psychiatric ward and its meaning to patients and staff members.

Paper I

To describe the health care environment on a locked psychiatric ward.

Paper II

To describe encounters in the health care environment on a locked psychiatric ward.

Paper III

To elucidate the meaning of being a care provider on a locked acute psychiatric ward.

Paper IV

To elucidate the meaning care has to patients on a locked acute psychiatric ward.

THEORETICAL VIEWPOINTS

Symbolic interactionism

A locked psychiatric ward involves individuals and groups of people engaged in interaction with each other, all in a specific context. When studying a phenomenon such as the health care environment on a locked psychiatric ward, symbolic interactionism can be used as a theoretical viewpoint to better understand actions and meanings among those involved. Symbolic interactionism is a theory of social psychology based on the assumption that humans learn about and define their world through interaction with others. The sociologist George Herbert Mead (1863/1934) laid the foundations for this theory, the methodology of which was further developed by Herbert Blumer (1969) and has been widely used in sociological as well as other types of research. Symbolic interactionism is based on ideas about human groups and societies, social interaction, objects, the human being as an actor, human action, and the interconnection of the lines of action (Blumer 1969). It seeks to explain human behaviour in terms of meanings; that people act towards things (i.e. physical objects, other human beings, groups of humans) on the basis of what meaning they have for them, they do not just respond to stimuli or act out cultural rules. It is thus the meaning that determines the action. The meaning a thing has for a person arises in interaction with others; it is not inherent in the object but is a social product. Thus, people learn how to see the world from each other and develop shared meanings about things. Additionally, the meaning that people attach to situations, things, others and themselves is handled and modified through a process of interpretation. The actor points out to himself the things that have meaning, and then interprets the meanings influenced by the situation and the direction of his actions. The process of interpretation is a dynamic process, and depends on the meanings available and how the situation is perceived (Taylor & Bogdan 1998).

Power and psychiatric care

In this thesis, where the focus is on psychiatric care on a locked ward, power dynamics need to be reflected on since the use of coercion is an exercise of power from different viewpoints. Power can be inherent, not only in care relationships but also in physical circumstances as well as in society's expectations. When exploring power and empowerment, four theoretical approaches have been discussed in nursing: critical social theory, organizational theory, social psychological theory and poststructuralism (Bradbury-Jones, Sambrook & Irvine 2008). The poststructural approach to power, using the works of the French philosopher and historian Michel Foucault, can lead to a more critical analysis and a way to challenge what is self-evident in care, something that is aimed for in this thesis. Here, some viewpoints of power from the works of Foucault, which are related to psychiatric care, are presented. Foucault (1988/1961, 1991/1975) explains expressions of power by studying historical and contemporary society. His analysis of the history of madness has an in-

direct focus on power, and by describing the way people with mental illness have been separated from society through the centuries he showed how power was exercised towards them. From the 17th century, the 'madmen' were placed together with criminals and poor people in confinement, the purpose of which was to prevent idleness and had no concern with curing the sick. The precursors of the mental hospitals a century later were the separate asylums established in the early 19th century. The development of asylums was parallel with that of psychiatry as a practice in its own right. Foucault asserted that this freed the 'madmen' from chains but made them the most confined and invisible of all 'madmen' in history when they were isolated from society in the asylums (Foucault 1988/1961). Foucault claimed that observation became a tool for a disciplining power exercised in prisons as well as in asylums and mental hospitals. By making it possible to observe the prisoner or patient all the time, their awareness of being observed makes them correct themselves. This is an arrangement that makes power automatic and de-individualized, according to Foucault (1991/1975). It is achieved not by use of physical force but by influencing people's behaviour and by virtue of being more effective.

According to Foucault (1998/1976), power is, however, not the same as institutions or structures but is relational and operational, and relations of power are active where they have a productive role. Power relations are at the same time goal-oriented and non-subjective; no power is exercised without intentions and goals, at the same time as it has an implicit and unexpressed character that makes it anonymous. One characteristic of power is that where there is power there is resistance, and where there is resistance there is power. Resistance is one side of power relations and Foucault claims that it is in this field that power must be studied (Foucault 1998/1976). These viewpoints of power will be used to discuss aspects of power found in this thesis.

METHODOLOGY

Capturing a phenomenon such as the health care environment, which is difficult to define and, furthermore, capturing expressions that could be associated with having a ward locked, call for an inductive method, which allows great openness to the phenomenon being studied. An ethnographic method was thus chosen, which makes it possible to include physical as well as psychosocial and cultural aspects of the health care environment (Roper & Shapira 2000). The anthropologist Bronislaw Malinowski established ethnography in the early 20th century as detailed, long-term field-work, using participant observation, written up as a monograph about a people (Malinowski 1966/1922). Ethnography as method is basically used to describe cultures and subcultures as well as to search for the meaning of actions and events in the culture. The method is well suited to exploring clinical practical issues in health care; it is used in health anthropology and nursing research as well as being established in medical contexts (Bloor 2001, Kiefer 2007, Roper & Shapira 2000). One of the most famous and important ethnographies in the field of psychiatric care is the sociologist Erving Goffman's *Asylums* (1991/1961). The theoretical foundation of his ethnography was symbolic interactionism, as he had his roots in the Chicago School of Sociology where it was developed (Deegan 2001). In the mid-1950s, Goffman (1991/1961) was a participant observer in a psychiatric hospital and described the life in a 'total institution' from the patient's perspective. He found that the patients' self was violated in a number of ways by the institution. More recent examples of ethnographical studies in the psychiatric field are a Norwegian thesis, based on phenomenology, concerning interaction between psychotic patients and nurses (Hem 2008) and a Swedish thesis about practices related to coercion in psychiatric and legal settings (Sjöström 1997). An English project involves studies about coercion and risks inherent in life on acute psychiatric wards (Quirk *et al.* 2003, Quirk, Lelliott & Seale 2005) and Australian studies with ethnographic approach focus on nursing in acute psychiatric care after the mental health reform (Cleary 2003, Cleary & Freeman 2005) and social control in psychiatric nursing (Hamilton & Manias 2008). The Norwegian and Australian studies are in the field of nursing, while the Swedish and English studies are sociological. Even if there is no wealth of ethnographic studies of psychiatric care, it is evident that the method can be used to probe problematic issues in such a context. Goffman's (1991/1961) way of critically studying a psychiatric institution by observing people's interaction inspired the choice of ethnography as the method in this thesis. Also important was the ability to adopt a holistic perspective by capturing the range of activities, knowledge, and beliefs of the group being studied, and the physical context in which it took place (Roper & Shapira 2000).

Methods

Participant observation

The main method for collecting ethnographic data is participant observation, together with formal and informal interviews and the collection of existing

documents. To comprehend a culture that is not your own close contact over an extended period of time is needed, and by observing activities and by asking members of the group about what is happening, the researcher gradually reaches an understanding of the beliefs and practices of the group. In order to get all this information, it is essential to have access to the field of interest, which often involves a gatekeeper, a person in the setting who facilitates acceptance and contact with people (Roper & Shapira 2000, Taylor & Bogdan 1998). The observations are usually documented in the form of brief field-notes made in conjunction with the observation, but often out of sight of the persons being observed. Informal interviews consist of probing questions asked to people in the field, often in the form of casual conversation, when something of special interest has occurred during the observations that need to be further explained. These interviews can either be written down or tape-recorded. An awareness of the researcher's knowledge of the field before starting the study is needed; the more you know about or are involved in the field of study, the more difficult it is to study it, to see its tacit cultural rules (Taylor & Bogdan 1998).

My pre-understanding of the studied context thus needs to be articulated. I have worked since the mid-1970s as a psychiatric nurse specialist in similar settings as the one studied, but had no earlier connection with the hospital or the ward. In my work, I have followed the change in care in terms of the reduction in the number of beds leading to having wards locked more or less permanently. Initially, a concern often discussed by nurses was how to manage ethical problems that come from having voluntary patients on a locked ward, but at the time it was seen as a more or less normal condition. I felt that there was a lack of interest by local management and on an official level in these questions, and sometimes also on the part of colleagues; an awareness of the kind of power that psychiatric care exert on all patients when wards are locked. I thus wanted primarily to scrutinize this area in my thesis. As an observer you also influence to a greater or lesser degree what happens and this must also be taken into account. By using self-reflexivity, the researcher can maintain awareness of his/her own role and influence on the setting studied (Emerson, Fretz & Shaw 2001, Roper & Shapira 2000). In this thesis, this was done by writing a diary containing the reflections I made during observations and by discussing such reflections with my supervisors.

Interview

A formal interview is used to ask more specific questions after having acquired a general understanding of the field and the people through observations (Roper & Shapira 2000). This is a qualitative interview intended to help the researcher to gain access to a person's perspective on what is being studied and what meaning it has for him/her. This requires open questions where the interviewees are free to speak, to relate their experiences in their own words, and the interview therefore often has the form of conversation. When the researcher has already learned something about informants and setting through field-work a general interview guide can be used with prob-

ing questions about subject areas to be explored during the interview. Thus the interviewer can be free to build a conversation around the subjects of interest (Patton 2002, Taylor & Bogdan 1998).

