



UiT The Arctic University of Norway

Department of Health and Care Sciences, Faculty of Health Sciences

Competent help during acute psychosis

A qualitative interview study with patients admitted to acute psychiatric wards

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OTHERWISE

I got out of bed
on two strong legs.
It might have been
otherwise. I ate
cereal, sweet
milk, ripe, flawless
peach. It might have
been otherwise.
I took the dog uphill
to the birch wood.
All morning I did
the work I love.

At noon I lay down
with my mate. It might
have been otherwise.
We ate dinner together
at a table with silver candlesticks. It might
have been otherwise.
I slept in a bed
in a room with paintings
on the walls, and
planned another day
just like this day.
But one day, I know,
it will be otherwise.

Jane Kenyon

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ORIGINAL ARTICLES

Article 1:

Sebergesen K, Norberg A, Talseth A-G (2014). Being in a process of transition to psychosis, as narrated by adults with psychotic illness acutely admitted to hospital. *Journal of Psychiatric and Mental Health Nursing*, 21: 896-905. Open access. DOI:10.1111/jpm.12158.

Article 2:

Sebergesen K, Norberg A, Talseth A-G (2016). Confirming mental health care in acute psychiatric wards, as narrated by persons experiencing psychotic illness. An interview study. *BMC Nursing*, 15: 1-15. Open access. DOI: 10.1186/s12912-016-0126-x. 1-15

Article 3:

Sebergesen K, Norberg A, Talseth A-G (2016). “I want to go home, but I need to stay”: The transition to become ready for discharge from acute psychiatric wards, as narrated by persons who experienced acute psychotic illness. *International Journal of Nursing and Clinical Practices*, 3(1): 1-10. Open access. [Http://dx.doi.org/10.15344/2394-4978/2016/179](http://dx.doi.org/10.15344/2394-4978/2016/179)

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Appendices

I: Letters of permission: Regional Ethical Committee for Medical and Health Research (REK)

II: Letters of permission: Norwegian Centre for Research Data (NSD)

III: Information about the research project and informed consent form

IV: Interview guide

SAMMENDRAG

Akutt psykose er en alvorlig tilstand. Mennesker med akutt psykose blir vanligvis innlagt på akuttpsykiatriske sengeposter for behandling og nødvendig pleie og omsorg. Det er lite forskningsbasert kunnskap om hvordan pasienter erfarer å få kyndig hjelp gjennom akutt psykose. Formålet med denne avhandlingen er å utforske og å beskrive hva kyndig hjelp gjennom akutt psykose kan være for pasienter innlagt i akutt psykiatriske sengeposter. Avhandlingens teoretisk referanseramme er sykepleietenkning i en tradisjon etter Florence Nightingale.

Avhandlingen baseres på en tredelt kvalitativ studie med et utforskende og beskrivende design. Deltakerne i studien var pasienter med en kjent psykoselidelse innlagt i akutt psykiatriske sengeposter. De ble intervjuet om sin erfaring med pleie og omsorg gjennom sin akutte psykosetilstand. Lydfilene fra de kvalitative forskningsintervjuene ble transkribert til intervjuetekst som ble innholds-analysert. Resultatene ble publisert i tre artikler vedlagt avhandlingen.

Tre aspekt i utøvelsen av pleie og omsorg synes å ha sentral betydning for den kyndige hjelpen pasientene fikk. For det første er utformingen av og atmosfæren i de akuttpsykiatriske sengepostene og strukturen i pleie- og omsorgsarbeidet vesentlig. For det andre trenger sykepleiere kunnskap om psykoselidelse, om akutte psykoser og om den enkelte pasients tilstand som akutt kritisk syk. Til sist, må pleie og omsorg være nøye tilpasset den enkelte pasients tilstand som akutt kritisk syk for at pasientene skal få kyndig hjelp gjennom akutt psykose.

Resultatene indikerer at for at pasienter skal få kyndig hjelp gjennom akutt psykose må akuttpsykiatriske sengeposter ha gode rom og arbeidsstrukturer som sikrer at utøvelse av akutt kritisk pleie og behandling skjer i samarbeid med pasienten selv, med pasientens familie og med lokalt helsepersonell som har oppgaven å følge pasienten opp etter utskrivelse. Videre, sykepleiere i akutt psykiatriske sengeposter trenger spesialisert kunnskap om psykoselidelse og om den enkelte pasients tilstand som akutt kritisk syk for å utøve akutt kritisk pleie til pasienten. Sist men ikke minst, foreslås ny forskning som undersøker og beskriver sykepleiere sin erfaring med å utøve kyndig pleie og omsorg til pasienter gjennom akutt psykose.

ABSTRACT

Acute psychosis is a severe condition. People with acute psychosis are usually admitted to acute psychiatric wards for treatment and nursing care required. There is little research-based knowledge of what these patients experience as competent help during acute psychosis. The aim of this dissertation is to explore and describe what competent help may consist of during acute psychosis for patients admitted to acute psychiatric wards. The theoretical frame of reference is nursing philosophy in the Florence Nightingale tradition.

This dissertation is based on a qualitative three-part study with an exploratory and descriptive design. The study participants were patients with a known psychotic disorder admitted to acute psychiatric wards. They were interviewed about their experiences of nursing care during acute psychosis. Audio files of the qualitative research interviews were transcribed into text that was subject to content analysis, and the results were published in the three articles attached to the dissertation.

Three aspects of nursing and care practices seemed central to the competent help received by the participating patients. First, the design and atmosphere of the rooms in acute psychiatric wards and the structure of nursing and care work seemed central. Second, the nurses need knowledge and understanding of psychotic disorders, acute psychosis and of the individual patient as an acutely critically ill person. Finally, to provide competent help to patients during acute psychosis, the nursing care needs to be closely adapted to the individual patient as acutely critically ill.

The results indicate that a number of factors of nursing care are essential. Acute psychiatric wards must have suitable rooms and structures for the provision of acute critical care and for the cooperation with the individual patient, his or her family members and local health care personnel responsible for the further follow-up after discharge from the ward. Further, the nurses on acute wards need specialized knowledge about psychotic disorders and the individual patient's state of acute critical illness to provide sound critical care to the patient. New research is proposed to explore how nurses experience and provide care to patients as competent help during acute psychosis.

1.0 INTRODUCTION

The aim of this dissertation is to explore and describe what competent help may consist of during acute psychosis for patients admitted to acute psychiatric wards. The dissertation is based on a qualitative, exploratory and descriptive research study. The research participants were recruited among patients in acute psychiatric wards who had a known psychotic disorder. The data consisted of texts from qualitative research interviews with the participants about how, at the time of the interview, they experienced the help they received during acute psychosis. The interview texts were analysed using qualitative content analysis and the results were reported in the three attached articles, which were published in international nursing research journals (Articles 1, 2 and 3).

1.1 Background to the study

As a nurse with over 30 years of experience in mental health care, my particular interest in nursing and caring for patients with acute psychosis arose while working in an acute psychiatric ward for ten years from 2000. I found that nursing care for patients with acute and severe psychosis was vital for many patients but also challenging to give to some patients. However, I found that most patients were helped to feel better during their stay on the ward.

During this ten-year period, patient involvement in their treatment and care, referred to as user involvement, gained far greater importance and focus than previously (Patient Rights Act, 1999). Did this mean that staff on acute psychiatric wards should practice nursing care differently from before? Well, perhaps. Studies have shown that user involvement in care in acute psychiatric wards is difficult to implement (Norvoll, 2007; Skorpen & Øye, 2009). To ensure patient involvement, researchers suggested a decrease in structures for care such as procedures and routines in acute wards that they associated with older care structures from psychiatric hospitals, while new working methods involving cooperation between nurses and individual patients should become more prominent (Norvoll, 2007; Skorpen & Øye, 2009).

In my clinical work, I found that cooperation with acutely psychotic patients in everyday matters was both natural and necessary to achieve. This cooperation was closely linked to everyday routines such as helping patients to get up and to personal care. Furthermore, nurses could use this everyday cooperation to help alleviate patients' mental distress. As I saw it, cooperation was embedded in the actual care work. However, in official documents, cooperation in user involvement was described quite differently (Ministry of Health and Care Services, 2006). The patient's complaints and challenges were highlighted as the *subject* for health personnel and the patient to discuss and in this discussion the patient should be involved in planning treatment and other measures (cf. Ministry of Health and Care Services, 2006). From my point of view, nurse-patient cooperation in actual care work and nurse-patient cooperation in a "user involvement" way of working were different, in fact perhaps too different. The two working methods, with their different philosophies, were not consistent. This may have been why user involvement, as it was described at the time, was difficult to implement in acute inpatient psychiatric care. I became increasingly eager to find and develop ways to cooperate with acutely psychotic patients in my nursing care work. However, in my engagement in this matter, I discovered that the voice of the acutely psychotic patient was quite absent in the ongoing user involvement debate among health politicians, health professionals, and representatives of users and their relatives that took place in the 2000s. I therefore became increasingly interested in what patients themselves thought about the help they received when admitted to a psychiatric ward during acute psychosis.

This interest took on a more specific form in collaboration with experienced researchers and led to the present study.

1.2 Psychotic disorders

Psychosis is defined as a mental state with impaired contact with reality, which manifests itself in unusual perceptions (Aarre & Dahl, 2018). Psychotic disorders as a diagnostic group are defined on the basis of certain specific symptoms such as hallucinations, delusions, and mental and behavioural

disorders (ICD-10 2016¹). Schizophrenic disorders, acute and transient psychotic disorders, schizoaffective psychosis and paranoid psychosis are all considered as types of psychotic disorders (Aarre & Dahl, 2018). The prevalence of psychotic disorders in the population is estimated at 15-20 per 100 000 per year, i.e. 750-1000 new cases of psychosis annually in Norway. Between 100 000 and 200 000 people are estimated to have psychotic disorders in Norway today (Norwegian Institute of Public Health, 2019).

Psychotic disorders typically occur in adolescence or early adulthood (McGorry, Killackey & Yung, 2008). However, recent epidemiological evidence shows that a quarter of people diagnosed with psychosis were in their 40s (McGrath, Saha, Al-Hamzavi et al., 2016). People having diagnosis of psychotic disorders are at risk of recurrent episodes of acute psychosis (McGorry et al., 2008; McGorry, 2015). Acute psychosis, as name suggests, is a mental state strongly and abruptly different from the ordinary state, affecting people's perception and often their ability to take care of themselves and their needs, social functioning and ability to work (Casey, Rodriguez, Northcott et al., 2011). For people living with a psychotic disorder, recurrent acute psychoses and medication increase the risk of poor health, physical illnesses and early death compared to the general population (Casey et al., 2011).

The health authorities in Norway and other comparable countries focus on preventing psychotic disorders in the population and preventing and reducing recurrent acute psychoses and associated suffering for people with psychotic disorders (Norwegian Directorate of Health, 2013; NICE, 2014). Early intervention of treatment for people who experience early signs of psychosis has been reported as effective (Marshall & Rathbone, 2011; Randall, Vokey, Loewen et al., 2015). People who experience acute psychosis, despite preventative interventions, generally receive treatment and care in acute psychiatric wards in Norway and other comparable countries (Thornicroft & Tansella, 2013; Thornicroft, Deb & Henderson, 2016). Studies show that patients report improvement in symptoms and functioning during a stay on an acute psychiatric ward (Ruud, Gråwe & Hatling, 2006; Svindseth,

¹ Two code systems for diagnosing mental diseases, disorders and related health problems are used: The International Statistical Classification of Diseases (2016) - ICD-10 and the Diagnostic and Statistical Manual of Mental Disorder - DSM V (2015). Due to Norway's membership of the World Health Organization (WHO), Norway uses the ICD-10 (2016) code system.

Nøttestad & Dahl 2010). However, there has been little research to show how treatment and care in acute psychiatric wards help patients to recover (Svindseth et al., 2010; Thornicroft et al., 2016).

1.3 Aims

Acute psychosis is a serious condition and may be perceived as being detached from oneself, others and one's safe environment, even from life itself (Barker, 2001 ab). People with acute psychosis may need competent help, as provided by nurses in the form of care in acute psychiatric wards.

The main aim of this dissertation, which is based on the three articles, was to explore and describe what competent help may consist of during acute psychosis for patients admitted to acute psychiatric wards.

The aims of the different three studies reported in Article 1, 2 and 3 were:

Study 1: The aim was to explore the experiences of becoming psychotic among patients with psychotic illnesses prior to interventions and admittance to acute psychiatric ward.

Study 2: The aim was to explore and describe how the mental health care provided by nurses was experienced as help to feel better, as narrated by patients with psychotic illness in acute psychiatric wards.

Study 3: The aim was to explore, describe and understand how patients' experienced becoming ready for discharge from acute psychiatric wards, following an acute psychotic illness.

The three articles formed the basis for the research question of this dissertation:

What aspects of nursing care are of most importance in providing competent help to patients with acute psychosis admitted to acute psychiatric wards?

1.4 Scope and structure of the dissertation

This dissertation discusses what competent help during acute psychosis, with a focus on nursing care, may consist of for patients admitted to an acute psychiatric ward. Norwegian specialist mental health

care provides the background to the dissertation. The dissertation does not explicitly discuss issues related to ethical challenges and the use of coercion in mental health care. However, issues related to ethics and coercion are touched upon in discussions of what competent help may consist of. The dissertation does not discuss general aspects of nursing care for patients with psychotic disorders, but those that appear to be essential for patients to receive competent help during acute psychosis in acute psychiatric wards.

The background to the dissertation is explained in more detail in Chapter 2.0. Chapter 3.0 presents previous research that led to the formulation of the aim of the dissertation. Chapter 4.0 describes nursing philosophy in the Florence Nightingale tradition as the theoretical frame of reference of the dissertation. Chapter 5.0 presents the scientific approach, methodology and implementation of the study. Chapter 6.0 presents the results, and in Chapter 7.0, the results are discussed in light of the aim and frame of reference and relevant literature. Chapter 8.0 contains concluding remarks and possible implications for practice and further research and finally, Chapter 9.0 consists of the references used in the dissertation.

1.5 Key concepts in the dissertation

Acute psychosis: Acute is defined as sudden, sharp and intense. Psychosis is a mental state that affects human perception, i.e. the processing of sensory impressions in thought processes and external reality (Aarre & Dahl, 2018).