Document

Gaining an understanding of all the written documents such as patient records or policies and procedures can give relevant information that supplements observational and interview data. These additional data can make it possible to follow changes over time or to compare intentions formulated in a policy with what is actually done on, for example, a hospital ward. Personal documents such as letters, photos and diaries are also used in ethnographic research; these can help people recall memories and old feelings in an interview or provide the researcher with important information when starting questioning. Cultural artefacts, things that are specific to the context, may also provide interesting supplementary information (Roper & Shapira 2000, Taylor & Bogdan 1998).

Setting

The study was carried out in 2003/2004 on a locked acute psychiatric ward located at a psychiatric department in a general hospital in western Sweden. Inclusion criteria for the setting were:

- Acute psychiatric care, admissions 24 hours a day
- Locked entrance door, constantly
- Admitting patients both voluntarily and involuntarily
- Having a gatekeeper in the setting, a person who facilitates access
- Leadership and staff willing to cooperate

Wards mainly for psychotic patients were excluded because these patients could be more sensitive to being exposed to an outside observer (Hem, Heggen & Ruyter 2007). Furthermore, wards characterized as psychiatric intensive care units were avoided since restrictions are used more on these wards than on general acute psychiatric wards (Salzmann-Erikson *et al.* 2008) and we wanted to capture subtle phenomena in voluntary care that could be less visible in a restrictive and controlled environment. Wards specialized in forensic care were excluded for the same reason.

The ward comprised a 12-bed acute psychiatric unit intended for patients in an acute phase of affective and eating disorders. During the 3½-month study period, the most common diagnosis was major depression. Patients were admitted both involuntarily in line with the Compulsory Psychiatric Care Act (SFS 1991:1128) and voluntarily; out of a total of 42 care periods, eight involved involuntary admission. Of these eight patients, one was admitted in accordance with The Forensic Psychiatric Care Act (SFS 1991:1129), which was an exception on this ward. The mean time in care during the study period was 36 days and the bed occupation rate was 102%, i.e. the ward was at times

overcrowded. The entrance to the ward was locked and had not been open during the last year as there was always at least one patient in involuntary care. According to the management, it was probably several years ago since the last time the ward was open, but they had no documentation on the matter to refer to.

The ward was staffed by registered nurses (n=11), enrolled nurses in mental health (n=15), one ward manager (registered nurse), one psychiatrist whose time was divided between the ward and the affiliated mental health centre. Of the registered nurses working during the study period, four had completed a specialist educational program for psychiatric nurses and four were attending the program part-time. Two of the specialist nurses as well as three of the enrolled nurses in mental health came from the affiliated mental health centre and worked only a few days per month on the ward. The registered nurses were younger (range 27-55 years, median 33) and had less experience in psychiatric care than the enrolled nurses (age ranged between 30-65 years, median 53). Additionally, there was one assistant physician, one secretary and one cleaner on the ward. The centre also made psychologist and social worker resources available. When staffing levels were low or patients needed close surveillance, temporary enrolled nurses often had to be employed and as a result, 25 persons (age ranged between 20-62 years, median 33) were specially recruited at various times. This was partially due to several regular staff members taking time off work to continue their education. Some of them attended an educational program with a focus on the involvement of patients' families and networks in care initiated by the management of the department.

The ward was built in the mid-1970s and had separate areas for patients and staff members; the doors between these areas were locked, which meant that the patients could not enter the staff area without help from a staff member. In the common areas on the ward were a corridor, dining room, dayroom, and smoking room to which patients and visitors had full access. Eight of twelve beds were in single rooms. The staff area included offices, lunch room and store rooms.

Participants

Participants (patients, staff members, and visitors) were selected for observation including informal interviews (**I-II**) with a view to obtaining as rich and varied information as possible (Patton 2002). The choice of places and situations determined which persons were observed. Since observations were mainly made in the common areas and staff areas of the ward, staff members, patients and visitors spending their time in these areas became participants in the observations. The patients were only in exceptional cases observed in their rooms, provided that I as a researcher obtained permission from the patient or was invited. Consequently, patients who spent most of the time in their room are less represented in the observations. I accompanied registered nurses and enrolled nurses in their work on fourteen occasions, and these persons were

selected with a focus on their willingness to accept being observed. If a studied event raised questions that required further investigation, the patient or the staff member was asked if they would be willing to answer some questions (informal interview).

Ten staff members (N=10) were selected by purposeful sampling for formal interviews, with the same intentions as in the case of observations, i.e. with an emphasis on variety and richness in information. The selection was made with help from the manager of the ward in order to find a mix representing a suitable variation in sex, age, profession and work experience. All staff members who were approached agreed to participate.

Ten patients (N=10) were included in the study and were selected to be interviewed with similar intentions as in the case of staff members, and represented a variation in sex, age, diagnosis, time in hospital and legal status in hospital. Additionally, patients' interest in sharing their experiences was an inclusion criterion. Some registered nurses on the ward were involved in the selection of participants and they contacted me when a patient was about to be discharged and I decided on his/her participation based on variation criteria. The patients were asked during their last week in hospital if they would agree to being interviewed. A total of fourteen patients were asked about participation. Two patients declined, one withdrew after an interview had been conducted, and one was excluded because of poor technical quality. Of these four dropouts, two were men.

Data collection

Table 1. Aims, participants, and data collection methods

| Paper | I* | II* | III | IV |
|-------------------------------|--|--|--|--|
| Aim | To describe the health care environment on a locked psychiatric ward | To describe encounters in the health care environment on a locked psychiatric ward | To elucidate the meaning of being a care provider on a locked acute psychiatric ward | To elucidate the meaning care has to patients on a locked acute psychiatric ward |
| Data collection method | Participant observations Informal interviews with patients and staff members Collection of documents | | Formal interviews with staff members | Formal interviews with patients |
| Scope and number | 250 hours during 3½ months | | N=10 | N=10 |

*Paper I and II did also comprise an acute psychiatric ward

Initially, data were collected by means of participant observations, including informal interviews and collection of existing documents. The wealth of data from observations made it necessary to present the findings in two papers of which one had the aim to describe the health care environment (I) and the other to describe encounters in the health care environment (II). Later, in order to elucidate the meaning of being a care provider, formal interviews with staff members (III) were performed, and formal interviews were conducted to elucidate the meaning of care for patients (IV).

To facilitate access to the ward one of the supervisors of this thesis acted as gatekeeper, with a position at the psychiatric department where it was to be performed. After being introduced, I had a number of meetings with staff members to ensure that everybody was in agreement with the purpose and my role. Management and several staff members showed great interest, which made it easy to initiate the investigation and establish rapport with people on the ward. Additionally, the ward manager saw the study as an aid in finding subjects for improvement.

When carrying out participant observations (I-II) I adopted an overt passive role, meaning that my purpose for being there should be known and that I did not take part in the care. To assure openness, all patients and staff members were informed about the study and my role, I was dressed in my own clothes while most staff members wore working clothes, and I also wore a badge with my name and 'doctoral student' printed on it. Visitors were given information in a pamphlet at the entrance and in the dayroom about the study in general and that observations were being conducted. When making observations, I did not actively participate in care. Before I started the observations, this was made clear to the staff members so they would not expect me to interfere, unless someone (patient or staff member) was in danger. When introducing myself to each patient, I gave the same information to them.

The period of participant observations lasted for 3½ month; in total, about 250 hours distributed over all the days of the week and at different times, with the exception of the period between midnight and 6.30 am. It started with an initial exploratory period of 3-4 weeks of participant observation, about 2-4 hours/day, with the aim of getting to know the ward and the people, and let them get to know me. The intention was to obtain a general picture of people, events and environment. This made it possible to acquire an overview of different mini-groups and their members and to establish contact with future key informants, i.e. persons who were interested in sharing their experiences and had important information. This initial phase aimed at finding areas for more intensive and systematic observation (Roper & Shapira 2000, Taylor & Bogdan 1998). Situations, actions, locations, and actors were documented in the field-notes made in conjunction with observations. I did not participate in any nursing actions but accompanied staff members in their work, spent time with patients, or sat in the dayroom and other places frequented by patients and staff, observing what happened. I also attended various staff meetings

and observed the staff in their daily work in the nurses' office. Communication with patients was mainly on the patients' initiative and observations of patients' rooms were mainly made when accompanying the nurses. Planned meetings including patients were, with a few exceptions, not observed. At the end of the day, the field-notes were transcribed in greater detail in the form of descriptions of what had happened. The informal interviews were either audio-taped or transcribed by hand during the interview.

Documents concerning the organization, the goals of the department and the ward, laws, routines, instructions, a drawing of the ward design were collected on the ward as well as information addressed to patients, next of kin, students, and new staff. Additionally, photos of the ward were taken to show the physical environment, although no people were photographed.