Nurses: Nursing and care are provided by various healthcare personnel, such as registered nurses² and other health care workers who may have specialized in psychiatric nursing, mental health in general or mental health and substance abuse. The term nurse is used in this dissertation, as a collective term for staff who provide nursing and care.

² In 2017, about 6000 registered nurses were working in specialist mental health care in Norway (Melby, Ådnes & Kasting, 2017).

Specialist mental health care: “Specialist mental health care is understood to mean specialist examination and treatment of people with mental illness, as well as the nursing and care required” (Mental Health Act, 1999, § 1-2). Acute psychiatric wards are part of specialist mental health care and are located in hospitals.

Patient: The term patient is used for persons receiving or being offered help by health care services or who approach such services with a request for help (Patient Rights Act, 1999, § 1-3).

Competent help: Competent is defined as “having the necessary and special ability, knowledge or skill to do something successfully”. Competent help may thus be care provided with the necessary and special knowledge and skill. Competent is an adjective indicating a quality of health care. It may refer to the care provider or to the resulting action, as in “competent help”.

Being ill: This is a general term used by ordinary people and is related to a person’s experience of a changed state that others may also recognize as “he/she is ill”. Being ill refers to a condition where the person is unable to do certain things that he/she can normally do (Travelbee, 1999; Elstad, 2014).

2.0 BACKGROUND TO THE DISSERTATION

2.1 Historical threads

In Norway, the state is responsible for mental health services.³ Mental health services are provided in community and specialist mental health care. The current organization of mental health services must be seen in the context of an earlier radical decrease in specialist mental health care in hospitals and a corresponding increase in community mental health care (Ministry of Health and Care Services, 1997-98). This change is in line with global mental health policies and is referred to as a change from closed institutional psychiatric care to a new mental health service characterized by openness, holistic, person-centred care and user involvement, as well as being grounded in an acknowledged broad knowledge base (WHO, 2001; WHO, 2007; WHO, 2009). However, the change must also be seen in the light of longer historical trends.

Three clear historical threads underlie today's mental health service since the Act on the Treatment and Care of Insane Persons was adopted in Norway in 1848. Firstly, the emergence of the medical field of psychiatry as a treatment science, characterized by optimism for future effective treatment of the mentally ill, first in asylums and later in the psychiatric hospitals built in Norway from 1855 to 1962⁴. There have been continuous attempts to develop effective treatment of mental disorders within various psychiatric traditions such as biological, psychodynamic and social psychiatric medicine (Aarre & Dahl, 2018).

A second thread was the antipsychiatric movement seen in a number of Western countries during the 1960s (Foucault, 1961/1999; Goffman, 1961; Szasz, 1961/2010). Various authors representing this movement identified psychiatry as a field that colonized problems in people's lives and turned these into constructions of disease, subjected people to inhuman treatment in the name of psychiatry, and

³ Mental health services, the responsibility of the state, are based on a model whereby all citizens have equal rights to health and social care, and on values such as solidarity between people and the responsibility to care for those who are ill and weak (Karlsson & Borg, 2014).

⁴ Gaustad Asylum was opened in 1855 in the Norwegian capital Oslo, then called Kristiania. The last mental hospital built opened in 1962 in Tromsø (Fause, 2013).

legalized the abuse of power and the isolation of people (Foucault, 1961/1999; Goffman, 1961; Szasz, 1961/2010). Norwegian health policy strategies for a new mental health service can be traced back to this criticism of psychiatry (Ministry of Health and Care Services, 1997-98). Care led and practised by nurses was associated with and understood in terms of psychiatric treatment in hospitals and medical science. This understanding can be seen as the background to the discontinuation of special education in psychiatric nursing in 1997 and its replacement by interdisciplinary further education in mental health care (cf. Andersen, 2018; Fause, Lyngved, Rolland et al., 2018).

The third historical thread is developments in nursing. Modern nursing was established through nursing education that started in England in 1860 and in Norway in 1868 (Mathisen, 2006; Elstad, 2014). Following the establishment of modern nursing, nurses were responsible for and participated in the care of mentally ill people both in private care and in asylums and mental hospitals (Fause, 2013). The first Norwegian nursing textbook, written by deaconess and nurse teacher Rikke Nissen in 1877, contained a separate section on care for the mentally ill (Mathisen, 2006).

In conjunction with the development of asylums and later mental hospitals, well-qualified nurses were employed as leaders. The nurses improved the wards and conditions for the patients (Lysnes, 1982). Care of mentally ill patients was specifically connected to bodily care, cooking, hygiene, work and rest, night and day rhythms, and pleasant rooms and outdoor areas for patients. Emphasis was also placed on protecting patients from harming themselves, being humiliated, harming others and from discomfort during medical examinations and treatment (Lysnes, 1982; Fause, 2018). In hospitals, a need for more knowledge of the care of patients with mental disorders was identified and specialized education in psychiatric nursing was started by Marie Lysnes in 1954 in Norway (Fause, 2019). In this context, nursing care for the severely mentally ill grew in importance. Patients with severe mental disorders are still admitted to specialist mental health care facilities for treatment and care, but today for short-term hospitalization.

2.2 Specialist mental health care

Specialist mental health care is specialist examination and treatment for people with severe mental illness in addition to the nursing care required (Mental Health Act, 1999). Specialist mental health care is owned and operated by the regional state health authorities in Norway and is regulated by the Mental Health Act (1999). The purpose of the act is to ensure that the establishment and implementation of specialist mental health care takes place in a responsible manner and in accordance with human rights and fundamental legal principles, with minimal use of coercion.

Specialist mental health care is primarily provided on the basis of patient consent in accordance with the provisions of the Patient Rights Act (1999). A doctor or another qualified clinician refers patients to specialist mental health care. Specialist mental health care is either planned or in the form of emergency treatment and either voluntary or, if necessary, based on a decision on involuntary care. Involuntary care is provided as described above, but without the patient's consent (cf. the Patient Rights Act, 1999). A patient's competence to consent must be continuously assessed by a specialist in psychiatry or adult psychology and, if feasible, decisions on involuntary care should be changed to voluntary care as soon as possible (Directorate of Health, IS-1, 2017).

Specialist mental health care reinforces community mental health services⁵ (Directorate of Health, IS-2076, 2014). It is provided at so-called district psychiatric centres (DPS)⁶ and in hospitals. Hospitals offer various forms of specialized mental health care, including treatment and care in acute psychiatric wards (Directorate of Health IS-2076, 2014).

The social mission of specialist mental health care is to provide services to people with severe mental disorders who seek care and treatment that cannot be provided by the community mental health care.

Specialist mental health care is also tasked with providing inpatient treatment and care to people with

⁵ Primary mental health services include general practitioners, various work and activity services, home-based and outpatient services and 24-hour emergency inpatient and residential services (Directorate of Health, IS-2076, 2014).

⁶ District psychiatric centres include stationary and peripatetic outpatient services, 24-hour emergency services, and short-term inpatient units for examinations, treatment and care (Directorate for Health and Social Affairs, IS-1388, 2006; Directorate of Health, IS-2076, 2014)

severe mental disorders who are unable or unwilling to consent to such treatment and care. Specialist mental health care, especially acute psychiatric wards, has been criticized to its use of coercion in treatment and care (Andersen, 2018; Wynn, 2018). Specialist mental health care also involves the responsibility of its staff to provide treatment and nursing care to patients. Further, it has a duty to participate in the public debate to improve mental health care to enable patients who need help in acute psychiatric wards to receive competent help when they need it and for as long as they need it (cf. Aarre, 2018; Andersen, 2018).

2.3 Acute psychiatric wards

Patients with acute and severe mental illness are generally admitted to acute psychiatric wards if primary mental health care or that offered by the DPS is insufficient (Directorate of Health, IS-2076, 2014). Acute psychiatric wards are located in hospitals in every county⁷ in Norway. The acute psychiatric wards are designed to provide treatment and nursing care to patients throughout the acute phase of their illness. However, in some of the larger towns and cities in Norway, patients are admitted to acute emergency to be subsequently transferred to general acute psychiatric wards for further treatment.

Acute psychiatric wards are tasked with providing patients with severe mental illnesses, admitted voluntarily or involuntarily, with immediate help, examinations, treatment and nursing care (Mental Health Act, 1999). The majority of patients admitted to acute psychiatric wards require immediate help and may be in a condition, such as psychosis, involving great anxiety, fear or violent behaviour that may pose a significant risk to the life or health of the patient or others (Directorate of Health, IS-2076, 2014). Under the Mental Health Act (1999), patients must receive help with personal care and daily hygiene that prevents any health risk. Help should also be provided in ways that are not unnecessarily comprehensive or that violate the patient's integrity (Mental Health Act, 1999).

⁷ Under current county structure (2019), the northernmost county in Norway, Finnmark, does not have an acute psychiatric ward. Patients from Finnmark have to use the ward in the neighbouring county of Troms.

The Mental Health Act (1999: § 3-5) sets out professional and material standards for acute psychiatric wards that use coercion. The structure of the ward must enable patients to receive the help they need. This implies a suitable architectural design, suitable interior and furnishings, and the ward must be designed to provide patients with easy and unhindered access to fresh air and activity. Further, it is important that the ward is equipped with patient safety and security in mind, in accordance with requirements for responsible treatment and care (Directorate of Health, IS-1, 2017).

Requirements for professional, responsible treatment and nursing care and adequate opportunities for activity also entail requirements for competent staff (Directorate of Health, IS-1, 2017). High-quality nursing care and treatment are ensured through a continuous 24-hour service consisting of three shifts for nurses (morning, evening and night).

2.4 Competency requirements for care staff in acute psychiatric wards

Nursing staff in acute psychiatric wards have a duty to take care of patients safely and securely around the clock, provide them with necessary nursing care, participate in examinations and treatment, and assist patients during their illness and recovery phases (Directorate of Health, IS-2076, 2014; Directorate of Health, IS-1, 2017).

The Health Personnel Act (1999) provides general guidelines for competency requirements for health personnel in health care services in Norway, as follows: health personnel should be able to perform their work in accordance with the requirements for sound professional care and treatment that are to be expected based on the person's qualifications, the nature of the work and the general situation (Health Personnel Act, 1999: 2.1 § 4). The duty to provide responsible care is linked to the qualifications of the staff, which implies both formal and experience-based qualifications (Health Personnel Act, 1999). Nurses and other health care staff, with or without further education in mental health care, are

employed in acute psychiatric wards and are considered to be qualified (Melby, Ådnanes & Kasting, 2017)⁸.

At various colleges and universities in Norway, nurses can take interdisciplinary further education or master's degree programmes in mental health, mental health care or mental health and substance abuse⁹. At present, there is no possibility for nurses to specialize in mental health or psychiatric care. A survey of the fields studied in the interdisciplinary further education courses showed that students received a comprehensive introduction to mental health, interdisciplinary collaboration, networking and user participation (Fause et al., 2018). An evaluation of the courses showed that students were satisfied with the knowledge they acquired in these areas (Ådnanes & Harsvik, 2007). However, students in interdisciplinary further education and nurses working in specialized mental health care asked for knowledge in some specific areas. They would like to learn about severe mental illness, symptoms of severe mental disorders, the use of coercion and alternatives to coercion, medication treatment and medication-free treatment, physical complications that can result from mental disorders, medication treatment and substance abuse (Ådnanes & Harsvik, 2007; Melby et al., 2017). The students and nurses in the study also wanted opportunities to develop their clinical skill in cooperating with and assisting people with severe mental illness and in collaborating with their family members (Ådnanes & Harsvik, 2007; Karlsson & Kim, 2015; Melby et al., 2017). Current interdisciplinary further education in mental health and mental health care does not seem to meet the knowledge needs of nursing staff to enable them to provide competent help to patients with severe psychotic disorders who are admitted to specialist mental health facilities and acute psychiatric wards.

2.5 The patients on acute psychiatric wards

A national study published in 2006 provides a detailed picture of the patient population on acute psychiatric wards in Norway at the time (Ruud et al., 2006). In 2006, most patients in acute psychiatric

⁸ In a national study, Melby et al. (2017) have pointed out that registered nurses form the majority of care staff in specialist mental health care.

⁹ Auxiliary nurses and other health care staff can take further education courses in mental health and substance abuse at vocational colleges in Norway.

wards had been diagnosed with psychosis and psychosis-related disorders. Of the total patient population, 95% were emergency admissions, while 41% were admitted involuntarily. The average length of stay was 9.5 days. The causes of admission were often described as severe anxiety, destructive behaviour, and a risk to the patient and to some extent to others. The average age of the patients was 41 years, and there were equal numbers of men and women (Ruud et al., 2006).

National health care surveys describe the inpatient population in specialized mental health care during 2013-2017 as very similar to that of 2006. The majority of patients are still those with psychosis and psychosis-related disorders, the average length of stay is now 10-15 days, and emergency and involuntary admissions are little changed since 2006 (Directorate of Health, IS-2825, 2017). However, studies have suggested, compared to other comparable countries, that the use of involuntary admission in Norway is relatively high (Wynn, 2018). National studies suggest that the numbers of patients treated on the basis of a decision to use restraint and seclusion have increased in recent years, while the use of pharmacological and mechanical coercion has decreased (Directorate of Health, IS-2812, 2018). There are no complete figures on the number of individual people admitted to acute psychiatric wards.

2.6 Recent developments

The regional state health authorities have overall responsibility for providing high quality, responsible and considerate mental health care. In order to ensure that specialist mental health care meets this requirement, there is regular inspection by government officials. The Civil Ombudsman's Unit to Prevent Torture and Inhuman Treatment makes regular visits to mental health facilities to identify errors in care practices and demand improvements as necessary.

Three different reports (Civil Ombudsman, 2016; 2017; 2018) from inspections of acute psychiatric wards at three hospitals in Norway highlight errors in the practice and documentation of decisions on coercion, and in the implementation and evaluations of measures used on patients admitted

involuntarily¹⁰. In addition, the reports by the Civil Ombudsman reveal deficiencies in the provision of care to patients, and specific mention is made of the lack of plans for nursing during seclusion and plans for what nurses should observe in relation to patients' psychotic condition and changes in their condition. The reports also reveal inadequate patient care that could lead to health risks and danger (Civil Ombudsman, 2016; 2017; 2018). One may question whether the unsatisfactory practices could be seen in the context of the limited opportunities for nursing staff to specialize in the care of severely mentally ill people admitted to acute psychiatric wards.

2.7 Summary

The health authorities stipulate that the qualifications of health care workers, such as tertiary education and experience, must meet the requirements to provide professional, responsible and considerate care in the specific activities in the area of the Norwegian health care service in which they are employed. In acute psychiatric wards, this means that nursing staff must have basic and necessary expertise in nursing care, and experience and/or further education that specifically meet the need for competent help of acute patients with severe mental disorders. There currently appears to be a gap between the health authorities' requirements for health care workers' qualifications and the possibility for nursing staff in acute psychiatric wards to specialize in nursing and care fields related to acute and severe mental illness.

¹⁰ Errors and deficiencies are reported on physical conditions in wards, limited opportunities for activity and fresh air, seclusion of patients, documentation on the use of seclusion, mechanical coercion and forced medication.

3.0 PREVIOUS RESEARCH

Over the past fifteen years, there have been many international studies on the care of patients in acute psychiatric wards. This research can be seen in the context of the fact that in the past two decades, in most western countries, such wards have been given a clearer mandate of providing short-term emergency treatment and nursing care to patients with acute and severe mental illness (cf. Thornicroft & Tansella, 2013; Thornicroft et al., 2016).

Norwegian doctoral dissertations have discussed the treatment offered in acute psychiatric wards. Norvoll (2007) discussed acute psychiatric wards in terms of the tension between treatment and control illustrated by a study of the seclusion methods used in acute wards. Skorpen and Øye (2009) discussed daily life in a psychiatric facility through an analysis of social therapy practices. Other dissertations have focused on nursing and care in acute psychiatric wards, such as that of Vatne (2003), who examined nurses' logic in boundary-setting situations discussed through the concept of rationality. Hem (2008) discussed the characteristics of nursing, especially psychiatric nursing, in situations where nursing based on altruism is challenged.

These dissertations have led to reflection on how acute psychiatric wards and the nursing care provided there may be understood from different perspectives. Some of the authors argue for new structures in acute psychiatric wards and the development of working methods based on user involvement and social therapy. The dissertations also discuss the need for new ways of working and a new theory of nursing for acute and severely mentally ill people. However, there is little discussion of how nursing care in acute psychiatric wards can comprise competent help for patients during acute mental illness or crises. In relation to the aim of this dissertation, relevant international research on nursing care in acute psychiatric wards was reviewed.

3.1 What does it mean to be psychotic?

To gain insight into what patients who have experienced psychosis might need from nursing care; studies that explored patient experiences of psychosis were reviewed. Most patients with psychosis

sought help, but some hoped the psychosis would pass or wanted no help (NAMI, 2011; McCarthy-Jones, Marriott, Knowles et al., 2013¹¹; Kaite, Karanikola, Merkouris et al., 2015¹²). Psychosis was described as extensive losses, a loss of a sense of reality, of the sense of self, identity and self-esteem, and of the person's own sense of body. It also led to the loss of work capacity, income and hope for recovery and the future (Leiviskä Deland, Karlsson & Fatouros-Bergman, 2011; McCarthy-Jones et al., 2013; Kaite et al., 2015). These losses increased anxiety, insecurity and uncertainty, and the psychotic symptoms interfered with sleep, appetite, everyday routines and relationships with others (Leiviskä Deland et al., 2011; McCarthy-Jones et al., 2013). Patients felt intensely lonely (Nyvoll, 2008) and socially stigmatized (Clement, Schauman, Graham et al., 2004; Keen, George, Scragg et al., 2017). When the psychosis had diminished, patients described recovery as a reconstruction of themselves and of relationships with others and with their environment (McCarthy-Jones et al., 2013) and life continued with the worry of becoming acutely psychotic again (Walsh & Boyle, 2009; Manuel, Hinterland, Conover et al., 2011; Gerson & Rose, 2012).

There is limited research describing how patients experienced acute psychosis, which is generally indicative of hospitalization in an acute psychiatric ward.

3.2 On nursing care in acute psychiatric wards

Patients' experiences of nursing care in acute psychiatric wards have shown that they trusted the nurses who spent time with them and attempted to understand them and help them to cope with their suffering and symptoms (Gilburt, Slade, Rose et al., 2008; Stewart, Burrow, Duckworth et al., 2015; Nugteren, van der Zalm, Hafsteindottir et al., 2018¹³). Cooperation and good relationships with nurses were positive experiences for recovery (Denhov & Topor, 2012; Stewart et al., 2015), while lack of cooperation with nurses was a negative experience and made patients wonder whether they could recover (Kuosmanen, Hätönen, Jyrkinen et al., 2006; Bee, Playle, Lovell et al., 2008). Nursing care

¹¹ McCarthy-Jones et al. (2013) provided a review and meta-synthesis of 97 qualitative studies with a total of 1942 participants.

¹² Kaite et al. (2015) provided a review that included 17 qualitative studies with a total of 242 participants.

¹³ Nugteren et al. (2018) provided a review of 28 qualitative studies, where they asked: How do patients experience their admission and stay in acute, closed psychiatric inpatient wards?

increased patients' quality of life (Pikänen, Hätönen, Kuosmanen et al., 2008) and staff who related to patients as ill people who needed help were appreciated by patients (Stewart et al., 2015). Patients called for more information about their illness and pointed out that discharge from an acute psychiatric ward had to be well planned, because they were vulnerable to alcohol or drug abuse and a relapse of psychosis (Glasby & Lester, 2005; Walsh & Boyle, 2009), and they needed responsible and competent follow-up care after discharge (Manuel et al., 2012; Gerson & Rose, 2012; Loch, 2014). Patients wanted to know whom they could contact at home should they become psychotic again (Manuel et al., 2012; Gerson & Rose, 2012).

Being involuntarily admitted to a closed acute ward, with restrictions and control during their stay, gave some patients the feeling of being treated with disdain and disrespect, increasing their uncertainty and frustration over their treatment (Kuosmanen et al., 2006; Norvoll, 2007; Katsakou, Bowers, Amos et al., 2010). These findings have been confirmed in subsequent studies (Enarsson, Sandman, & Hellzen, 2011; Nugteren et al., 2015; Salzmänn-Erikson & Söderquist, 2017; Lindgren, Ringner, Molin et al., 2018¹⁴). However, patients also felt that coercion might be necessary when they needed protection from their own actions and needed to be restrained (Norvoll, 2007; Lorem, Steffensen, Frafjord et al., 2014). The negative experience of involuntary admission can be reduced by kindness and good contact with care staff, information about coercion and restrictions, and opportunities to negotiate restrictions (Alexander, 2006; Katsakou et al., 2010; Stewart et al., 2015).

In 2004, Koivisto, Janhonen and Väisänen explored how psychotic patients experienced nursing care as help and found that the best help was provided by nurses who spent time with them, tolerated their psychosis and helped them to alleviate the psychotic symptoms. Salzmänn-Erikson & Söderquist (2017) found that patients experienced their stay in intensive acute psychiatric wards as a positive life-changing experience, although the stay was involuntarily. The content of the care that helped patients was not examined in these studies.

¹⁴ Lindgren et al. (2018) provided a meta-analysis of 15 papers using a qualitative approach. This systematic review aimed to investigate how patients experienced the isolation of locked wards and seclusion in psychiatric inpatient wards.

Studies of relatives' experiences have described the struggle to ensure competent treatment for the patient and helplessness and despair when their family member did not want help (Ewertzon, Cronquist, Lutzen et al., 2012). The relatives were torn between being loyal to the patient and being loyal to their idea of the type of help the patient needed (Weidmand, Hedelin, Hall-Lord et al., 2011), and they expressed a need to talk to and cooperate with health care staff (Ewertzon et al., 2012; Førde, Norvoll, Hem et al., 2016). Relatives wanted to support the patient during hospitalization (Førde et al., 2016) but felt discredited by health professionals who provided them with limited or no information, referring to their duty of confidentiality (Weidmand et al., 2011; Førde et al., 2016). Relatives were afraid that the patient might suffer when hospitalized (Førde et al., 2016; Wyder, Bland, McCann et al., 2018).

Several studies have shown that nurses describe their main tasks in an acute ward as 24-hour presence, observing patients, creating a safe and secure environment for them, helping them with intensive care needs, alleviating their symptoms by e.g. helping them to sleep, making efforts to achieve good relationships with them, and helping them to better health and recovery (Bowers, Simpson, Alexander et al., 2005; Cleary, Hunt, Horsfall et al., 2012). However, work related to efficient treatment, administration and documentation, and requirements for order on the ward could prevent nurses from providing individual patients with good nursing care (Bowers et al., 2005; Björkdahl, Palmstierna & Hansebo, 2010).

Studies examining what knowledge nurses needed to provide good care to patients with acute psychosis emphasized the need for knowledge about psychosis and skill in approaching psychotic patients. Further, in order to cooperate and communicate with patients, nurses needed to work on their flexibility and creativity and call on a wide range of skills to help anxious, confused, chaotic and frustrated patients (Deacon, Warne & McAndrew, 2006; Bowers, Brennan, Winship et al., 2009).

Studies that examined how nurses reasoned and acted in challenging conflict situations with frightened and angry patients found that their approach to the situation varied from rapidly taking control to sensitively seeking contact and cooperation with the patient to find solutions with the patient (Björkdahl et al., 2010; Looi, Gabrielsson, Sävenstedt et al., 2014). Studies have shown that when

nurses spent time with patients, intervened early and were trained in preventative approaches and cooperation with other care staff, conflicts and violent situations in acute wards were reduced (Bowers, James, Quirk et al., 2015).

Other researchers have found that nurses experienced being torn between a commitment to do good for the patient and loyalty to a common approach among staff (Enarsson, Sandman & Hellzen, 2008). Gabrielsson (2015) pointed out that nurses experienced a moral struggle between the desire to give individual patients good care and the structures and cultures of acute wards that did not allow for person-centred nursing. Hem (2008) argued that care in acute wards also involves supporting patients when it is difficult for them to receive help, which presents nurses with challenging situations. Ethical reflection and guidance in groups of nurses have been investigated as tools that could enhance nurses' ability to deal with situations of "challenging care" (Molewijk, Hem & Pedersen, 2015).

3.3 Is the acute psychiatric ward a setting for good nursing care?

In an ethnographic study, Quirk, Lelliot and Seale (2006) showed that although patients were admitted to closed acute wards, they described the wards as open, because hospitalization is short, other patients are admitted and discharged, relatives and friends come to visit and staff from primary health care comes to meetings. The closed ward with its restrictions and control was perceived as necessary, safe and secure (Quirk et al., 2006). This has been confirmed in interview studies with patients (Wyder et al., 2018). By contrast, Shattell, Andes and Thomas (2008), found that patients feel that acute psychiatric wards are prison-like location. Enarsson et al. (2011) described patients' helplessness in the face of rules and restrictions on the wards. Norvoll (2007) and Norvoll, Ruud and Hynnekleiv (2016) argued that closed wards and the practice of placing patients in seclusion units cannot be documented as promoting recovery and is experienced by patients as an abuse of power. Skorpen and Øye (2009) described how the room arrangement and work structure of acute wards did not appear to be good therapy to help patients recover.

3.4 Summary

This review of previous research shows that few studies have examined how patients have experienced nursing care as competent help during acute psychosis. This dissertation can therefore help to fill this gap of knowledge.

4.0 THEORETICAL FRAME OF REFERENCE

In order to meet the aim of this dissertation, i.e. to explore and describe what competent help may consist of during acute psychosis for patients admitted to acute psychiatric wards, the theoretical frame of reference chosen was nursing philosophy¹⁵ with roots going back to Florence Nightingale.

4.1 Back to Nightingale

The theoretical frame of reference is not elaborated on in the three articles, but is based on a theory of nursing¹⁶ in mental health care derived from the English psychiatric nurse, researcher and textbook author Phil Barker, and his colleague (Barker, 2001 ab; Barker & Buchanan-Barker, 2005; Barker & Buchanan-Barker, 2010). Barker and colleagues have formulated some basic principles to describe nursing in mental health care. Nursing is to help people who are at risk of mental illness by preventing such illness, to help people who have mental illness through their illness and to help them to feel better and, if possible, to recover. Illness is a transient state experienced by the individual patient. Illness is generally expressed by the patient as symptoms and distress, and as disruptions in social relationships with other people and in the patient's daily activities and life. Nursing must always, as an essential principle, be based on the patient in his particular condition and situation (Barker, 2001ab). Barker's theory makes a distinction between nursing and treatment. The basic principles of Barker and his colleagues' thinking about nursing have clear roots in Florence Nightingale's philosophy (cf. Barker, 2001 a).

Florence Nightingale was born in 1820 and died in 1910. Nightingale had no higher education, but was well versed in languages, philosophy, mathematics, statistics and epidemiology. She became involved in social issues, especially health care and nursing. Nightingale visited Kaiserswerth¹⁷, which

¹⁵ The Norwegian nurse and philosopher Ingunn Elstad (2014) uses the term "nursing thinking" to describe nursing with clear roots back to Florence Nightingale and her book "Notes on Nursing". Elstad (2014) discusses Nightingale's text in the current context of nursing and nursing research, also drawing on other fields such as philosophy.

¹⁶ Barker's (2001 ab) model of nursing for people with mental illness, the Tidal Model, is an intermediate theory and guide to help nurses practise best nursing adapted to the individual patient as a person.

¹⁷ Kaiserswerth was a pioneering hospital in Prussia, run by nuns (Elstad, 2014).

increased her interest in nursing. She later practised nursing in hospitals, in patients' homes and in military hospitals. Nightingale is considered the founder of modern professional nursing and in 1860 she published her textbook "Notes on Nursing. What it is and what it is not". Her book is considered a classic in the field of nursing (Elstad, 2014).

The next part of this chapter focuses on three key aspects of Nightingale's nursing philosophy: what illness is, what nursing is, and the patient as a subject.

4.2 Understanding illness: A natural process, a condition and an experiential concept

Nurses must have knowledge of illness in order to provide sound nursing care to patients (Nightingale, 1860/1997). Nightingale describes illness as a natural process of rebuilding, as a condition and as experience, and her understanding of illness separates nursing from medicine as a subject and practice.

In medicine as a treatment science, a patient's expression of illness was classified and categorized in terms of individual diseases, as one disease (Elstad, 2014). The disease was detached from the ill person and the object for the doctor to treat. Nightingale (1997: 69) expresses this well: "Is it not a mistake to look upon diseases, as we do now as separate entities, which must exist, like cats and dogs?" Nightingale understands illness as a natural rebuilding process of human life. She assumes that all illness, at some stage in its course, is more or less a rebuilding process that is nature's response to people's lives in the environments and conditions in which people live (Nightingale, 1997).