Formal interviews (III-IV) with patients and staff members were made and documents collected after the period of participant observations. The interviews were held in an office on the ward except for two interviews with patients held in an office at the affiliated mental health centre. Interview guides were used (Patton 2002), with questions that emerged from observations and a literature review. In the interviews with staff members (III), the opening question was "what is it like, working on a locked ward", together with probing questions about contact with patients and their next of kin, patients' participation in care, work situation/cooperation, and the physical environment. The interviews with staff members lasted between 18 and 45 minutes (median 33 minutes). In the interviews with patients (IV), the opening question was: "Tell me what you think it has been like to be cared for on a locked ward" together with probing questions about contact with staff and fellow patients, the ability to leave the ward, participation in decisions, having visits, and the physical environment. The interviews lasted between 9 and 47 minutes (median 23). All interviews were tape-recorded and transcribed verbatim.

Data analysis

When carrying out participant observations, an initial analysis of observational data is performed continually, data are categorized and organised in patterns that explain the phenomenon of interest and, through interpretation, progressing towards more abstract generalisations (Roper & Shapira 2000). In ethnographic research, content analysis often is used as a technique to analyse data. It has been found to be useful in ethnographic research and has evolved from being a purely quantitative method to one capable of analysing all kinds of verbal, pictorial, symbolic, and communication data (Krippendorff 2004, Mantzoukas & Jasper 2004). By means of qualitative content analysis a search for the meaning in a text is possible, having much in common with any effort at qualitative data reduction (Baxter 1991, Patton 2002).

All data were analysed by means of qualitative content analysis, with some degree of distinction in the way it was performed between observational data and formal interviews. In papers I and II, the focus was on descriptions based

on field-notes, informal interviews, and documents, which call for less interpretation in analysis compared to the interpretation of the formal interviews (III-IV) in which the purpose was to elucidate meaning. The analysis of field-notes and informal as well as formal interviews was performed in several steps and started with a reading of all the data. In the analysis of the field-notes, text that was relevant to the research question was marked. After that, meaning units were identified and condensed into the core content. These new units formed a condensed version of the original text and the condensed meaning units were then coded. The data from observations generated a large number of codes, which made it necessary to initially group them on the basis of a pattern originating from the early stages of the analysis. In the next step, the codes were adjusted to ensure consistency. Thereafter, an interpretive phase, which comprised the development of sub-themes and themes, began (Baxter 1991, Patton 2002). The documents collected that provided background data on the ward organisation were not analysed by means of qualitative content analysis, but were used as support in the analysis of the observations.

In the analysis of the formal interviews, the same process was followed with a few exceptions. After reading all the data, text that was relevant to the interview question was marked and condensed into the core content and the condensed text were then coded. Here, the codes were instead initially organised according to subject areas in the interview. The codes were checked and adjusted to ensure consistency after which the interpretation resulted in sub-themes and themes (Baxter 1991, Patton 2002). Since the observational data were my interpretation of what happened and was said on the ward in the form of text, greater caution in the interpretation was needed compared to the interviews. To validate the analysis, the supervisors followed the data analysis in its entirety by reading, checking and discussing, and this method was used throughout the process.

Ethics

Ethical approval for the thesis was obtained from the Research Ethics Committee of Lund University (LU-222-03). The ethical difficulties in this thesis concern patients' and staff members' exposure due to having only one setting for data collection, and the use of participant observations and interviews as methods for collecting data. Since the ethnographic method used in this thesis requires a long period of collection of various types of data from the same context, a second setting for data collection that would have minimized the risk of identifying participants was not an option. Instead, awareness of how findings were presented in the papers was necessary, such as caution when using quotations and making descriptions, and not revealing sex of persons where there were few persons employed in the same profession. Nevertheless, there is always a risk that persons within the group of staff members and patients can recognise each other. This may lead to breaking down protective silences held in a group (Murphy & Dingwall 2001) if something is revealed that is not common knowledge in the group and which can be relevant to the staff members in this thesis.

When participant observations were performed, the rights of persons being observed, such as privacy, respect, or self-determination, were at stake. The management had consented to participation in the study after talking with staff members, but that did not imply that every staff member or temporary staff member agreed to be observed all the time. With this in mind, they were informed that they could ask me to leave the room whenever they wished and, additionally, I did not attend any meeting without permission. In spite of this, staff members may have felt uneasy about my presence, but no one mentioned anything.

The patients were not asked about consent to being observed since if one patient refused, it would have been impossible to carry out the study. An argument for overriding the ethical standpoint of consent is that psychiatric inpatient settings are one of the most secluded and secret domains in society, and are thus in many respects protected from insights from outside persons. Additionally, in these settings power over an extremely vulnerable group of people is exercised, even though legally. This argument was also put forward by Sjöström (1997) when studying discursive practices related to coercion in psychiatric and legal settings when making participant observations. Examples from the observations in this thesis shows that some patients saw my presence as a kind of protection; one patient called me their policewoman, protecting patients from harm by the staff, although emphasizing that the experience of harm was from another ward. Another patient invited me to her court hearing on the decision about whether involuntary care should continue or not. My interpretation was that the patient felt she might be treated more fairly if an observer from the outside was present. In several cases both patients and visiting next of kin took the opportunity to tell me what they thought about the ward and the care. It was obvious to me that they took this chance to speak out when there was someone from the outside interested and listening, and both positive and negative views were expressed in this way.

This shows that there is much to gain when making observations in such a context, but that the disadvantages for individuals must not be overlooked. Hem *et al.* (2007) argue that the principle of obtaining informed consent is extremely problematic when making observations in acute psychiatric care, especially in the case of patients with a psychosis; it requires both ethical awareness, knowledge of challenges in the qualitative research methodology and specialist therapeutic competence from the researcher (Hem *et al.* 2007). In this thesis, one patient who was suspicious and very anxious turned to me asking what I was doing on the ward. Although we had met before and I had informed her about the study during an earlier admission, my presence worried her. I repeated the information and assured her that no one who had been observed could be identified afterwards, which made her a little calmer. The patients in our study had options to avoid being observed, primarily by staying in their room, since the majority of observations were made in the common areas of the ward. In these areas, patients had their meals, watched television and socialized. The observations may have influenced the presence and contact with others in the case of patients who did not want to be observed.

FINDINGS

Control and responsibility

The ward was part of the psychiatric department at a general hospital (I) and the department was situated in a separate building built in the mid-1970s. The ward was well maintained and decorated, and patients were at times involved in both planning and decisions regarding decorations. It was designed (II) in a way that made it impossible for staff to see the entrance and people coming and going unless they were next to the door. The findings from observations showed that the common areas on the ward offered space and opportunities for encounters between patients, staff members and visitors. There was an atmosphere of relaxation and pleasure, where people on the ward spent time together or just sat by themselves. But being together was at times demanding, as when patients unintentionally acquired an insight into other patients' suffering. For the patients (IV), the ward was a place of refuge when they were at home and contact with family and friends, became too strenuous. Staying on the ward made the patients feel secure and happy, it was perceived as a peaceful place that one could long for, and the physical environment contributed to a sense of homeliness. Nevertheless, patients felt that visiting younger family members might be ashamed of coming to a place like this. Although they were by and large content with the ward, the patients missed a place where they could be by themselves, somewhere to meet without interaction with and the unavoidable surveillance of staff members.

For the staff members, the health care environment included control, sense of responsibility and a shared responsibility with patients and next of kin. In the findings from paper I, the health care environment is characterized by control. To master the situation, to be in control as a care provider, the staff members used a system of legally binding rules and ward routines. This concerned control over allowing patients to leave the ward for a walk or leave, safety routines when searching for objects patients could harm themselves with, and the use of control as a part of the treatment. Before letting a patient out, nurses had to check what had been agreed on earlier with the patient and decided by the psychiatrist, and they had also to ensure that the patient was in fit condition to leave the ward. This involved both voluntarily and involuntarily admitted patients. For the staff members (III), having control was needed to feel secure themselves but was also connected to what their duties were and to their sense of responsibility for the patients' safety and wellbeing. The responsibility of making a judgment before letting patients out was sometimes a heavy burden for the nurses, who were afraid of what could happen, having had negative experiences in the past. This indicated a sense of moral distress stemming from management expectations of being in control and their own sense of responsibility for patients' wellbeing even outside the ward, but not being able to have that control. The control staff members performed (I) as part of the treatment included the use of treatment contracts and close surveillance in order to support the patient and prevent destructive behaviour. In the

interviews with staff members (III), it was found that carrying out close surveillance contributed to their sense of demands being made on them, it added extra pressure in an already demanding work environment as it made them feel tied down and not always able to complete other tasks or take breaks. Additionally, staff members' involvement in exercising control (I), such as opening the entrance door and carrying out checks, constantly interrupted them in the course of their duties. Although they tried to be in control, staff members sometimes failed to fully control what the patients did; in spite of close surveillance, patients managed to injure themselves. This system with many forms of control created an illusion that full control was possible, and failures that were difficult to avoid were yet another burden on staff members.

By sharing responsibility for care with patients and their next of kin, staff members relinquished some of their control (I). In this way, patients and their next of kin were involved in planning and decision-making about the care, often concerning temporary leave and discharge. In the interviews with staff members (III), it emerged that this was part of their striving to achieve good quality in care. For the patients (IV), being involved in planning and decision-making in care contributed to alleviation of suffering as it strengthened their self-determination.

For patients, the health care environment meant being controlled and dependent. The observations in paper I showed that to the patients, being the subject of control meant being the underdog. This weak position meant that someone else had control over the situation and they were dependent on the staff. Patients were admitted either voluntarily or involuntarily to the ward, and involuntary care could be changed to voluntary after some time and vice versa. Being admitted involuntarily could be a terrible experience, but at the same time it gave them a sense of security and was necessary. All the patients were dependent on the judgement of staff members and their time for their freedom of movement, i.e. to be able to leave the ward. This sometimes evoked feelings of being shut in. The interviews with patients (IV) showed that the care meant that they were exposed to stress, which included being dependent and being trapped. This dependence was shown in patients' feelings of lack of choice and influence on care; they missed alternatives to care on a locked ward and more treatment options, and found it difficult to influence care when they were not asked or did not have sufficient knowledge about treatments. For patients, care also meant being trapped in a situation where they had to accept being controlled and having closeness to fellow patients forced on them. Staff members' control as a result of having the ward entrance locked made patients feel un-free and watched, although some of them felt that surveillance by the staff was something one had to put up with. For patients in a particularly vulnerable situation, such as balancing between voluntary and involuntary care, being on a locked ward aroused feelings of insecurity. Another example was a patient suffering from a temporary loss of memory as a side-effect of electroconvulsive treatment who felt terrified after each treatment, not remembering why she was locked in. The combination

of treatment side-effects and being locked in made the patient suffer a lot, in spite of repeated information and support from nurses.

Although controlled and dependent, the patients were active and had demands and expectations on the care they received. This was found both in observations and interviews. They expected staff members to be easy to get in touch with and to treat them respectfully (II, IV). The patients emphasized (IV) that they had their own responsibility in care, illustrated by both a positive and understanding attitude and actions based on their own initiatives. Additionally, the patients made it clear that what happened outside the ward when they were out on a walk or on a leave was their own responsibility. If patients' expectations (I, IV) regarding having a say and be listened to in care were not met, they tried to make themselves heard by means of both active and passive strategies. To make staff members listen, some patients acted together as a group and made complaints about the care.

Relationships on the ward

In the findings, it was also shown how relationships between people on the ward were a part of the health care environment and the meaning of these relationships. In the encounters between patients and staff members (II), both caring and uncaring relationships were seen, and while a caring relationship was built on showing the patient respect, and on closeness between staff and patients, the uncaring relationship was in many respects its opposite. It was characterized by lack of respect, distance, and mistrust. The findings from interviews with patients (IV) show that a caring relationship involved being respected and acknowledged by staff members, which strengthened the patients' integrity, and thus contributing to alleviated suffering. Getting support in the form of staff members' sensitivity to patients' needs (II, IV) was yet another important part of the care that alleviated suffering. An uncaring relationship was also found (II), which was characterized by lack of respect, distance and mistrust. Staff members failed to show respect by exposing patients in front of others and by not taking patients seriously. Some patients felt that staff members were distant and they felt rejected. Mutual mistrust between staff members, patients and next of kin was seen; that the patients were not honest with the staff, that the staff did not provide the best possible care, and that next of kin were critical of care.

Caring relationships with next of kin and friends (II) were also of value to the patients. This was illustrated in the social intercourse that took place on the ward, when arranging something recreational for the patient or including the patient in ordinary family matters. The support coming from next of kin (IV), through their involvement before coming to the ward and in the care while admitted, shows other aspects of a caring relationship that alleviated patients' suffering. They offered support in a way that could not be given by staff by coming for visits, being company on walks and during home leave, and giving comfort in situations when a patient was frightened and in despair.

Nevertheless, the involvement of next of kin could also be a source of worry to the patients, that it could put pressure on next of kin and influence their relations negatively. This made some patients forgo visits in order to protect next of kin from stress, and to avoid further pressure on themselves.

In the findings a picture emerges of fellow patients being unacknowledged but still significant persons in a patient's care (II, IV). The relationships between patients were unrecognized compared to those with staff members, and were not always visible and accessible to the staff. Patients were unintentionally involved in each other due to care activities being performed in the common areas of the ward, and crying and loud conversations being heard from patients' rooms in the dayroom. Fellow patients were sources of stress, as they were sometimes perceived as being trying and threatening, and their presence was experienced as intrusive and too close. On the other hand, fellow patients alleviated suffering by being there, giving support when no one else did. They stepped in when staff was not available, had not noticed the need, or had no time. Their presence also meant that there was someone to spend time with and share experiences with. The staff members' limited interest in patients' relationships with each other, when they were not regarded as a resource in care, indicated a paternalistic way of knowing what the best was for the patient.

To the staff members, the meaning of the health care environment was also about working together, handling demands, and getting stimulation. The staff members felt that (III), in striving for good quality in care, they had a mutual need for each other, seeing each others' strengths and weaknesses. An informal care provider outside the team, but who still cooperated with the nurses, was the cleaner who kept an eye on the patients' wellbeing without interfering in care. Stability in team and ward management was needed to make staff members feel secure in their work. Accordingly, changes in care implemented in order to improve the quality care, including new ways of communicating and cooperating, revealed tensions and power struggles between staff members. It was also a demanding job at times (I, III) due to a heavy and intense workload, where pressure and threats from patients was one component. Nevertheless, the work was experienced as meaningful and stimulating, with increased self-understanding and personal development, resulting from the relationships with patients.

DISCUSSION

General discussion of the findings

The main characteristics of the health care environment on the locked acute psychiatric ward in this thesis were the web of relationships between people on the ward and the use of control. It was shown how all kinds of relationships can contribute to the patients' care both positively and negatively, but also the way control is inherent in relationships between patients and staff members. In the following section, the web of relationships and the meaning of responsibility in the care on the locked ward are discussed, as well as the control in care and manifestations of power. But first, the meaning of a locked psychiatric ward as it was shown in this thesis is briefly discussed – from a historic perspective and from the perspectives of society and patients.

The meaning of a locked psychiatric ward

From the days of the big asylums of the nineteenth century up until today, with very reduced and concentrated care settings, the intention of care is in one way or another expressed in the placement and design of buildings. The ward studied was situated in a general hospital, which meant that the asylum and mental hospital model had been abandoned, and the fact that the focus on offering patients a ward environment that was pleasant and well kept shows an awareness of environment as a treatment modality. Owing to the design of the ward staff members could not monitor the entrance unless they were next to the door, so the ward was either designed to be locked or intended for patients that do not need to be monitored. Caring for involuntary patients on an open ward calls for alternative ways of monitoring of the patient, such as staff making frequent routine observations or technical solutions for surveillance (Bowers, Crowhurst *et al.* 2002, Hamilton & Manias 2008), which is not common in Swedish care settings (Haglund *et al.* 2007, Kjellin *et al.* 2004).

The present practice of locking wards for the care of people with mental illness in order to protect them or society is thus basically the same principle as in the old asylums and later mental hospitals (Foucault 1991/1975, Goffman 1991/1961). With the radical reduction in hospital beds, the earlier ambitions to open up psychiatric inpatient care seem to have been abandoned and, in the Swedish context, without being questioned. In Swedish inpatient psychiatric care, about three quarters of all wards for adults were locked while about half of the patients were voluntarily admitted, forensic care excluded (Haglund *et al.* 2007, Socialstyrelsen 2008). Although these studies do not provide information about the distribution of voluntary patients, they do tell us that quite a large number of voluntarily admitted patients are on locked wards. This indicates a culture in society and in health care organisations that finds it acceptable to restrict a person's freedom of movement on the basis of a general opinion about people suffering from a mental illness (that most of them have to be on locked wards/must be locked in) and not on basis of the needs of the

individual patient. In other words, if you are in need of psychiatric inpatient care, in most cases you have to accept being locked in. This is a manifestation of the power of society over patients with a mental illness, who need inpatient care, which is not paid attention to by the general public or even recognized as a problem. It is not hard to imagine what this means in terms of the stigmatisation of people suffering from mental ill-health, which still is a major problem (Angermeyer & Dietrich 2006).

Nevertheless, both observations and interviews with patients showed that for them, the ward was a place to come to when they were in need of care. It was a place of refuge that gave them a sense of security, peace, homeliness, and pleasure, which was a great asset to these patients. The role of inpatient psychiatric care is mostly seen as being a last resource when open forms of care have failed and being admitted is often seen as a failure, but as is shown here, for patients it could also represent a place of refuge when illness and suffering are hard to manage at home. Inpatient care has left patients with negative experiences of feeling unsafe, helpless, and disrespected by staff (Robins *et al.* 2005, Wood & Pistrang 2004), and is associated with shame and stigma (Borge & Fagermoen 2008, Jones & Crossley 2008). This surely contributes to reluctance to seek help, while a ward representing a place of refuge may make it easier for patients to accept inpatient care in critical situations. In such cases, it is important to support the qualities of the health care environment that makes a ward a place of refuge in critical situations for patients suffering from a severe mental illness.