Nightingale (1997) also argues that illness is a condition. In her thinking, illness does not exist as one illness. Illness is always linked to someone, to a human being. Illness can be used as an adjective that indicates a quality of a human condition, such as illness condition. A condition is mobile and changeable; it can increase, decrease and increase again and changes in a patient's condition can be expressed by e.g. the colour, smell and temperature of the skin (cf. Elstad, 2014). However, Nightingale (1997) argues that a person's state of illness must be nuanced through various conditions with particular characteristics or physiognomies. Health also has typical characteristics, as when a

person recovers from illness. If the nurse is ignorant of the characteristics of illness states and recovery, her observation will be imprecise and her nursing will be arbitrary.

Nightingale also points out that the individual patient who is ill has his particular characteristics.

Nightingale (1997) notes that when someone sees what a nurse can accomplish when caring for a sick person, they may understand the care as a “mystery” or witchcraft. Nightingale argues that this is skilled nursing practice. “Good nursing consists simply in observing the little things which are common to all sick, and those which are particular to each sick individual” (Nightingale, 1997: 159).

4.3 What is nursing and what is it not?

What characterizes nursing, according to Nightingale? Nursing is not medical treatment. Nursing facilitates nature’s reconstruction process; it increases well-being and helps the patient overcome physical and mental imbalances. Nightingale (1997: 32) states that nursing is to provide fresh air, light, warmth, cleanliness, calm and good and correct nutrition, and to ensure that the patient does not lose strength. Nursing addresses illness as part of human life.

Observation is a foundation for good nursing. In order to observe the patient’s condition, the nurse must look at the patient; the nurse must have knowledge of what is to be observed, what can be observed and how. The nurse observes the patient’s condition by looking at elements such as skin temperature, pulse and breathing, skin tension and colour, the colour and odour of urine and faeces, pain, the patient’s posture and movements and the overall impression (Nightingale, 1997). At the same time, the nurse must observe the particular features of the individual patient and the observation must be detailed. Nightingale encourages the nurse to direct her gaze, i.e. to see and understand the patient, through observation. In Nightingale’s day, notions such as *the patient’s voice* and *the patient’s experience* were not important aspects of nursing as they are today, but Nightingale asks the nurse to observe the patient, based on a methodology that involves turning towards the patient and always asking oneself how the patient is.

For Florence Nightingale (1997), it is important where the sick person is and where he is being cared for. A ward must encourage recovery. The design of the ward is a key element; it should have

windows that can be opened. Nightingale calls for warmth, light, fresh air and cleanliness, and the interior design is also important. Nightingale (1861/1997) refers to knowledge that a person's environment will affect the development of the person's illness and the recovery process.

Nursing is more than responsibility for a single patient. Nursing is to be responsible for many patients around the clock, which naturally requires a number of nurses. There must be a leader in the care of patients and Nightingale uses the term "person in charge" to describe the person leading the care workers (1997: 79). A nurse is not only responsible for asking herself: "How I can do the right thing?". Instead, the nurse must ask: "How can I make sure that the right thing is always done?" which refers to delegating responsibility in the nurse's absence. Nightingale shows that responsibility for a patient is personal, but one nurse cannot care for the patient all the time. Being responsible for the care of sick people requires a system where responsibility for the individual patient and the many patients can be followed up, understood and recognized in the wards, in the entire organization and in the books where patient records are kept. Here Nightingale refers to the importance of organizing the 24-hour nursing service in hospitals and other similar facilities in a recognizable manner, where the individual nurse is not indispensable, but where the next nurse on duty can take over the responsibility. Having responsibility and being in charge in a hospital are based on knowledge of illness and of being ill (cf. Nightingale, 1997).

4.4 The patient as a person

Nightingale's focus in nursing is undeniably the sick person. The Norwegian nurse and researcher Per Nordtvedt (2019: 69) writes: "While medicine had to base its view of humanity on scientific objectivity, as a necessary prerequisite for its development as a treatment science, Nightingale based nursing on the patient as a subject". This can be understood as a professional choice, but it is also a moral choice (Nordtvedt, 2019). Linking nursing to the patient as a subject spares the patient from unnecessary stresses and burdens and always involves consideration for the patient who is ill and unable or too exhausted to take care of himself or voice his opinion. In Nightingale's spirit, nurses who deal with sick people who often cannot take care of themselves are encouraged to ask themselves:

What is it like to be unable to take care of oneself? The subsequent actions can thus be based on the patient as a subject, and not solely on the nurse's understanding of what is best for the other.

4.5 Summary

Nightingale states that nurses need to understand and recognize human states of illness, such as psychosis, and the characteristics of the illness and of the individual person as ill. Nightingale distinguishes between nursing and medicine. Doctors see the symptoms and signs of a disease or disorder. Nightingale sees the characteristics of the person's condition and of the individual person as ill. In order to provide competent help, the nurse must understand and recognize typical features of illnesses, and be open to the particular characteristics of the individual expressing his or hers illness as being ill. If the nurse does not know the features of the illness and is not open to the person's characteristics, the nursing provided will be imprecise and haphazard.

5.0 METHOD

In light of the aim of the dissertation, the research design for the present study (Studies 1, 2 and 3) was qualitative, exploratory and descriptive. The research work, planning, data collection, analysis and reporting on the individual sub-studies were performed in a work process that included regular collaborative meetings in the research team¹⁸. The meetings adopted a working method characterized by openness, critical questions, reflection and adaptations of the research work. In this chapter, the scientific approach, design, methodology and implementation of the study are presented and discussed. The chapter concludes with ethical and methodological considerations.

5.1 Scientific approach

Elstad (2014) refers to the nursing tradition and philosophy of Florence Nightingale as a basis for a scientific approach to understanding what nursing as competent help may be. Elstad (2014) points out that in order to explore what competent help can consist of, the researcher must look where the nurse is looking, i.e. at the patient. In this study, the scientific approach was to explore how patients experienced receiving help during acute psychosis. This study has an understanding of acute psychosis as a changeable condition over time and nursing care must always be adapted to the patient's condition and situation (cf. Barker & Buchanan-Barker, 2005). In order to explore what competent help can be, help is examined during the course of acute psychosis (cf. Elstad, 2014: 21).

Patients' experience of nursing care during acute psychosis is the source of greater insight into what competent help during acute psychosis may consist of. It raises questions about how new understanding and new knowledge can be gained through experience. Experience is understood here as something that is (Rundquist & Barbosa da Silva, 2000; Elstad, 2014). In nursing practice, the nurse must relate to the patient's experience of illness as well as to her observations of the patient's condition. She should not question whether the experience is true or not. In some contexts, the experience expressed by the patient will be different from the nurse's experience of the very same

¹⁸ The research team consisted of the three authors of Articles 1, 2 and 3.

situation or an event that has involved both of them. However, in order to understand what nursing care is, the researcher must consider the patient as a subject who experiences (Buber, 1966).

According to Buber (1966), experience is experienced by a person who is always in relation to another person about something. In this understanding, experience is both subjective and relational.

Experience can provide insight into what the patient and nurse have in common, in this case the care as something the nurse provides and the patient receives.

The patient's experience of receiving help is essential for the researcher to understand competent help. Consideration of the patient's understanding may challenge, and change, the researcher's preunderstanding of nursing care and new understanding may evolve. In nursing practice, the nurse's understanding is challenged every day by new patients and new situations. In research, understanding may be challenged and developed systematically. Elstad (2014), drawing on the German philosopher Hans George Gadamer, shows that understanding is a movement from understanding something as something, through the meeting between one person's and another person's understanding of something, which disturbs the first person's understanding, to the possible development of a new understanding. A circular movement of understanding thus appears, which is the basis for the formation of knowledge.

5.2 Study design

In view of the lack of studies on competent help for patients with acute psychosis, the chosen design was qualitative. Qualitative studies are suitable when the aim is to understand a human phenomenon or event, human actions and interpersonal interactions (Polit & Beck, 2012). However, qualitative studies must have a specific methodological design, with methods suitable to answer the problem, research question, or defined aim of a study (Polit & Beck, 2012). The aim of this study is to explore and describe what competent help during acute psychosis can be for patients in acute psychiatric wards, and it was therefore desirable to obtain detailed data-based descriptions of what helped these patients to feel better. This necessitated a qualitative study with an exploratory and descriptive design (cf. Polit & Beck 2012: 505).

Qualitative research interviews, inspired by Elliot Mishler (1991), were used in this study. Qualitative research interviews have been compared to a conversation between the interviewer and the interviewee about the area under study (Mishler, 1991). Such interviews are a suitable method when the researcher wants data that provide detailed descriptions of what is being explored. To obtain detailed descriptions, Mishler (1991) recommends that the interviewer use open-ended questions to allow the person being interviewed to provide detailed answers. In the interviews, the interviewer must listen attentively to the person to be able to ask for detailed descriptions and relevant details and must be aware of when it is appropriate to ask, in order to avoid interrupting the person's answers. In the conversation between the researcher and the participant, a new understanding of the area under study may develop through questions and answers, and new, deeper questions and answers (Mishler, 1991).

Qualitative content analysis based on Graneheim and Lundman (2004) was chosen as the method of analysis. This method allowed for data-based descriptions (the manifest content) of the area under study and further interpretation of the meaning of the content of the resulting texts (the latent content). Qualitative content analysis is suitable when the area being studied is small or poorly described previously (cf. Graneheim & Lundman, 2004; Vaismoradi, Turunen & Bondas, 2013; Elo, Kääriäinen, Kanste et al., 2014).

5.3 Implementation of the study

The study was conducted in three parts:

Study 1 explored and described participants' experiences of becoming psychotic before receiving psychiatric help and being admitted to an acute psychiatric ward.

Study 2 explored and described participants' experiences of the help they received during acute psychosis in an acute psychiatric ward.

Study 3 explored and described participants' experiences of becoming ready for discharge from an acute psychiatric ward following acute psychosis.

5.3.1 Setting

Four acute psychiatric wards in two hospitals in Norway participated in the study after the hospital management had been approached¹⁹ and approved participation and data collection as described in the research protocol for the study. The wards each accommodated 10-12 patients and were located in medium-sized towns in Norway with responsibility for emergency assistance to people with serious mental conditions, such as acute psychosis. An acute psychiatric ward contains patient rooms, which are generally en-suite single rooms, a living room, a dining room, TV rooms and a corridor to connect the various rooms. In addition, there are rooms where therapists and nursing staff work, rooms where patients and staff work together, and visiting rooms. The wards may contain rooms or units designed for the care of patients secluded²⁰ from other patients and from the ward as a whole. Most acute psychiatric wards in Norway are closed units²¹.

Doctors and psychologists responsible for patient treatment were employed on the wards. For all aspects of care of patients, nursing staff with or without a specialization in psychiatric nursing or mental health care were employed. The treatment and care of a patient are planned by the patient's treatment team, which consists of the patient himself, and usually two nurses and one therapist. The patient's contact person is a nurse, who is responsible for giving the patient the help he needs on a 24-hour basis during the course of his illness.

5.3.2 Recruitment of participants

The study participants were recruited from patients admitted to acute psychiatric wards. The inclusion criteria were that they spoke Norwegian, were over 18, had a severe mental disorder, and were acutely admitted, either voluntarily or involuntarily. Further, patients had to be considered competent for research participation by their therapist before being invited to participate. Patients signed an informed

¹⁹ A formal request was sent by the main author of the articles to the management of the acute psychiatric wards of two hospitals in Norway.

²⁰ This is a particular Norwegian form of seclusion, known as 'skjerming' (shielding), where the patient is not isolated from staff.

²¹ In closed units, the main doors of the ward are locked and only the staffs have the keys. Patients ask for the doors to be unlocked when leaving and entering the ward.

consent form for participation. The qualitative research interviews were scheduled to take place in the hospital during the patient's stay in the acute ward. Patients who were to be discharged within three days of admission were not asked to participate, as interviews were difficult to arrange in such a short time.

The doctor in charge, the ward nurse, and a designated research contact in each ward were responsible for selecting candidates for participation, based on the inclusion criteria. Each patient received oral and written information about the study from the research contact (Appendix III). The candidates had two days to decide whether to participate, and were offered the opportunity to meet the researcher who was to conduct the interviews before deciding whether or not to participate. Two candidates met the researcher and stated that this meeting was an important factor in their decision to participate. Twenty candidates were invited and 14 returned a signed informed consent form. Two of the 14 were discharged from the ward before an interview could be conducted. The patients were participants in Studies 1, 2 and 3.

5.3.3 Participants

Twelve patients, four men and eight women, aged from 18 to 64 years, took part in the study. The participants stated that they had a psychotic disorder that had been diagnosed at previous admissions. At the time of the interview, one of the participants was without housing. All participants stated that they had contact with nurses and other health workers in primary care and at the local DPS when they were at home.

Table 1. The participants	
Number	12 participants
Gender	8 women and 4 men
Age	18-64 (2: 18-25; 0: 25-35; 4: 35-45; 5: 45-55; 1: 55-65)
Self-reported diagnosis	4 reported schizophrenia, 1 paranoid schizophrenia, 5 bipolar disorder including psychosis, 2 drug-related psychosis
Voluntariness	8 involuntarily, 4 voluntarily admitted
Housing in flat or house	11
Homeless	1
Living alone	3
Living with a partner and/or other family members	8
Full- or part-time studies, work or activities	8
Duration of this acute inpatient stay in weeks	1-8

5.3.4 Interviews

The qualitative research interviews were planned and conducted in a semi-structured form (cf. Mishler 1991). The interview guide was designed with questions on participants' experiences of nursing care from the time they were admitted until discharge was being planned (Appendix IV).

All interviews were conducted at the hospital, in suitable rooms outside the ward. Interviews were recorded digitally. The introductory question was: Can you tell me what brought you here to the acute psychiatric ward? According to Barker and Buchanan-Barker (2005), this is a suitable question in clinical interviews with acutely admitted patients to give them the opportunity to describe the

background to their admission in their own words. Their understanding and terminology regarding how they experienced nursing care during the various phases of their stay were carefully noted by the interviewer as topics to return to and explore further in order to elicit their detailed descriptions of nursing care.

Interviews were conducted from December 2008 to June 2009. Each participant was interviewed once and interviews lasted from 50 to 90 minutes. They were recorded as digital audio files and transcribed²² word-for-word to form an interview text that comprises the study data. The total length of the text was 312 pages in font size 12 with 1.5 line spacing.

5.3.5 Analysis

Stepwise qualitative content analysis inspired by Graneheim and Lundman (2004) was used to analyse the interview text. The text was initially read closely by the researchers to gain an idea of what it was about as a whole and to identify different content areas. The text was sorted into three content areas that became the units of analysis in Studies 1, 2 and 3. Each unit of analysis was further analysed, guided by Graneheim and Lundman's (2004) description of the stepwise procedure.

The first step in the analysis was to gain an overall understanding of the interview text in the units of analysis of each of the three studies. The text was then divided into meaning units²³, which were condensed, coded and sorted according to similarities and differences, and arranged in groups of sub-categories. The sub-categories were then organized and constructed into categories in relation to the study aim, and illustrated in tables. The final step of the analysis was to read the categories and related sub-categories through the question: What are the descriptions about? Graneheim and Lundman (2004) recommend looking for elements that link up the categories, like looking for a thread of meaning that runs through the results. The interpretation of what linked the categories was formulated as a theme in each study.

²² The main author of the three articles transcribed the interviews to an interview text.

²³ A meaning unit is a constellation of words or sentences that relate to the same central meaning (Graneheim & Lundman, 2004:106).

When using content analysis, researchers are advised to decide whether to focus on the manifest or latent content of the text (Graneheim & Lundman, 2004). This decision must be seen in relation to the aim of the study. In the present studies, the researchers searched the detailed descriptions (the manifest content) and the interpretation of the meaning of the content (the latent content) according to the purpose of each study. For this reason, coding of meaning units was kept at a low level of abstraction, i.e. close to the descriptive content of the text.

5.4 Ethical reflections

The study was approved by the Regional Committee for Medical and Health Research Ethics (REK 2012/2013²⁴) and the Norwegian Centre for Research Data (NSD15721/2006²⁵) (Appendix I and II). Due to delays in conducting the analysis, an extension was sought for storing the code key that linked the participants to the data, which was approved. The code key was deleted during 2015 when the analysis of the interview text was completed.

The study was planned to conform to key ethical principles for health research (WMA, 2013). Nevertheless, some aspects of ethical reflections following the research process are of particular importance in this study and are discussed here. All health research is based on informed consent by the participants. To provide informed consent to participate, potential participants must receive information on the study and understand the implications of the invitation to participate, as well as the advantages and disadvantages of participating in the research. This meant that particular attention was paid to ensuring that those responsible for recruiting participants and those who selected candidates and provided oral and written information and an invitation to participate, were specifically instructed to assess whether participants were capable of giving informed consent and to make sure that each person understood what he was being asked to do. This assessment was particularly related to ensuring that participants with a psychotic disorder, which may periodically affect a person's understanding and ability to make decisions, understood what participation in the research implied and the fact that it

²⁴ The study was first approved in 2006 by REK (110/2006) and notified as amended in 2008. It was later registered as REK 2012/2013.

²⁵ Responsibility for privacy and data security was formally transferred to the regional health authority in 2009.

could involve both advantages and disadvantages (cf. Smith, 2008; Beebe & Smith, 2010; Hategan, Parthasarathi & Bourgeois, 2014).

Some participants had been admitted on the basis of a decision on compulsory care. Researchers have highlighted that patients admitted involuntarily may feel compelled or obliged to participate in research when invited to do so during hospitalization (Hem, Heggen & Reuter, 2007; Hategan et al., 2014). For this reason, it was emphasized in the recruitment that the research contact who invited the person to participate should not be involved in treatment or care of the patient. This was a way to mitigate participants' feeling of compulsion. Further, when the researcher met the participants, the researcher ensured that each participant were able to participate in the research and understood that he or she could freely withdraw from the study at any time without any consequences for their treatment in the ward.

The participants in this study were acutely admitted due to psychosis. This may suggest that they could have been particularly vulnerable to emotional reactions related to being interviewed about their condition and situation. They were therefore informed orally and in writing that they could have emotional reactions during and after the interview. Before the interviews began, the researcher explained that the participants themselves could decide how much detail and depth they wanted to provide in their descriptions and that they could ask for breaks as needed. They were also told that the research contact would help them if they had emotional reactions that they felt they needed to talk more about with their therapist in the ward.

In addition, participants shared their experiences in detail with the researcher in the interviews. In the articles based on data from a small number of participants, emphasis was placed on describing the psychosis and the nursing care in such a way that the participants could not be identified. The quotations were modified and the participants' identity was obscured to prevent recognition by others.

5.5 Methodological considerations

Researchers have discussed various concepts and strategies to ensure credibility in qualitative studies (Lincoln & Guba, 1985; Morse, Barrett, Mayan et al., 2002; Graneheim & Lundman, 2004; Elo et al.,

2014; Graneheim, Lindgren & Lundman, 2017). Lincoln and Guba (1985) outlined five criteria for evaluating trustworthiness in a qualitative study: credibility, dependability, conformability, transferability and authenticity²⁶. Qualitative researchers have used the concept of trustworthiness, but instead of evaluating trustworthiness through evaluation criteria, Graneheim et al. (2017) have argued that trustworthiness is assured through critical questions, reflection and collaboration between researchers in a team throughout the research process and step by step in a particular study.

Credibility in qualitative studies depends on a well-planned research study, with a clear background, a reliable sample of participants that can provide rich data on the area under study and an analysis that ensures validity and demonstrates a clear association between the data and the results (Elo et al., 2014; Graneheim et al., 2017). In the present study, the aim of the dissertation and selection of the study area seem to have a clear connection to the context and the research background.

In the present study, the researchers were interested in data with detailed qualitative descriptions of the area being explored. This called for critical discussion and reflection on who might have relevant experience of the area (cf. Robinson, 2014; Graneheim et al., 2017). Patients who themselves have experienced acute psychosis and nursing care in an acute psychiatric ward were chosen as study participants, as their experiences represent an invaluable source to describe the content of competent help during acute psychosis. However, it may be questioned whether descriptions by patients with psychosis, which partly involves perceptual aberration, will provide reliable data. Researchers have pointed out that reliability does not depend on whether participants have a diagnosis such as a psychotic disorder, but on whether they have the opportunity to articulate and describe their experience of psychosis and the help they receive (cf. Carpenter, Gold, Lahti et al. 2000; McGorry et al., 2008).

This study had a limited number of 12 participants, which may seem to be a small sample. However, Graneheim et al. (2017) indicate that reliable data for qualitative content analysis do not depend on the size of the sample, but on whether the data are rich in content and suitable to provide nuanced and

²⁶ The fifth criterion was added in 1995 by Lincoln and Guba.

detailed descriptions of the area being studied. In the present study, as Elo and Kyngas (2008) suggested, a preliminary analysis of the data was performed by the first and third authors of the articles during the data collection in order to gain an overview of the content of the data and an idea of when the interviews did not provide any new information on the study area. After the twelfth interview, the interviews provided no new information, and no more interviews were conducted.

The qualitative research interviews were conducted as conversations, which were open and resembled a dialogue between equals. However, the conversation was guided by the researcher to the specific areas being explored in the study. In this way, there was asymmetry between the two parties and Wifstad (2018) points out that a qualitative research interview is a professional conversation and the reliability of the data depends on the researcher knowing which topics she is exploring. However, qualitative interviews, being thematically structured through questions, involve a certain risk that the interviewer's structure will dominate over listening to what the participant has to say, where the interviewer is seeking confirmation of her own preunderstanding (cf. Wifstad, 2018).

The interviews dealt with events in a period when the participants had experienced acute psychosis, which can be a sensitive and difficult topic but also good to talk about (cf. Frank, 1995). Interviewing participants about nursing care during psychosis required the researcher to be sensitive and responsive to what was being said, to judge when she could ask new and exploratory questions, and to listen closely to the words used by participants in their descriptions. Their words and concepts were then used again by the researcher in exploratory questions rather than introducing the researcher's concepts, which might have disrupted the participants' understanding of what they were describing. The interviews were held in rooms outside the acute psychiatric ward in each hospital. It was important to be in rooms where the interviews would not be disturbed, which were also large enough to allow participants to walk around the room as they talked, which a number of participants preferred to do. This also required a microphone powerful enough to provide good audio recordings of the interviews.

The interviews were conducted from December 2008 to June 2009. One may question whether data collected ten years ago are reliable enough to address the aim of the dissertation and whether the dissertation is relevant today. People's experiences of psychosis refer to conditions and disorders that

do not change over time. People's need for help and care during psychosis also seems to be a fundamental human trait, although the organization of nursing care has changed during the history of nursing (Lysnes, 1982; Mathisen, 2006). However, the field of study, the acute psychiatric ward, has been organized in the same manner for the past ten years and recent inspections of acute psychiatric wards show that the data in this study are highly relevant and the study itself appears to be relevant by producing knowledge that can improve such wards (cf. Civil Ombudsman, 2016, 2017, 2018).

In the analysis, the researchers were aware that the stepwise guide for qualitative content analysis described by Graneheim and Lundman (2004) has both advantages and limitations. Firstly, this method of analysis was advantageous for a novice researcher by providing her with a stepwise analysis process to follow. In this method of analysis, collaboration within the research team to agree on the interpretation level of the data, the use of codes, and the construction of sub-categories, categories and themes was presented as a strategy to ensure credibility in the analysis (Graneheim & Lundman, 2004; Graneheim et al., 2017). At the same time, detailed guides for analysis may constrain the necessary creativity that inspires researchers to explore further. In this context, it was important that the experienced researchers (the second and third authors) in the team could challenge the method of analysis and let the data lead the way in the analysis, which Elo et al. (2014) and Graneheim et al. (2017), emphasize as the strength of content analysis. In this study, where the data-led descriptions were of greatest importance, the level of abstraction was kept low in the analysis and there is thus a clear connection to the data in the results.

In the analytical steps as described by Graneheim and Lundman (2004), the significance of the researchers' preunderstanding is not explicitly discussed. However, this was an aspect of dependability (Graneheim et al., 2017). In this study, preunderstanding was discussed in the collaboration between the researchers and challenged throughout the research process to prevent it from unconsciously influencing the interviews, the analysis of the text, and the interpretation and construction of categories that form the structure for communication of the results. Sandelowski (2011) has introduced a number of researchers with different backgrounds as a way to address dependability.

Credibility in a qualitative study depends on the transferability of the study in the research process leading to the results (Elo et al., 2014). In the present study, the analysis process was reported step by step in the articles with examples of the abstraction and interpretation process in tables and figures (cf. Graneheim and Lundman, 2004). The credibility of a study can also be understood in terms of whether the results correspond with previous research. The results of this study show that competent help during acute psychosis has a core meaning: patients must receive acute critical care that is adapted to their particular acute psychotic condition and the experience of being acutely critically ill is important to endure and overcome acute psychosis. The results are consistent with a previous study that showed that nursing care helped patients through acute psychosis (Koivisto et al., 2004). The results also correspond in greater detail with personal accounts of psychosis such as the experience of being critically ill and in need of care for a period (Grant et al., 2014). In this way, the results are credible in that they agree with other research and accounts, but offer a new way of understanding what competent help can consist of (cf. Graneheim & Lundman, 2004; Graneheim et al., 2017).

6.0 RESULTS

With the aim of the dissertation clearly in mind, the results of Articles 1, 2 and 3 are presented. The results of the three articles are based on data from interviews with the same 12 participants about their experiences of nursing care during acute psychosis. The results are presented in the chronological order the articles were published.

6.1 Becoming psychotic

In Study 1, the aim was to explore and describe how patients with a psychotic disorder, admitted to an acute psychiatric ward, experienced becoming psychotic prior to admission. Being psychotic was described as different ways of being in a transition to psychosis. The results provide insight into the differences between participants' experiences of becoming psychotic and how they were helped to admission to the acute psychiatric ward.

Some participants described having noticed small early changes in their condition they recognized and described as familiar signs of psychosis. Despite measures they had previously found could halt or reduce psychosis, their physical and mental turmoil increased, with insomnia, poor concentration in everyday activities, and the insecurity and fear connected to being at home while becoming ill with a severe psychosis. The participants understood that they needed help and went to see clinicians in the emergency ward or at their local surgery. They were immediately admitted to the acute psychiatric ward and accepted this.

Other participants described acute changes in their condition as sudden unexpected signs of psychosis. They were overwhelmed by psychotic symptoms and struggled to maintain control over themselves and their actions. They were unable to verbally express their condition to others. Family members saw them and understood the acute psychosis and sought help from health professionals, who then visited the participants' homes and talked to them and their relatives. The participants received immediate help, and expressed gratitude for being understood as acutely psychotic and critical ill by their family members and health care professionals and accepted admission to the acute ward.

Another group of participants described changes in their condition as unclear signs of becoming ill. They had noticed something was wrong long before being admitted; they had felt ill and sought help. But they were not offered mental health help. The changes in their condition continued. Some participants described experiences such as increased energy, clarity and drive. Other participants described increasing hallucinatory voices that supported and loved them and punished and disciplined them. This group of participants was mostly alone, some staying in bed for some time and others rushing around and doing things that made others react. At a certain point, health professionals came to their home to intervene, with or without police assistance. They became frightened and refused the help they were offered. They were taken away for examinations and admission to an acute psychiatric ward against their will. In retrospect, they wished that clinicians had understood how ill they were and contacted their family members who could have assisted them in admission.

When the participants themselves or their relatives asked for help and used words such as psychosis, they received immediate help. By contrast, those who did not describe their problems as psychosis seemed to be offered help much later and then in some cases against their will.

6.2 Confirming mental health care

Study 2 explores how psychotic people experienced nursing care in an acute psychiatric ward as help to feel better. The central finding was that nursing care that acknowledged participants as acutely psychotic and critically ill helped them gradually to endure acute psychosis, to get through their acute critical illness and to feel better.

The participants described being acutely psychotic and ill as being unable to do anything; they could not speak, much less describe their condition and needs to the nurses in the acute ward. They described nursing care that confirmed them as psychotic and ill as help as follows: the nurses understood them as acutely psychotic and ill and helped each one of them with nursing and care actions adapted to the individual's condition and situation. The nurses were with the participants around the clock, taking care of them to prevent them harming themselves or acting inappropriately. The nurses provided the participants with food and drink and helped them with personal care and to

sleep. The nurses asked few questions and acted quietly, firmly, securely and safely. Such nursing care helped the participants to endure their acute psychosis.