Patients' own experience of stigma was not made visible in observations or interviews, but was shown sometimes a problem for patients in contact with next of kin, such as when younger family members were ashamed of visiting the ward. Here, the locked entrance may be a symbol and physical sign that confirms the public view of psychiatric illness and care as being associated with stigma, thus making relationships with next of kin more difficult (Angermeyer *et al.* 2006, Hinshaw 2005). It is then important to reflect on what signals are sent to a visitor to a locked psychiatric ward, where the first impression may be associated more with prison than care. Since people react to the meaning things have for them (Blumer 1969), the meaning that a locked entrance has, especially to visiting next of kin, must be taken into consideration. Some next of kin very likely regard a locked ward as constituting an assurance that their family member is safe and protected, but it is the negative consequences that need to be subjected to greater scrutiny.

The web of relationships and the meaning of responsibility

The health care environment on the ward studied turned out to include a complex web of relationships between people on the ward, which was a major asset in patients' care, although problematic at times. The actors involved in relationships were the patients, staff members, co-workers, patients' next of kin and friends and fellow-patients. Almost all the actors had relationships with more than one other actor, they had different roles in different relation-

ships, and the relationships were of varying importance for the patients' care. In the centre of this web of relationships was the patient, who had relationships on the ward with staff members, next of kin and friends, and fellow patients. The patient thus had several roles; he/she was a patient, a family member, a friend, and a fellow patient. Staff members' relationships were with patients, patients' next of kin, and their co-workers on the ward. Next of kin had relationships with the patient and staff members, and visiting friends had a relationship with the patient. People act on the meaning that they attach to situations, other people, things and themselves and they adjust their activities to one another, thus forming a group life (Blumer 1969). The variety and complexity of actors and roles thus formed the character of group life, or the web of relationships, on the ward.

The findings show that these relationships contributed to alleviating the patient's suffering, but also to stress. The relationships that patients had with staff members represented a professional relationship, the quality of which was vital to the patient when he/she was in hospital. A caring relationship characterized by respect, closeness, and recognition strengthened the patients' integrity and was essential for alleviation of suffering. This confirms earlier research findings, that a caring relationship results in the improved mental wellbeing of the patients (Finfgeld-Connett 2007). And consequently, in the present study, an uncaring relationship characterized by lack of respect, distance and mistrust contributed to patients' feelings of stress. When discussing the quality of relationships, patients' dignity must be taken into account, since maintaining one's dignity was shown to be important for patients in a caring relationship (Berg & Danielson 2007). The significance of being treated with dignity is shown in several studies, it is a prerequisite of quality in psychiatric inpatient care (Schröder & Ahlström 2004, Schröder *et al.* 2006) and promotion of patients' health processes (Svedberg *et al.* 2003). Patients expect their dignity to be maintained while in hospital, as shown in a study of somatic care (Matiti & Trorey 2008). The experience of the uncaring relationship found in this thesis most probably violated the patients' dignity, while experience of a caring relationship strengthened it (Svedberg *et al.* 2003, Talseth *et al.* 2001). In this present study, the cleaner of the ward was on the periphery of the staff group; she could not interfere in care but still cared about the patients and protected them from harm. She saw the patients' vulnerability and protected them in a way that did not impact on their dignity without patients always being aware of it. This also ought to be considered as caring, despite there being no personal relationship, and contributed to strengthening the caring qualities of the health care environment.

Patients' relationships with next of kin and friends when they were on the ward could continue, and for the patients, their interaction meant security and support. Nevertheless, upholding these relationships was at times problematic due to the pressure on next of kin or the patients needing a break. Both patients themselves and staff members nurtured these relationships because they played an important role in the patients' care. Next of kin provided support both in cooperation with the staff and in private contacts with the patient,

and research shows that the social support from next of kin and friends is important for a patients' recovery from a depression (Skärsäter *et al.* 2005). Next of kin usually know a lot about the patient, something that is fundamental in order to be able to care for someone (Mayeroff 1990/1971). This is one reason why their participation in care is so essential, provided the patient agrees to their involvement. The involvement of next of kin in inpatient psychiatric care was previously often obstructed by staff as the family was identified as being responsible for the mental illness, and their involvement has slowly increased in recent decades (Jubb & Shanley 2002). Although the view of the family has changed, involvement may still be diminished by the contradictory demands that staff members sometimes experience when facing the needs of the patient and the needs of next of kin (Sjöblom, Pejler & Asplund 2005).

A change towards more involvement of next of kin cannot depend solely on interest and engagement, it needs to be supported by special education and intervention programmes, as shown by Korhonen, Vehviläinen-Julkunen and Pietilä (2008). Such an education programme was initiated by the management on the ward in this present study and some of the staff members attended the programme during the period of data collection. This may have contributed to the positive experiences of next of kin involvement shown here; next of kin actively supported the patient, and patients and staff members valued their involvement. However, a younger family member's shame and reluctance to visit the parent and the mistrust between staff members and next of kin that was also found could be signs of shortcomings in the support of next of kin, which is part of staff members' work and something that is still lacking to a large degree in psychiatric care (Sjöblom *et al.* 2005, Wilkinson & McAndrew 2008).

In this study, the relationships between patients became visible. These relationships seemed to fill a gap between the professional staff relationship and the more personal next-of-kin relationship. Such a relationship contained qualities that only the fellow-patients could provide; the experience of being in the same situation, including illness and care; being company when no one else was around; and sharing the experience when feeling discontented and complaining about care.

In a Norwegian study by Skorpen *et al.* (2008), it was found that when patients socialized with each other and no staff members were present, they expressed themselves as ordinary people do, not as patients. The patients retained their civil identity together with a patient identity, which maintained their dignity while in hospital (Skorpen *et al.* 2008), and this was made possible through their interaction with each other. Furthermore, fellow patients can be the ones caring and giving support in hospital, when the relationship with staff members fails (Shattell, Andes & Thomas 2008). The relationships between patients in the present study were also problematic at times, and contributed to a stressful health care environment, something that is described more extensively in research than are the advantages of such relationships (Quirk *et*

al. 2005, Robins *et al.* 2005, Wood & Pistrang 2004). What this thesis adds to earlier research is that the relationship with fellow-patients can also be important for the patients' recovery, providing social support in situations where next of kin and friends are not available, and has the potential to maintain patients' dignity while in hospital.

The relationships that staff members had with each other were valued as being important for the quality of care. Accordingly, tensions in these relationships impacted on the patients' care. The interaction between staff members cannot be seen as isolated and solely their concern (Blumer 1969), rather, it is a part of the relationships around the patients, thereby influencing patients' experience of the health care environment. This implies that conflicts in the staff group need to be solved for the sake of both staff and patients. The web of relationships shown here was not complete for all patients, for some patients it was certainly insufficient. As a staff member responsible for a patient's care, it is thus important to be aware of the gaps in the patient's web of relationships, what qualities of care are missing, to be able to fill these gaps.

Earlier research on relationships in psychiatric inpatient care has shown the great importance of its quality (Gilburt *et al.* 2008, Olofsson & Norberg 2001), while in this thesis the variety of relationships is shown, how they are interconnected to each other and are significant for patients' care. Social interaction is often taken for granted, but here the complexity of interaction in the health care environment of a locked psychiatric ward is shown. Furthermore, because of the constant process of interpretation of the world that each person is engaged in (Blumer 1969), the meanings of relationships are continually re-interpreted. This requires staff members to be constantly engaged in and aware of these processes.

It was shown that staff members put a lot of effort and time into practising control and that they also had a sense of responsibility for their work and the patients' wellbeing. The following section contains a discussion of how control and responsibility were related, with a focus on the staff members. Having control was one of their obligations, laid down in laws and routines, and included involvement of the patients in decisions about care, which is also regulated by law (SFS 1982:763). The staff members had an ambition to involve patients and next of kin in a way that implied shared responsibility in care. With focus on a locked ward, shared responsibility was mostly shown as regards patients' freedom to leave the ward. In some situations, staff members felt that their responsibility towards patients was a burden, while patients in the same situation asserted that it was up to them to be responsible for their actions. Here, responsibility appears to have two meanings; as a means to make patients more independent or as a moral obligation. Sharing responsibility was a means used by staff to involve patients and next of kin in care in order to make the patient independent of staff and in time able to leave the ward. Relinquishing control and sharing responsibility involves trust, that staff members trusted them. Acute psychiatric care is shown to comprise a

structural distrust based on the control of patients by having the ward locked, examining patients' belongings, the use of restraint, and visible alarm devices worn by staff (Hem *et al.* 2008). The trust shown by sharing responsibility with patients and next of kin on our ward was thus very probably undermined by the staff's use of control.