The acute psychosis subsided and the participants were able to explain their psychotic symptoms and problems to the nurses and physicians. They were invited to discussions about nursing care and medication that could help them. They described how the important part of these talks was to come together to find solutions and helpful measures. This collaboration strengthened the relationship between participant, physician and nurse. The participants felt that the nurses and doctors respected their experiences and opinions and they, in turn, expressed respect for the knowledge and expertise of the doctors and nurses.

When the participants were feeling better, the nurses helped them to think about their home situation. Participants had meetings with their family members, clinicians from the acute ward and primary health care staff. At these meetings, they apologized to their family members for situations that had arisen because of their psychosis, and made a plan for discharge and follow-up care at home. Participants felt reassured that they would receive help at home if they became acutely psychotic again.

The results show that nurses have the knowledge and skills to help acutely psychotic, critically ill patients, who are unable to speak or look after themselves, to get through acute psychosis.

6.3 “I want to go home, but I need to stay”

Study 3 explores and describes participants’ experiences of becoming ready for discharge from an acute ward following acute psychosis.

Participants described how they wanted to return home as soon as possible after acute psychosis, but they also knew that they needed to stay on the ward longer before being ready for discharge. They described their condition after acute psychosis as being physically exhausted and mentally fragile, with an unclear situation at home. They needed to become physically stronger and in better mental balance, and to be more certain about their home situation, if their family members were ready to get

them back home and about their own ability to cope at home without soon becoming psychotic again. Participants recovered quickly when they were given the time they needed in the ward and follow-up care and support by nurses.

Some nurses did not appear to realize that after acute psychosis, the participants needed time, support and help to get ready for discharge. Participants became insecure and afraid of being discharged prematurely and becoming acutely psychotic again.

6.4 What do the results tell us?

The results in Articles 1, 2 and 3 show how patients admitted to acute psychiatric wards described help in different contexts: to be admitted to the ward, to receive care when they were acutely psychotic, and to get ready for discharge from the ward. The results were considered across Articles 1, 2 and 3 in relation to the question: What do the results tell us about competent help during acute psychosis?

Firstly, the results show that the participants were in an acute psychotic state and critically ill and thus needed immediate help. They described receiving competent help when they were safely cared for in the ward, when they met nurses who had good knowledge of psychosis and understood them as acutely psychotic and critically ill and, receiving nursing care adapted to them as individual sick people, which also assured their dignity.

Few researchers have explored and discussed the care provided by nurses in acute psychiatric wards as competent help during acute psychosis. To gain greater insight into what competent help during acute psychosis may consist of, the results are further discussed through the question: *What aspects of nursing care practices are of central importance in enabling acutely psychotic patients to receive competent help during acute psychosis?*

7.0 DISCUSSION

The aim of this dissertation is to explore and describe what competent help during acute psychosis may be for patients with a psychotic disorder who are admitted to an acute psychiatric ward.

The present study highlights some key aspects of nursing and care practices of central importance in enabling patients admitted to acute psychiatric wards to receive competent help during acute psychosis. Firstly, the acute psychiatric ward as a setting seems to be important. Secondly, nurses' knowledge of patients' acute psychotic state and of individual patients as acutely critically ill also appears to be significant. The third aspect that seems important for the provision of competent help during acute psychosis is nurses' critical care practices for acutely psychotic and acutely critically ill patients.

7.1 The acute psychiatric ward: A setting for nursing care for people with acute psychosis

Despite radical changes in the organization of mental health services, with a reduction in specialist mental health care and a comprehensive expansion of a variety of primary local mental health services, acute psychiatric wards are essential in providing competent help to patients with acute psychosis.

Acute psychiatric wards in specialist mental health care have been mandated to provide immediate help, treatment and necessary nursing care to patients admitted due to severe mental disorders (cf. Mental Health Act, 1999). The present study indicates that the acute ward as a setting and the structure of nursing and care work in the ward are important for the provision of high-quality nursing care to patients during acute psychosis.

7.1.1 The design and atmosphere of the rooms

How important are the design and atmosphere of the rooms in acute psychiatric wards for the provision of nursing care to patients? Acute psychiatric wards, as settings for treatment and nursing care, have for many years been studied and discussed by researchers. On the one hand, acute wards

represent confinement, power and control over patients (Quirk & Lelliot, 2001; Norvoll, 2007; Shattell et al., 2008; Skorpen, Andersen, Øye et al., 2009; Øye, Bjelland, Skorpen et al., 2009; Salzmann-Erikson & Söderquist, 2017). On the other hand, acute wards represent a safe and secure setting for patients (Quirk et al., 2006; Shatell et al., 2008; Salzmann-Erikson & Söderquist, 2017; Wyder et al., 2018). Discussions of acute psychiatric wards in previous studies have largely revolved around whether or not the treatment provided in contemporary wards can be understood in light of the tradition of psychiatric care where patients were detained in closed institutions (cf. Goffman, 1961; Foucault, 1961/1991). The present study highlights the acute psychiatric ward as a safe and secure place to arrive at for patients with acute psychosis where they receive nursing care as competent help during their psychosis (Articles 1, 2 and 3).

In nursing, the design of hospital buildings, the design of rooms in wards and the atmosphere in the rooms have traditionally been important aspects to take into account (Lysnes, 1982; Martinsen, 2000; Mathisen, 2006). The Norwegian architect Norberg-Schulz (1992) pointed out that the architecture of buildings reflects their function and that the architecture influences the function of the buildings and what takes place there. The history of the building, the design of its rooms and the atmosphere in the rooms must be considered when attempting to understand the importance of a building and its rooms (Norberg-Schulz, 1992). The architect Bergsland (2008) has pointed out that good architecture can create good hospital buildings, functional rooms in wards and a pleasant atmosphere in the rooms that can make the ward a suitable place to help people with mental disorders. Bergsland's (2008) ideas about the design and atmosphere of the rooms adapted to the function of acute psychiatric wards are strongly reminiscent of Nightingale's thinking on good rooms where patients can be and receive nursing care.

The design and atmosphere of the rooms in today's acute psychiatric wards may be understood in relation to nursing history. Florence Nightingale (1997) stated that rooms in wards must be designed for sick patients, for the nursing and care of the patients throughout their illness, for their recovery and for their protection from degrading and harmful treatment during their stay. In Norwegian asylums and later psychiatric hospitals in the last century, nursing thinking was clearly visible. Lysnes (1982)

described how the newly appointed head nurse Marie Sundet at Faret Asylum in 1916 was keen to ensure that the asylum rooms were designed to enable the care staff to be with the patients, observe them and monitor their condition in order to help them with everyday tasks. In order to create dignity and a pleasant atmosphere in the rooms for the patients, nurses decided that the beds had bedclothes, the ward rooms had curtains, tablecloths and furniture, and patients were now served food on plates instead of in zinc bowls (Lysnes, 1982). Lysnes (1982) pointed out that the nurses in the asylums created an atmosphere that would protect the involuntarily admitted patients and make life pleasanter for them.

Today's acute psychiatric wards must be adapted to the function of receiving patients with acute and severe mental illness for short-term secure, responsible care and treatment. Bergsland (2008) pointed out that rooms in psychiatric wards must be designed to enable people with mental illness to cope with staying there. The rooms should in themselves make the stay easier for patients. This means that the arrangement should enable patients to find their way around, with a room structure familiar from other hospital wards, where the rooms have a clear function, e.g. patient room, bathroom/toilet, living rooms, dining room, TV room, meeting rooms and nurses' rooms such as duty rooms, handover rooms and medicine rooms. Rooms must be light and airy, patients must be able to get outdoors into the fresh air and there must be opportunities for them to be active. Such wards can help patients to recover, according to Bergsland (2008). Further, rooms in psychiatric wards must have an atmosphere of security and safety for patients, and the buildings and interiors must be designed with security and safety in mind, but without being like prisons (Bergsland, 2008). Bergsland's requirements for the architecture of psychiatric wards are similar to those aspects for acute psychiatric wards highlighted in the Norwegian Mental Health Act (1999).

In the present study, the importance of good patient rooms was presented through descriptions of how the acutely psychotic and critically ill patient was in the patient room with nurses who provided assistance with personal care, served food and performed everyday tasks in a safe, calm and quiet atmosphere. In other words, patient rooms must be suitable for the provision of nursing care. Research on nursing care for acutely mentally ill people emphasizes the nurse's presence with the patient, to

create a feeling of security, to observe and assess the patient's condition and to provide care adapted to the patient's severe and critical mental state and generally comprehensive and complex care needs (Koivisto et al., 2004; Bowers et al., 2005; Cleary et al., 2012; Salzmann-Erikson & Söderquist, 2017). Comprehensive and complex needs may be variously expressed by the patient, with behaviour ranging from being very frightened and withdrawn from other people to being very anxious, agitated and aggressive towards others.

The Norwegian Mental Health Act (1999) and related regulations emphasize that acute wards must have appropriate rooms for seclusion of patients, when a patient is assessed as likely to embarrass himself or others or pose a risk to his own or others' health or life. Seclusion, which is now regulated as a coercive measure, has been developed on the basis of psychodynamic thinking that patients can improve if they have fewer impressions to process. Seclusion is not based on evidence that it helps patients recover as an environmental therapeutic measure (Norvoll et al., 2015). However, this study indicates that patients in states of acute psychosis who feel acutely critically ill need suitable rooms where there is no risk of self-harm and where nurses can be with patients continually, and where intensive critical care can be provided and received. Suitable patient rooms can enhance the possibility of providing safe, secure and competent help to patients.

In the present study, the acute psychiatric ward was described as a safe and secure setting, with a quiet and calm atmosphere and nurses who noticed the patients and provided them with good nursing care during acute psychosis. Other studies have described how admission to the acute ward rescued patients from chaos, threats and great insecurity in their home environment (Deacon et al. 2006). Further, routines, order and clarity in the acute ward provided a feeling of security and helped patients to achieve routines and order themselves (Shattell et al., 2008; Wyder et al., 2018). Bergsland (2008) described the importance of designing psychiatric wards where patients can see nurses and be seen by them without having the feeling of being monitored. For example, the nurses' room should be strategically located, with windows that allow nurses and patients to see each other, which enhances patients' feeling of security. These descriptions are reminiscent of Nightingale's (1997) philosophy that highlights seeing and observing the patient as a pillar of good nursing care. However, seeing and

observing patients may also be understood as control and power over them (Salzmann-Erikson & Söderquist, 2017). In this context, the Norwegian nursing philosopher Kari Martinsen (2000) has discussed nurses' observation of patients in terms of the way they look at patients, which may vary according to the knowledge of the individual nurse. Seeing and observing patients may mean seeing patients as suffering and attempting to gain insight into their suffering, monitoring changes in their condition and watching over them (Martinsen, 2000). However, seeing and observing patients may also mean checking on them to control them (cf. Martinsen, 2000). The rooms in acute psychiatric wards must be designed to enable nurses to see and monitor patients' condition as a basis for providing competent help.

Nightingale (1997) argued that the atmosphere in the rooms of a ward must be compatible with the needs of the sick patient. The present study indicates that the acute psychiatric ward was suitable when patients were in an acute psychotic state and acutely critically ill. However, the acute ward seemed less suitable when the patients improved and prepared for discharge from hospital. The Swedish researchers Salzmann-Eriksson and Söderquist (2017) have discussed intensive psychiatric units, which could be experienced as safe and secure by patients in acute psychosis, but could be perceived as threatening, confined and limiting for patients in recovery. Other researchers have also pointed out that the room structure in acute wards, with few rooms where nurses and patients can sit down and talk, may limit nurse-patient cooperation and thus opportunities for patient involvement in their own treatment and for therapeutic processes leading to recovery (Skorpen et al., 2009; Øye et al., 2009).

Acute psychiatric wards are primarily designed for immediate help, treatment and care for acutely mentally ill patients. However, the physical structure of such wards and the atmosphere of safety and security may not reflect the requirements for openness in a ward suitable for sound nursing care for patients recovering from acute psychosis (cf. Article 3).

7.1.2 Structures in nursing and care practices in acute psychiatric wards

When patients with psychotic disorders become acutely psychotic, primary local mental health services are usually insufficient to provide competent help. Patients with acute psychosis admitted to

acute psychiatric wards generally need nursing care around the clock (cf. Thornicroft & Tansella, 2013). This requires a number of nurses, who work morning, evening and night shifts. Continuous nursing care in psychiatric wards has a fixed, familiar structure found in other wards and hospitals where care is provided around the clock. What is the significance of the structure of care work for the provision of nursing care to patients?

In nursing, the 24-hour continuous structure has been familiar ever since nursing took form as a modern field. Nightingale (1997) stated that the nurse in charge must provide structures and routines that enable several nurses rather than a single nurse to be responsible for the care of a patient. The structures may include duty rotas for nurses, procedures for transferring responsibility for patients from outgoing to incoming nurses, and fixed structures for all nursing duties, food preparation, housekeeping, cleaning, medical work and the provision of nursing care to all patients on the ward. The structures ensure responsibility for patient care around the clock, day after day (cf. Nightingale 1997).

Drawing on Nightingale's philosophy, the Norwegian nursing philosopher Ingun Elstad (2014) has explored further how 24-hour continuous nursing in hospitals and other facilities is linked to nurses' responsibility²⁷ for patients. In today's 24-hour continuous structure of nursing care, the care responsibility for each patient in the ward is handed over from one nurse to the next, via written and oral reports. The reports describe the patient's illness or disorder, what the patient is being treated for, the patient's condition, how the patient is feeling and what the next nurse must monitor and observe in order to help the patient if there is a change in his condition. The report is based on what the patient's condition has been and provides guidance for care in the immediate future based on knowledge of how the condition may change (cf. Elstad, 2014). The duty and reporting structures in nursing care and the regular procedures for what nurses write in patient reports and what they report orally emphasize that the responsibility to provide nursing care to the individual patient and to all patients is not merely a

²⁷ Ingunn Elstad (2014) refers to the German Jewish philosopher Hans Jonas (1994) who used the terms "Verantwortung für Zu-Tuendes" (continuous responsibility for one's actions) and "Verantwortung als causal Zurechnung begangener Taten" (the responsibility for actions performed in the past).

personal responsibility for the individual nurse but a shared responsibility for all nurses involved in the continuous provision of care. This joint responsibility ensures that nursing care for acutely mentally ill patients can be provided around the clock in acute psychiatric wards.

The joint responsibility for providing high-quality care to patients in the acute psychiatric ward is not only reflected in the 24-hour continuous structure. To ensure that all patients receive satisfactory care, nurses must help each other to see and understand each patient's condition in order to provide sound care to the individual patient. In nursing, the joint responsibility for patients is expressed as "working together". Working together, means cooperating on the nursing care of the individual patient and of all patients on the ward (cf. Hamran, 1992). Working together is both a way for nurses to learn care practices from each other and a way of practising nursing care in a responsible and gentle manner, especially for the acutely critically ill patient (cf. Hamran, 1992). In today's critical care nursing, which is bedside nursing, the principle of nurses working together is carefully practised in order to address the complex needs of the physically critically ill patient (cf. Elstad, 2014). In practice, working together may involve actions such as turning patients in bed. In order to perform such actions safely and responsibly, nurses employ well-practised techniques to cooperate on washing patients, changing their clothes, changing the beds and making patients comfortable in bed. Hamran (1992) showed that working together required nurses to practice this kind of patient care together, in a particular choreography of rhythmic movements in a fixed pattern, which also needed to be changed for individual patients.

In the present study, cooperation between nurses was described in relation to patients who were increasingly frightened and anxious and required a safe and considerate approach, and particular skills in communicating and interacting with them in order to provide them with the help they needed. One situation described is where a nurse came to take over responsibility for a patient from another nurse when the situation between the patient and the other nurse became too challenging and conflictual. In conflictual situations, there is likely to be an increased risk of the patient causing harm to himself or others (cf. Bowers et al., 2015). In the present study, nurses appeared to help and collaborate with each other when they saw that another nurse's knowledge and skills were inadequate, in order to provide

the best possible care for the patient. A previous study of nurses in charge on acute wards also showed that the nurses understood responsibility for patients as a joint responsibility; helping each other to observe and understand a patient's condition and providing sound practical care to the patient were established care procedures in the acute ward, especially for the most severely mentally ill patients (Sebergesen, 2002).

Other researchers have also described joint responsibility for the patient as a potential for providing responsible nursing care to patients in conflictual situations that may arise between nurses and acutely psychotic patients. Bowers et al. (2015) described collaboration between nurses in conflictual situations as key to reducing the risk of harm to the patient or others. Such collaboration involved e.g. practising approaches such as relating to the patient's fear in such a situation rather than to his agitated behaviour. In a previous study, Looi et al. (2014) showed that nurses naturally reacted by paying attention to their own safety in a conflict with a patient, which could constrain their ability to observe and their responsibility for monitoring the patient. Bowers et al. (2015) showed that nurses' shared responsibility for the patient's well-being and practical collaboration in approaching and offering help to the patient resulted in safer actions to help the patient out of conflict situations in a successful and respectful manner. Molewijk et al. (2015) have suggested how nurses can enhance their knowledge of challenging care situations in group guidance and reflection sessions with other nursing staff. Other researchers have argued that challenging nursing and caring actions could be discussed by the nurse and patient involved, possibly with the help of an external party who could lead the dialogue (Karlsson & Borg, 2013).

Hamran (1992) argued that there exists a nursing culture in which nurses work and participate that involves patterns of knowledge, opinions and skills. However, structures and routines in all cultures, including nursing care, are shaped by those who work there, and by patients and by society outside the ward. Nurses are responsible for ensuring that structures and routines in nursing care are suitable to provide the patient with high-quality care. This requires nurses to have knowledge of the basic value of the structures, namely to ensure sound patient care, and to be critical when the structures become

too fixed and inflexible, thus preventing individual patients from receiving optimal care (cf. Björkdahl et al., 2010; Enarsson, Sandman & Hellzén, 2008; Enarsson et al., 2011).

In the present study, the patient's treatment team, consisting of nurses, the therapist, the patient himself and sometimes relatives, is described as a structure that appears to be central to linking treatment and nursing care together as a whole. Barker and Buchanan-Barker (2005; 2010) have described the importance of interdisciplinary teams in acute psychiatric wards, but there is little research on this structure. However, this study described collaboration in the treatment team between the patient, nurse and doctor where the doctor took account of the patient's experience with medication, thus giving the patient a say in the planning of medication treatment. Hamann, Kruse, Schmitz et al. (2010) presented similar findings in their study, where collaboration in the treatment team appeared to be essential. However, this contrasts with the results described by Bee et al. (2008), Skorpen et al. (2009) and Øye et al. (2009) in their studies, where there were inadequate opportunities for user involvement in acute psychiatric wards.

In the present study, collaboration in the treatment team also included the patient's family members and primary care staff from the patient's local area. This collaboration seemed to involve the kind of follow-up care the participants needed at home, the risk of new acute psychotic episodes and plans for what the participant and family members could do in a new crisis. Previous studies have highlighted such cooperation important to reduce early readmissions for the discharged patients (Manuel et al. 2012; Loch, 2014). In the present study the patients appreciated collaboration that included their family and local health professionals; this helped them feel more secure and ready for discharge from the acute ward. Other studies have shown that working methods in acute psychiatric wards can include cooperation with the patient's family and other networks, which patients and family members found beneficial during acute mental illness (Emaus, Dahl & Sebergesen, 2016; Jacobsen et al., 2018). Responsibility for the patient's need for treatment and nursing care does not appear to be limited by nurses to the stay in the acute ward; instead it follows the patient out of the ward with an eye on where he or she normally lives his/her life, i.e. his/her home.

The structures of nursing and care in acute psychiatric wards seem to be of central importance for nursing and care practice as competent help during acute psychosis. However, these structures must be open and allow for flexible solutions in order to provide sound care to the individual patient.

7.2 Being acutely psychotic and acutely critically ill

The kind of knowledge that forms the best basis for providing optimal nursing care is subject to debate in mental health nursing (cf. Barker & Buchanan-Barker 2005; 2009; Hummelvoll, 2012). The present study indicates that nurses in acute psychiatric wards used knowledge of psychotic disorders, of patients' acutely psychotic state, and of the individual patient as acutely critically ill to provide sound nursing care to patients with acute psychosis. How important is this knowledge for nursing and care practices for patients with acute psychosis?

In their basic nursing education, nurses learn about various mental states that can be diagnosed as psychotic disorders. However, discussions about knowledge of mental disorders in general and psychotic disorders in particular are often linked to the question of which knowledge forms the basis for diagnoses of mental disorders (Nordenfelt 2007; Barker & Buchanan-Barker, 2009; Aarre, 2018; Andersen, 2018). The Swedish nursing researcher Nordenfelt (2007: 7) has discussed understandings of illness and points out that the understanding that forms the basis of diagnostic manuals can be defined as follows: "A has a disease if, and only if, there is at least one organ of A's which functions subnormally²⁸, given a statistically normal environment" (Nordenfelt 2007:7). This understanding of illness links disease to functional abnormalities in at least one of the body's organs (cf. Nordenfelt, 2007) and can be understood as a "machine fault understanding" (Wiftad, 2018). This understanding separates illness as an illness from the person who is ill and is therefore narrow. Critics have suggested a comprehensive understanding of illness that includes the patient's experience of suffering and the patient's familial, social and socio-economic situation as aspects of importance for the development of mental illness (cf. Nordenfelt, 2007; Aarre, 2018). In mental health nursing, diagnoses of mental

²⁸ Here Nordenfelt (2007) is referring to Boorse, C. (1997), "Rebuttal on health" in J.M. Humber and R.F. Almeder (eds.) *What is a disease?* New Jersey: Biomedical Ethics Reviews, Humana Press.

disorders have mainly been criticized as an unsuitable basis for providing nursing care to patients, based on the idea that the aim of diagnosing an illness or disorder is to guide the content of the treatment of the mental disorder (Barker & Buchanan-Barker, 2009). Nursing is not treatment; it means helping people to prevent mental illness, helping them during mental illness and helping them to feel better and if possible to recover (Barker 2001ab). Nurses therefore need knowledge that enables them to understand people with a mental disorder, their sometimes severe and painful condition and the situation of the individual as a mentally ill person (Barker & Buchanan-Barker, 2005) and as a sufferer (Hummelvoll, 2012). In other words, nursing must be based on the human being, the patient, who is experiencing mental illness and not primarily on the mental disorder the person has. This thinking corresponds to Nightingale's ideas about disease, illness and the individual as a sick person.

Nightingale's thinking suggests that nurses must know what diagnoses of psychotic disorders are, but they must also know what such diagnoses are not. Nurses must know that acute psychosis can be experienced as being in an acute psychotic state (cf. Nightingale, 1997). The term state or condition indicates a human quality and is used by nurses to describe a patient's general condition, state of illness or psychotic state (cf. Elstad, 2014). Knowledge of different conditions forms part of nurses' knowledge base to enable them to monitor changes in a patient's condition, based on characteristics of the particular state of illness and of the specific patient, in order to provide individualized high-quality patient care. The present study showed how nurses understood patients' acute psychotic state even though they had not described to the nurses how they felt. One can imagine that the nurses in the acute ward had knowledge of acute psychotic conditions through their knowledge of psychotic disorders in general and their experience of caring for many patients with acute psychosis. The nurses provided care to the participants with an approach that demonstrated that they understood the acute psychotic condition as clearly different from the participants' usual condition, and that the psychotic state was critical but temporary and could be alleviated with good nursing care. The nurses understood that the acute psychotic state was overwhelming, frightening and almost unbearable for the patient and that the patient was acutely critically ill.

Nurses' basic education provides them with knowledge of how patients can express being critically ill. In a nursing textbook, Travelbee (1999) described how being ill can be expressed in many different ways but the essence is that the patient is unable to look after himself and everyday tasks due to the illness. The nursing researcher Morse (2000) described from a study that nurses appear to know different ways patients express being critically ill and they recognize different expressions of illness, even when the patient is not physically ill or injured but is ill in connection with a traumatic and critical event. In the current study, the patients described how they realized that the nurses understood their acute psychotic state and their situation as acutely critically ill from the way the nurses behaved and provided care that was carefully adapted to the psychotic state and to the individual as acutely critically ill.

Psychotic patients' experiences of being ill have not been widely discussed and described by researchers who have investigated patients' experiences of psychosis (Leiviskä Deland et al., 2011; McCarthy-Jones et al., 2013; Kaite et al., 2015). This may be because researchers in nursing and mental health care generally avoid terms such as illness and "being ill" about patients' experiences with psychosis, which may be a way to distance themselves from a biomedical understanding of illness that links psychosis to a malfunctioning bodily organ (cf. Hummelvoll, 2012). However, patients who have experienced psychosis themselves and needed acute admission to hospital use expressions such as "I got sick completely" (Leiviskä Deland et al., 2011:34). Relatives also expressed that their family member was ill when seeking health care, for example: "Health services take me seriously when I contact them in order to get help when my wife gets *too ill* to stay at home" (Weidmand et al., 2011: 706). The authors of personal accounts of psychosis that led to admission to acute psychiatric wards described themselves as very, very ill prior to admission (Lauveng, 2013; Grant et al., 2014).

This suggests that personal or close relatives' experiences of the onset of acute psychosis are expressed in terms such as being ill or sick in order to convey that the person is unable to cope with the basic necessities of life due to a serious mental illness. Expressions such as "I am ill" are calls for help, as Toombs (1991) argued in her research on experiences of being ill and finding that one's

illness limits one's ability to look after oneself and perform everyday tasks. It may be that the results of the present study, which sought detailed descriptions of competent help during acute psychosis using an analytical method that provided data-driven descriptions (cf. Graneheim & Lundman, 2004), are consistent with how people normally refer to life-threatening conditions and situations.

Barker and Buchanan-Barker (2005) argued that patients who experienced acute mental illness were in a life-threatening condition. Being in such a condition involves a risk of breaking down completely (cf. Barker & Buchanan-Barker, 2005). We can imagine that the patients in the present study who were in acute psychosis and acutely critically ill were in a life-threatening condition. Individual patients expressed in varying degrees being unable to take care of themselves or to be responsible for others or their children, or to cope with everyday tasks, with being at home or at work, and some of them could not cope with life itself and the thought of continuing to live in their condition.

Nurses working in acute psychiatric wards appeared to have the necessary knowledge of acute states of psychosis to observe, recognize and understand individual participants as acutely psychotic and as acutely critically ill. According to Barker and Buchanan-Barker (2005), sound nursing practice that can provide competent help during acute psychosis depends on nurses understanding patients' condition as acutely psychotic and the situation of the individual ill person.

7.3 Critical care

Patients admitted to acute psychiatric wards have severe mental disorders; they may present with great fear, anxiety and may endanger themselves and others. These patients may be voluntarily or involuntarily admitted. Researchers have emphasized that nurses on acute wards must have specialized knowledge in nursing care in order to provide optimal nursing care to help patients through the acute phase of mental illness (Deacon et al., 2006; Bowers et al., 2005; Hem, 2008; Bowers et al., 2009; Cleary et al., 2012). Barker and Buchanan-Barker (2005) have argued that acute mental illness, which is a life-threatening condition, requires critical care (Barker & Buchanan-Barker, 2005). How important is critical care in giving patients competent help during acute psychosis?

The present study points out that when patients arrived at the hospital they were acutely psychotic, acutely critically ill and in a life-threatening condition. In the period leading up to their admission, the patients had become unable to perform the necessary activities of daily living. Several of them might have been drinking heavily or used drugs, injured themselves, and behaved in a way that endangered their lives. The nurses understood their critical condition and exhaustion and provided critical care with a focus on daily activities such as helping patients with food and nutrition, sleep and rest and personal care. They also helped them to endure and get through their almost unbearable state of acute psychosis. The patients described in detail how they received bodily care, which was associated with vulnerability and shame at being unable to take care of themselves, but was simultaneously received with gratitude. Receiving critical care gave the patients an experience of slowly regaining their body and themselves, becoming calmer and acknowledging that they needed help, which they described as an important factor in accepting the vital assistance that helped them towards recovery step by step (Articles 1, 2 and 3).

In the present study, the patients described the experience of receiving critical care as vital to staying alive and keeping a hold on life. These descriptions of nursing as help for life are reminiscent of the experiences that physically critically ill people have communicated about nursing during critical physical illness (Reir, 2004; Nordtvedt, 2014). Nursing helps the patient to take care of the patient body and his or her life there and then, to enable the patient to save his or her limited energy and use it for the next life-giving breath, the next minute, and to gather strength for the future (Reir, 2004; Nordtvedt, 2014). In the present study, the patients described critical care as helping them to rediscover their bodies and selves, which can be understood as gradually finding physical and mental balance. According to Nightingale (1997), nursing care means supporting the patient's natural processes by facilitating well-being to enable the body to find the necessary calm and support to heal and rediscover its balance. The nursing philosopher Elstad (2014) describes nursing as supporting the patient's life process, and as helping the patient with all his or her needs, ranging from the next breath to his or her will to live, in order to facilitate the natural processes.