The other meaning of responsibility for staff members was that of a personal responsibility towards another human being, to protect and care for him (Levinas 1985). This was a moral responsibility, experienced by staff members as burdensome in situations when they had to decide whether to let a patient out or not. For them, this was both about having the patients' life in their hands and about trusting the patient, which conflicted with each other. Both the feeling of moral responsibility in itself and its conflict with trust may have contributed to feelings of burdensome moral responsibility. External factors out of control for staff members that prevent them to do what they think is best for the patient can lead to moral distress or stress (Austin *et al.* 2003, Lüt-zén *et al.* 2003). The conflict in the present study is between the wish to do good and the difficulty in judging what was best for the patient. The expectation on staff members to be able to do this judgement in any situation when patients want to leave the ward may lead to moral distress or stress. Added to this, there may also be the fear of failure and being blamed if something happens to the patient outside the ward (Clark *et al.* 1999). But the patients also felt responsible for what they did when they left the ward, they did not place the responsibility for their life on staff members in the same way as they did on themselves. This illustrates some of the contradictory expectations on staff members, both to have control and to relinquish control and trust patients. The question is, then, whether the burden on staff members can be lifted by another way of dealing with responsibility for patients' freedom of movement, which could also potentially improve trust and strengthen patients' dignity.

Control in care and manifestations of power

This thesis show how control as a part of the health care environment was experienced by patients: being restricted in their freedom to move, and being controlled and monitored by staff members gave rise to feelings of being un-free, shut in and watched, and made patients feel insecure. The patients' experience of being controlled was closely connected to their dependence on staff members, which also concerned their freedom of movement as well as their lack of choice and influence on care. The dependence on staff members' time, judgement, and ways of involving patients in decisions in such situations reduced their options when it came to making their own decisions and acting accordingly. Even if involuntary care and control were accepted by some patients as being necessary or something one had to accept, one should not underestimate the patients' sensitivity to and awareness of control in care. Patients in an Australian study of a close-observation area in an acute psychiatric ward, who described themselves as very sick, emphasized that they could differentiate between therapeutic and controlling care (O'Brien & Cole 2004). For some of the most vulnerable patients in this thesis, a large degree

of insecurity was inherent in the way control was exerted, such as when not knowing when voluntary care would be changed to involuntary care or not understanding the circumstances of being locked in due to the side effects of treatment. For these patients, the locked door was perceived as a threat and an open ward would very likely have increased their feeling of security. Earlier research has shown that a locked ward entrance can be related to feelings of security and safety in patients as well as a provocation (Haglund & von Essen 2005, Hummelvoll & Severinsson 2001b). In this thesis, one of the findings is the feeling of insecurity due to being locked in among patients in a vulnerable situation.

When discussing control in care, the issue of power must also be taken into account. It is suggested that the use of two core elements of Foucault's work – disciplinary power and knowledge/power relationships - is useful when critically analysing and understanding power in nursing practice (Bradbury-Jones *et al.* 2008). The influence of control and surveillance on patients can be discussed from the perspective of a disciplining power, meaning that the awareness of being controlled and monitored makes people correct themselves and behave as expected (Foucault 1991/1975). Patients in the present study felt shut in and watched by the staff members. This may be the reason for patients identifying a need for their own space, free from staff members and their observations. Similar findings were shown in a study by Skorpen *et al.* (2008) where the smoking room was an inner sanctuary free from staff, which enabled the patients to be ordinary persons, not just patients. Disciplinary power was deliberately used on a ward in an Australian study; the overt practice of surveillance through nurses making regular observation rounds encouraged patients to discipline themselves. They used the power relation to keep involuntary patients on an unlocked ward, and the intrusion of surveillance was softened by nurses' use of chat and civility (Hamilton & Manias 2008). This may be a feasible way of managing an open ward environment with involuntary patients, provided that the mechanisms of power are made explicit to staff members, that they are fully aware of their power position, and that their skills in handling it are satisfactory. Disciplinary power is a force constantly in action in care when patients feel observed and may not be possible to avoid since observation of patients is a necessary method in care. Instead, the mechanisms of and reasons for observation must be made explicit and dealt with, particularly in psychiatric care.

Resistance is, as mentioned above, another force that makes it possible to identify power (Foucault 1998/1976). The patients in this study were not merely passive recipients of care but were active and took their own initiatives, which among other things was shown in resistance both on a personal level and by a group of patients who together made complaints about the care they received. The patients employed both active and passive strategies to make themselves heard, which included resistance when they did not accept decisions or were not listened to. The pressure and threats by patients to staff members can also be interpreted as signs of resistance. This shows that there were power differences between patients and staff members that the patients did not accept.

The ambiguity of voluntariness and the invocation of a coercion context in psychiatric inpatient care that is reflected in use of pressure and persuasion (Sørgaard 2007) and having voluntary patients on locked wards (Sjöström 2006) may be sources of resistance that are overlooked by staff members as being a part of the care culture. Increased involvement of patients in decisions about care and ensuring that patients are aware of their rights are necessary measures for handling such power differences.

A review of research on patients' involvement in mental health care concluded that greater treatment compliance was one of several improvements reported (Stringer *et al.* 2008). This is of special interest since resistance from patients to power differences in care may be hard to distinguish from, or be misinterpreted as, lack of compliance with treatment. Lack of compliance is commonly correlated to patients' personal attributes (Sjöström 2006), while resistance to power differences may be an alternative explanation of patients' unwillingness to cooperate. Research that shows patients' resistance in psychiatric care is rare, but gives examples of both physical resistance and addressing complaints to legal authorities (Johansson & Lundman 2002, Steinholtz Ekecrantz 1995). This thesis adds to earlier research an understanding of resistance to power differences as an alternative explanation of lack of compliance with treatment in psychiatric inpatient care.

Foucault argued that power is relational and that power relationships are not separated from other types of relationships but are inherent in them (Foucault 1998/1976). Accordingly the relationships found in the present study include power, both the caring and uncaring relationships, and in relationships between co-workers and patients. Taken together, this shows the complexity of the relationships in the health care environment on a locked psychiatric ward; it is not just a matter of caring or uncaring relationships, but also one of relationships, that have different meanings to those involved, all with ingredients of power in them.

It is the staff members' job to orientate themselves and other actors in this complex web of relationships, and to make the relationships work in a positive way for all involved; they are responsible for the patients' wellbeing and for supporting next of kin, and are expected to contribute to a good climate between co-workers. Research on the work environment in psychiatric inpatient care often focuses on specific problem areas such as the negative impact of violence by patients (Lawoko *et al.* 2004, Nolan *et al.* 2001) and different organisational factors (Fischer *et al.* 2007, Taylor & Barling 2004). Some researchers have applied a more open approach when examining psychiatric inpatient care, showing its unpredictable nature and competing demands for nurses (Cleary 2004, Hummelvoll & Severinsson 2001a). Another focus for research on the work environment is ethical challenges in psychiatric inpatient care, which usually are connected to the use of coercion. Use of coercion contributes to moral distress (Austin *et al.* 2008) and ethical conflicts in physicians and nurses (Olofsson *et al.* 1998, Olofsson *et al.* 1999).

The experience of work as being heavy and intense described in the present study has ingredients of pressure from patients, organisational factors and ethical challenges, but may just as well mirror the difficulty of handling the relationships between people on the ward. To this can be added the contradictory demands experienced by the staff members; to be in control and relinquish control at the same time. Nevertheless, the experiences of meaningfulness and stimulation, increased self-understanding and personal development show that this work environment also had a personal meaning of importance for the staff members. The source of these positive qualities was the caring relationships with patients, which then resulted in the wellbeing of not only patients but also staff members (Fingeld-Connett 2007). In her ethnographic study of interaction between psychotic patients and psychiatric nurses, Hem (2008) argues for a more realistic view of nurses' work. She suggests 'a virtue of the middle', somewhere in between the extremes of excellence and resignation, as a possible way of handling the challenges in the care of these patients. This thesis adds to earlier research an understanding of the complexity that staff members have to face in their work, resulting from the interrelated relationships with a number of inherent fields of power, which they have to handle in way that is fruitful for all involved.

Methodological considerations

In this section, alternative approaches and quality issues of the thesis are discussed. Choosing ethnography as method for describing the health care environment on a locked ward and finding its meaning for people involved made it possible to be very open, not deciding in advance what the major issues were, and to have a holistic perspective. An alternative approaches, in order to study this phenomenon, could have been a more delimited focus on, for example, ethical difficulties or power. Using the ethnographic method, manifestations of both can be captured and even if the same depth will not be reached, the context in which they occur can be elucidated more fully. Applying a critical theory approach may also have been an alternative. Critical theory seeks to critique and change society (Patton 2002), and since psychiatric care in many ways is linked to political currents in society through legislation and is subject to public opinion, it might have provided insights other than those gained in this study.

The researcher's pre-understanding and the participants' view of him/her can be a bias when collecting ethnographic data (Roper & Shapira 2000). Since I was familiar with the kind of care and setting I studied, I may have asked fewer questions during observations or interviews, as it is easy to think you know the answers in a familiar context. To handle this, I regularly discussed it with my supervisors throughout the data collection process. One advantage of being familiar with psychiatric inpatient care was my long experience of meeting patients suffering from severe mental illness, which may have facilitated my contact with them. It also contributed to my own sense of security when I was on the ward, since handling threats and violence from patients

was something I had professional knowledge and experience of. This could be a source of insecurity for a person unfamiliar with such a context and a limiting factor when making observations. The participants' view of me may also have been a bias; in my role as researcher, some information from the staff members may very well have been withheld, although I felt that they were both open and curious. Similarly, patients might have withheld information if my role on the ward had been unclear to them, not knowing if information given to me would be passed on to the staff. The procedure of informing patients, which is described in the data collection section, was intended to avoid such a situation, but did not preclude misunderstandings. Another phenomenon occurred that I initially was unsure about how to handle was that some staff members treated me as an expert and were sensitive to my questions, not defending themselves but eager to improve in their work. That made me think twice when asking questions as I was afraid of having too much influence on what happened on the ward.

According to Patton (2002), the credibility of qualitative research concerns the use of rigorous methods, the credibility of the researcher and his/her philosophical belief in the value of qualitative inquiry. The earlier detailed description in the method, data collection, and data analysis sections as well as the discussion of the use of the method and my pre-understandings have hopefully demonstrated the credibility of the thesis. Triangulation, i.e. the use of multiple methods and data sources, is also considered to be a criterion of credibility (Patton 2002). In this study, triangulation took the form of observations and interviews for data collection and patients, staff members and the researcher as sources of information. Some departures from the general description of the ethnographic method used in this study will be discussed. First, the time spent on participant observations can be criticized for being too short. There is no recommended duration for participant observations in ethnographic studies; it can range from a few months to several years. Instead, it is when no new insights are made that it is time to leave the field (Taylor & Bogdan 1998). In this study, 250 hours were spent on observation over a period of three and half months, which can be considered a minimum. On the other hand, my earlier experience of and knowledge about similar settings and the fact that the staff members facilitated my introduction on the ward reduced the time needed to get to know the place and be accepted, both important steps in an ethnographic study (Taylor & Bogdan 1998). Additionally, the limiting of observations to exclude most situations in patients' rooms and personal meetings between patients and staff members that did not occur in the common areas must be considered. Likewise, personal conversations between staff members were not observed. The findings from observations thus only reflect what was going on where they were performed, while the interviews provide supplementary information.

The second departure from the method was how the findings were analysed and presented. Usually, ethnographic data are analysed as a whole and written in the form of a book, while in this study data from observations and

formal interviews were analysed and presented separately in four papers (I-IV). The findings presented in the papers were analysed as a whole in the framework of the thesis and presented under the heading Findings. In this way, the findings can be disseminated to a larger audience by publishing as papers while taking advantage of the strengths of the method. The difficulties involved in performing separate analyses emerged in the analysis of the formal interviews; the findings were somewhat fragmented since the probing questions were based on the observations.

The length of the formal interviews with patients can be criticized for being fairly short (median 23 minutes) although only one was very short (9 minutes), which was not sufficient reason for exclusion since the text from all the interviews was analysed as whole. The fact that some patients were interviewed just before discharge may have influenced their ability to concentrate on the interview. Short care episodes mean that they are not free from illness/symptoms on discharge and that treatment side effects may influence their cognitive ability, which may be relevant even after discharge. Furthermore, the discharge process can cause stress in the patients if they do not feel prepared to leave. The advantage of interviewing close to discharge was that it facilitated recruitment of participants and practical arrangements, since the patient did not need to have an extra appointment after discharge. Also of importance was the fact that their impressions from the care were fresh, while an interview some months after discharge might have resulted in more reflected experiences. Both are just as essential but in this study, the former was aimed at. Another concern as regards these interviews is that only two of the ten participants were men, which reduces the anticipated variation but reflects the fact that female patients were in the majority on the ward at that time.

In order to validate the analysis of both observational data and the formal interviews, the supervisors read the content, checked my coding, and all three discussed the analysis until agreement was reached. Generalisation of findings is not applicable in qualitative research; instead, the concept transferability can be used. Transferability is a function of similarity between contexts (Patton 2002); the more similarity a context has with the context in a study the more transferable are the findings. To make such a comparison possible, a detailed description of setting and participants was made.

CONCLUSIONS

This thesis shows that the health care environment of the locked psychiatric ward studied was characterized by the relationships between people on the ward and by control in care. The complexity of the web of relationships between patients and their next of kin and staff members, as well as between patients, became apparent. In the case of the patients, this variety of relationships contributed to alleviating suffering through caring relationships with staff members and next of kin and support from fellow patients, each kind of relationship having its own value and complementing the others. What this thesis adds to earlier research is that the relationship with fellow-patients can be just as important for the patients' recovery as relationships with staff and next of kin. Relationships between fellow-patients provided social support in situations where staff and next of kin were not available and having a potential to maintain patients' dignity while in hospital. The relationships were nevertheless problematic at times, creating stress in the patients through uncaring relationships with staff members, difficulties in upholding relationships with next of kin and experiencing fellow-patients as intrusive and threatening.

The control in care was found to threaten patients' dignity and make them react by resisting. Control concerned involuntary care, patients' freedom of movement and checks of their belongings, and could also be a part of treatment. Staff members were obliged to exert control but also tried to share responsibility in care with patients and their next of kin. Sharing responsibility relies on trust which was counteracted by the use of control. Controlling other people is an act of power and the patients were subjected to disciplinary power when they were observed by the staff as a part of control. Both the undermining of trust and being subjected to disciplinary power threaten patients' dignity and consequently their health. Patients' resistance to decisions in care, which they did not accept, was another manifestation of the power differences between patients and staff members. This reaction to power differences could be an alternative explanation of the lack of compliance that often is associated with patients in psychiatric care, i.e. lack of compliance can be the patient's resistance to an unacceptable imbalance of power. These manifestations of power were a part of the web of relationships and made it even more complicated.

To the staff members, the health care environment meant both personal well-being and having a demanding job. This thesis adds to earlier research an understanding of the complexity that staff members have to face in their work, which is a result of the interrelated relationships with a number of inherent fields of power, which they have to handle in way that is fruitful for all involved. Staff members need to make the relationships work in a positive way for all involved as they are responsible for the patients' wellbeing, for supporting next of kin, and are expected to contribute to a good climate between co-workers. It reflects how the psychiatric health care environment on a locked ward is as an arena for human interaction and that no relationship can be viewed as insignificant for patients' care.

IMPLICATIONS

The findings in this thesis show the importance of viewing the health care environment of a locked acute psychiatric ward as both a field of interaction between people and a field of different aspects of power. Relationships and power cannot be dealt with as something separate, since power is inherent in all relationships. All relationships on a ward in one way or another interfere in a patient's care and staff members need to be aware of strengths, weaknesses and manifestations of power in the web of relationships around each patient. One should not underestimate the intensity and pressure that comes from working in such an environment. Consequently, its importance for staff members' experiences of a stressful work environment needs to be taken into consideration. When educating staff in different professions, the findings can be used to increase knowledge of and skills in the handling of all relationships around a patient; focusing on the relationship with the patient is not enough. Furthermore, power in care must be dealt with as inherent in relationships. These topics are also appropriate for reflection in staff supervision groups in order to support staff members in their work. The findings can be transferred and be useful in psychiatric care settings with a similar context as the one in this thesis. The findings can also be used in care organisations when dealing with insufficient differentiation of wards in Swedish inpatient psychiatric care.

This thesis can contribute to health care sciences with a deeper understanding of the meaning of health care environment in a patient's care and in the work environment. It points to the need to increase and emphasise patients' participation in care and to consider relationships on a ward as an active part of care. The thesis also demonstrates that research on relationships and power in care needs to be further developed.

FURTHER RESEARCH

Further research is needed on the experiences of next of kin of having a family member on a locked ward, and patients' significance for each other in psychiatric care is still an undeveloped area. The papers in this thesis were written by registered nurses and thus have a professional perspective even if attempts were made to reduce such an influence. More user involvement in research is needed to go beyond the professional perspective, which is particularly important in psychiatric care where power is a main issue. Further, the gender perspective is almost non-existent in research on psychiatric care, as in the case of this thesis, and must be taken into consideration regardless of the research topic.

SVENSK SAMMANFATTNING

Bakgrund

Den psykiatriska slutenvården har i de flesta västländer genomgått stora förändringar under de senaste decennierna, genom en radikal minskning av vårdplatser till förmån för öppnare vårdformer. Den slutenvård som finns kvar har att erbjuda akutsjukvård till de allvarligast sjuka under betydligt kortare vårdtillfällen än tidigare och detta har inneburit en koncentration av svårt sjuka patienter på färre vårdenheter. Patienter kan vårdas frivilligt eller mot sin vilja, d.v.s. med tvång, inom psykiatrisk slutenvård. I Sverige vårdas de flesta av de tvångsvårdade patienterna på avdelningar med låst entrédörr, medan andra metoder för övervakning av tvångsvårdade patienter är vanligare i till exempel Storbritannien. Undantaget är rättspsykiatriska avdelningar för patienter dömda till vård, de är i allmänhet alltid låsta. I Sverige är cirka tre fjärdedelar av avdelningar för vuxenpsykiatrisk vård alltid eller nästan alltid låsta (rättspsykiatrisk vård undantagen), medan endast knappt en fjärdedel av patienterna är tvångsvårdade och måste vistas på avdelningen (d.v.s. de har inte permission). Detta innebär att en stor andel av de frivilliga patienterna vårdas på låsta avdelningar. Rörelsefriheten är begränsad för alla patienter på en låst avdelning, då även frivilligt vårdade måste be personalen om hjälp för att öppna dörren. Forskning visar att patienter är känsliga för hur deras rörelsefrihet begränsas, både när det gäller direkt tvång och mer indirekt genom regler och påtryckningar. Det är även väl känt att en förhållandevis stor andel frivilligt vårdade upplever tvång i den psykiatriska slutenvården. Vård på låsta avdelningar har av patienter upplevts som såväl förlust av frihet som att det inneburit trygghet och säkerhet. Liknande motstridiga uppfattningar finns hos vårdpersonal som sett låsta avdelningar som ogynnsamt både för personal och för patienter, medan andra ansett att det har varit ett mindre problem.

Förändringarna av den psykiatriska slutenvården har också inneburit förändringar av arbetsmiljön för personalen. Hot och våld i kontakten med patienter är vanligare där än i de flesta andra sektorer av vården och även organisatoriska faktorer har stor betydelse för arbetsmiljön i psykiatrisk slutenvård. Den fysiska miljön i den psykiatriska slutenvården har historiskt haft både en kontrollerande och behandlande funktion, men den senare har minskat i betydelse sedan slutenvården i första hand numera handlar om akutsjukvård. Begreppet "vårdmiljö" kan ha olika betydelser men används i den här avhandlingen som ett samlande begrepp för både fysisk, psykosocial, och kulturell miljö i ett vårdssammanhang.

Syfte

Det övergripande syftet med denna studie har varit att få en ökad förståelse av vårdmiljön på en låst psykiatrisk akutvårdsavdelning genom att beskriva den och att klargöra dess betydelse för patienter och personal.

De specifika syftena för varje delstudie var:

- I. Att beskriva vårdmiljön på en låst psykiatrisk avdelning.
- II. Att beskriva möten i vårdmiljön på en låst psykiatrisk avdelning.
- III. Att klargöra vad det betyder att vara vårdare på en låst psykiatrisk akutvårdsavdelning.
- IV. Att klargöra vilken betydelse vården har för patienter på en låst psykiatrisk akutvårdsavdelning.

Metod

För att ha möjlighet fånga de olika aspekterna av vårdmiljön och vad den betyder för personer som vistas i miljön har etnografisk metod används. Det innefattade 250 timmars deltagande observationer under 3½ månad på en vårdavdelning, där så kallade informella intervjuer i samtalsform också ingick (delstudie I och II). Därefter gjordes formella intervjuer med tio (N=10) personal (mentalskötare, sjuksköterskor, enhetschef, läkare, städerska) för delstudie III och med tio (N=10) patienter för delstudie IV. Formella intervjuer innebär till skillnad från informella att man har en i förhand bestämd ingångsfråga. Fältanteckningar från observationer och informella intervjuer och utskrifterna av de formella intervjuerna analyserades med kvalitativ innehålls analys. Detta är presenterat i fyra olika delstudier (I-IV). I avhandlingens ramberättelse redovisas resultat av en samlad analys av resultaten från samtliga delstudier.

Den ovan beskrivna datainsamlingen genomfördes på avdelning som i huvudsak var avsedd för patienter i ett akut skede av depression, bipolär sjukdom eller ätstörning. Patienter vårdades frivilligt eller med tvång på avdelningen, och vid tiden för undersökningen så fanns även en patient dömd till rättspsykiatrisk vård inlagd. Avdelningens entré hölls alltid låst och avdelningen var uppdelad i en patient- och en personaldel, med låsta dörrar emellan.

Resultat

Resultaten från delstudie I som är baserade på observationerna visar att vårdmiljön överskuggades av olika uttryck för kontroll. Personalen hade kontrollen men saknade också kontroll; de försökte bemästra sin arbetssituation genom att följa regler och rutiner men misslyckades ibland. Samtidigt släppte de en del av kontrollen och delade de ansvaret för vården med patienter och närstående. Patienterna på avdelningen var kontrollerade av personalen; de var i underläge och beroende av personalen för sin vård och för att kunna lämna avdelningen. Inte desto mindre försökte patienterna göra sig hörda och reagerade på kontrollen genom att utveckla motstrategier; de utövade påtryckningar på personalen och ibland förekom en ganska öppen kamp för att få mer kontroll som patient.

I delstudie II, även den baserad på observationerna, framkom att vårdmiljön på avdelningen erbjöd utrymme för olika möten mellan människor, alltifrån professionell vård till privata möten och socialt umgänge. Detta innefattade både glädje och vänskap, såväl som oavsiktlig insyn i andra patienters lidande. Det visade sig både i ett vårdande samspel och ett icke-vårdande samspel mellan personal och patienter och deras närstående, och de innehöll kontrasterande kvalitéer som respekt och flexibilitet såväl som misstro och brist på respekt. Men där fanns också ett samspel som inte var erkänt eller uppmärksammat och som handlade om patienternas möten och samspel med varandra. Detta samspel kunde vara både stödjande och inkräktande och hade med stor sannolikhet också betydelse för resultatet av vården.

Innebörden i att vara vårdare (delstudie III) var för personalen att sträva efter god kvalité i vården, men också att utveckling av vården kunde innebära en känsla av maktförlust för vissa. Personalen hade ett behov av trygghet och säkerhet i sitt arbete; det uppnåddes genom en stabil arbetsledning, kontinuitet i patientkontakten och genom att ha kontroll. Trots att de hade en påfrestande arbetssituation upplevdes det som meningsfullt och stimulerande att vara vårdare. Deras ansvarskänsla för att arbetet skulle bli utfört och för patienternas välbefinnande var både en drivkraft och en börda.

För patienterna innebar vården på en låst psykiatrisk akutavdelning (delstudie IV) både att få lindring i lidandet och att bli utsatt för stress. Det som bidrog till lindrat lidande var erfarenheten av stärkt integritet och självbestämmande, av att få stöd och att ha avdelningen som en tillflyktsort. I kontrast till detta stod erfarenheten av att bli utsatt för stress i vården; det grundade sig i beroendet av personalen, att vara fångad i en situation med brist på inflytande och valmöjligheter, och i att vara kontrollerad.

Slutsatser

I resultatet från den samlade analysen av alla fyra studierna framkommer att dominerande inslag i vårdmiljön på en låst psykiatrisk akutvårdsavdelning var kontroll och ansvar och samspelen mellan alla som vistas där. Komplexiteten i väven av samspel mellan patienter och deras närstående och personal, såväl som mellan patienter blev uppenbar. Vart och ett hade betydelse för patientens vård och kompletterade varandra för att bidra till lindring i patientens lidande, men kunde i andra fall bidra till stress för patienten. Kontrollen som fanns i vårdmiljön hotade patienternas värdighet och fick dem att reagera med motstånd. Även om personalen försökte att dela ansvaret för vården med patienter och närstående riskerade den kontroll som personalen hade att utföra, tilliten mellan dem. Att kontrollera andra innebär också en makthandling, vilket innebar att det var maktskillnader mellan personal och patienter, och patienternas motstånd är ett tecken på att de upplevde att det fanns maktskillnader. Till komplexiteten i väven av samspel kan därför också läggas de maktskillnader som fanns mellan alla aktörer, här främst synligt mellan patienter och personal. För personalen innebär detta att de ska hantera

denna komplexitet i samspelet mellan alla på en vårdavdelning på ett sätt som är fruktbart för de inblandade. Detta kan vara en bidragande orsak till de påfrestningar som personal i psykiatrisk slutenvård ofta upplever i sitt arbete.

Den här avhandlingen visar på vikten av att se vårdmiljön på en låst psykiatrisk akutvårdsavdelning som en arena för mänskligt samspel och ett område innehållande olika aspekter av makt. Samspelet mellan människor på en avdelning, mellan patienter, personal, närstående och medpatienter, bör ses som en aktiv del av vården - inget samspel kan betraktas som oviktigt för patientens vård. Avhandlingen visar även på nödvändigheten av att öka patienternas delaktighet i vården, att vara uppmärksam på maktskillnader och på vilken betydelse de har för patientens vård. Avhandlingens resultat kan användas i utbildning av personal i olika professioner, både på grund- och specialistnivå, såväl som i handledning av personal. Resultaten kan också användas i vårdorganisationen vid förbättring av differentiering mellan vårdavdelningar efter patienternas olika vårdbehov. I praktiskt vårdarbete kan resultaten användas för att öka patienternas delaktighet och självbestämmande i vården, för att i högre grad betrakta närstående och medpatienter som delaktiga i vården, och för en ökad medvetenhet om maktspekten i samspelet med patienten.

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