Critical care also involved helping patients to endure their overwhelming, almost unbearable, acute state of psychosis, their strong feelings of insecurity and uncertainty, and their great anxiety that swelled over them during acute psychosis. Helping patients to endure acute psychosis could mean that nurses stayed with them and bore with their expressions of acute psychosis such as rejection or withdrawal or their emotional expressions such as great agitation, despair and anger. The nurses were in the patient rooms, sitting there, reading or knitting, looking up sometimes, serving the patients, and generally keeping quiet. The nurses did not talk much and did not ask questions, maybe because that would require answers from the patients who in the state of acute psychosis and, as one patient said, "...I was not in a condition to do anything" (Article 1).

Nurses were present in a calm and resolute manner and provided patients with nursing care when they had access to help them by being close to patients but at a respectful distance. According to Nightingale (1997), nurses must be steadfast in providing care, which gives the patient a feeling of security. Nurses must manage to be quiet and not ask patients unnecessary questions, to allow them to save their energy. People who are acutely admitted have become detached from their usual context and their everyday life; they are acutely psychotic and ill (cf. Selder, 1998). To become detached from one's usual context and condition may cause great uncertainty and insecurity and some people may even be terrified of disappearing into nothing (Selder, 1998). Barker and Buchanan-Barker (2005) have described acute mental illness as slipping away from oneself, from family members, friends, one's familiar situation, and even from life itself. Nurses who are continuously present become an anchor for the patient. Understanding the importance of being present, of enduring the situation with the patient, and confirming the patient's critical condition through caring acts were described in the study as acknowledgement of a human being worthy of good care and important to the nurse and other people. To use communication to acknowledge the patient and his condition and situation has been highlighted by other researchers as a key aspect of nursing for acutely mentally ill people (Vatne, 2003; Vatne & Hoem, 2008). In the present study, nursing and care practices were also experienced as acknowledgement and confirmation of the patient as an acutely critically ill person who temporarily needs nurses to be responsible for him or her and provide the patient with critical care.

The present study describes nurses as responsible for patients when they were at risk of harming themselves and endangering their own health and life, and worried about being a danger to other people. The nurses who were with the patients took care of them and made sure that they did not hurt themselves. The study describes how nurses observed and restrained patients when necessary with firmness and kindness, and in such a way that the patients felt they were being cared for as sick people. Nurses have a particular responsibility to monitor patients and protect them from harm by following them until they can return to their normal daily lives (Fause, 2018). Stewart et al. (2015) highlighted that being approached as ill when being acutely psychotic was of most importance for the inpatients and expressed as being taken care of. Monitoring and protecting patients in acute psychosis requires particular knowledge to understand how patients can be watched and restrained in a way the patient is able to accept. The present study described how some nurses who performed this part of critical care had sophisticated skills in being close to the patient while maintaining the necessary distance so that the patient did not feel he was being monitored or that his privacy was being invaded. Björkdahl et al. (2010) described how some nurses approached patients in situations where they needed to be restrained as if they were performing a careful dance on a tightrope adapted to the individual patient. Bowers et al. (2015) described how some nurses had acquired through practice the skill of imagining themselves in the patient's situation; they remained calm and not argumentative and thus created time and space to cooperate with and guide the patient in challenging situations. A common characteristic of the nurses seemed to be their particular knowledge of nursing and critical care practices in acute psychiatric wards based on insight into how it might feel for patients to be acutely psychotic and acutely critically ill. Barker and Buchanan-Barker (2005) emphasize the importance of nurses knowing that their responsibility for the patient is tied to the responsibility of providing the patient with optimal care, carefully adapted to his condition and needs, especially when he is unable to articulate his condition and voice his opinion.

Nursing education trains nurses to care for sick people who are unable to articulate their condition (cf. Elstad, 2014). As a methodological aspect of good care, Nightingale (1979) introduced the idea that the nurse should always ask herself: What is it like for this patient to be ill? In this way, Nightingale

made it clear that it is always the condition and situation of the patient as a sick person that determines nursing and care practices. When the patient is unable to articulate his condition as an ill person, the nurse must imagine what it is like for him to be ill (cf. Buber, 1966). However, it is challenging for the nurse to imagine herself in the place of an acutely psychotic patient who is acutely critically ill, in order to provide high-quality critical care. This requires the nurse to have knowledge and understanding of the patient's acute state of psychosis and of the patient as acutely critically ill. It also requires knowledge of providing nursing care adapted to acutely psychotic and critically ill patients.

8.0 CONCLUSIONS AND POSSIBLE IMPLICATIONS

8.1 Conclusions

Three aspects of nursing and care practices seem to be of key importance in enabling patients with acute psychosis admitted to acute psychiatric wards to receive competent help during their acute psychosis.

Firstly, the design and atmosphere of acute psychiatric wards must be tailored to the primary function of the acute ward, which is to provide treatment and care to people with acute and severe mental illness. Good structure in nursing and care work seems to be necessary to link treatment and care around the clock and throughout the course of the acute psychosis. Secondly, nurses' knowledge of psychotic disorders, of patients' acute psychotic state and of the individual patient who is acutely critically ill appears to be an important basis for providing sound patient care. Thirdly, the provision of critical care closely adapted to acutely psychotic patients who are acutely critically ill seems to be central to giving competent help during acute psychosis. The combination of these aspects is necessary to enable patients to receive competent help during acute psychosis in an acute psychiatric ward.

8.2 Implications for nursing in acute psychiatric wards

Nursing care for patients with acute psychosis requires the provision of care based on necessary and specialized knowledge. This implies that nurses must have basic and specialized knowledge of the patient's psychotic state and of the patient as acutely critically ill, in addition to clinical skills in order to provide high-quality patient care during acute psychosis.

Managers of acute psychiatric wards must take seriously the central aspects of nursing care as competent help during acute psychosis. These aspects must be reflected in the physical structure of the ward, in the routines and structures of nursing care and in the knowledge and clinical skills of the nurses.

This means that nurses must have access to specialized knowledge that enables them to provide competent and responsible help to patients during acute psychosis. Today, in Norway, there are insufficient opportunities for nurses to acquire such specialized knowledge in further education and master's degree programmes in mental health and mental health care. Managers in specialist mental health care must actively communicate this need for specialized knowledge to the Norwegian health authorities.

8.3 Implications for further research

The present study, based on patient experiences of nursing and care, emphasizes three key aspects in nursing and care practices of central importance in providing competent help to patients during acute psychosis.

A further study is proposed that explores and describes how nurses in inpatient specialist and primary mental health facilities and acute psychiatric wards experience nursing care as competent help for patients with psychosis. Questions that could be asked are: How do nurses describe what competent help for patients with psychosis may be? How do nurses provide patient care that consists of competent help?

9.0 REFERENCES

- Aarre, T. F. (2018). *En mindre medisinsk psykiatri*. Oslo: Universitetsforlaget.
- Aarre, T. F. & Dahl, A.A. (2018). *Praktisk psykiatri*. Bergen: Fagbokforlaget.
- Alexander, J. (2006). Patients' feelings about ward nursing regimes and involvement in rule construction. *Journal of Psychiatric and Mental Health Nursing*, 13(5), 543-553.
- Andersen, A. J. W. (2018). *Psykisk helsearbeid-en gang til*. Oslo: Gyldendal Akademisk.
- Ådnanes, M., & Harsvik, T. (2007). Evaluering av videreutdanning i psykisk helsearbeid. SINTEF Report.
- Barker, P. (2001a). The tidal model: the lived-experience in person-centred mental health nursing care. *Nursing Philosophy*, 2(3), 213-223.
- Barker, P. (2001b). The Tidal Model: developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, 8(3), 233–240.
- Barker, P., & Buchanan-Barker, P. (2005). *The Tidal Model. A guide for mental health professionals* (1st ed.). New York: Routledge.
- Barker, P., & Buchanan-Barker, P. (2009). The convenient myth of Thomas Szasz. *Journal of Psychiatric and Mental Health Nursing*, <https://doi.org/10.1111/j.1365-2850.2008.01310.x>
- Barker, P., & Buchanan-Barker, P. (2010). The tidal model of mental health recovery and reclamation: application in acute care setting. *Issues in Mental Health Nursing*, 31(3), 171-180.
- Bee, P., Playle, J., Lovell, K., Barnes, P., Gray, R., & Keeley, P. (2008). Service user views and expectations of UK-registered mental health nurses: a systematic review of empirical research. *International Journal of Nursing Studies*, 45(3), 442-457.
- Beebe, L. H., & Smith, K. (2010). Informed consent to research in persons with schizophrenia spectrum disorders. *Nursing Ethics*, 17(4), 425-434.
- Bergsland, K. (2008). Kan gode bygg bidra til psykiatrisk behandling? *Suicidologi*, 13(2), 1-3.
- Björkdahl, A., Palmstierna, T., & Hansebo, G. (2010). The bulldozer and the ballet dancer: aspects of nurses' caring approaches in acute psychiatric intensive care. *Journal of Psychiatric and Mental Health Nursing*, 17(6), 510-518.
- Bowers, L., Simpson, A., Alexander, J., Hackney, D., Nijman, H., Grange, A., & Warren, J. (2005). The nature and purpose of acute psychiatric wards: the Tompkins acute ward study. *Journal of Mental Health*, 14(6), 625-635.

- Bowers, L., Brennan, G., Winship, G., & Thodoridou, C. (2009). *Talking with acutely psychotic people: communication skills for nurses and others spending time with people who are very mentally ill*. London: City University. Last retrieved December 2019 from <https://www.kcl.ac.uk/ioppn/depts/hspr/archive/mhn/projects/Talking.pdf>
- Bowers, L., James, K., Quirk, A., Simpson, A., Stewart, D., & Hodsoll, J. (2015). Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial. *International Journal of Nursing Studies*, 52(9), 1412-1422.
- Buber, M. (1966). *The knowledge of man. A philosophy of the interhuman*. New York: Harper & Row Publishers.
- Carpenter, W. T., Gold, J. M., Lahti, A. C., Queern, C., Conley, R., Bartko, J.,...Appelbaum, P. (2000). Decisional capacity for informed consent in schizophrenia research. *Archives of General Psychiatry*, 57(6), 533-538.
- Casey, D. A., Rodriguez, M., Northcott, C., Vickar, G., & Shihabuddin, L. (2011). Schizophrenia: Medical illness, mortality and aging. *The International Journal of Psychiatry in Medicine*, 41(3), 245-251.
- Civil Ombudsman's Prevention Unit. (2016). *Besøksrapport Universitetssykehuset Nord Norge HF*. (2016/817)
- Civil Ombudsman's Prevention Unit. (2017). Akershus universitetssykehus, avdeling akuttpsykiatri.
- Civil Ombudsman's Prevention Unit. (2018). *Besøksrapport Psykiatrisk klinikk, Helse Bergen HF (Sandviken)*.
- Cleary, M. (2004). The realities of mental health nursing in acute inpatient environments. *International Journal of Mental Health Nursing*, 13, 53-60.
- Cleary, M., Hunt, G. E., Horsfall, J., & Deacon, M. (2012). Nurse-patient interaction in acute adult inpatient mental health units: a review and synthesis of qualitative studies. *Issues in Mental Health Nursing*, 33(2), 66-79. doi: 10.3109/01612840.2011.622428
- Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N.,...Thornicroft, G. (2015). What is the impact of health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, 45(1), 11-27. doi: 10.1017/S0033291714000129
- David, A. S. (1990). Insight and psychosis. *The British Journal of Psychiatry*, 156 (6), 798-808.
- Deacon, M., Warne, T., & McAndrew, S. (2006). Closeness, chaos and crisis: the attractions of working in acute mental health care. *Journal of Psychiatric and Mental Health Care*, 13(6), 750-757.
- Denhov, A., & Topor, A. (2012). The components of helping relationships with professionals in psychiatry: users' perspective. *International Journal of Social Psychiatry*, 58(4), 417-424.
- Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis: A focus on trustworthiness. *Sage Open*, 4, 1-10. doi:10.1177/215824401452263

- Emaus, H.S., Dahl Hegstad, I. & Sebergesen, K. (2016). Nettverksarbeid-gjøres det? Registrering av nettverksarbeid som en kvalitetsindikator i psykisk helsearbeid. *Tidsskrift psykisk helsearbeid*, 13(1-2), 97-106.
- Enarsson, P., Sandman, P-O., & Hellzen, O. (2008). "Being good or evil": Applying a common staff approach when caring for patients with a psychiatric disease. *International Journal of Qualitative Studies on Health and Well-being*, 3, 219-229.
- Enarsson, P., Sandman, P-O., & Hellzen, O. (2011). "They can do whatever they want": Meanings of receiving psychiatric care based on a common staff approach. *International Journal of Qualitative Studies on Health and Well-being*, 6, 1-11. DOI:10.3402/qhv.v6i1.5296
- Elstad, I. (2014). *Sjukepleietenkning*. Oslo: Gyldendal Akademisk.
- Ewertzon, M., Cronquist, A., Lutzen, K., & Andershed, B. (2012). A lonely life journey bordered with struggle: Being a sibling of an individual with psychosis. *Issues in Mental Health Nursing*, 33(3), 157-164, DOI: 10.3109/01612840.2011.633735
- Fause, Å. (2013). Framveksten av psykisk helsetjenester i Nord med et blikk på sykepleiens utvikling og bidrag. *Nordisk Tidsskrift for Helseforskning*, 9, 105-123.
- Fause, Å., Rolland, E. G., Lyngved, K., & Bremnes, O. (2018). *Tverrfaglig masterutdanning i psykisk helse og rus*. Norsk Sykepleierforbund. Nsf.no. Last retrieved: December 2019
- Fause, Å. (2019). Hva er sykepleie i psykisk helse- og rustjenesten? *Sykepleien*, 01, doi10.4220/Sykepleies.2019.74841
- Foucault, M. (1961/1991). *Galskapens historie i opplysningens tidsalder*. Oslo: Gyldendal Norsk Forlag.
- Frank, A. W. (1995). *The wounded storyteller: body, illness, and ethics*. Chicago: University of Chicago Press.
- Førde, R., Norvoll, R., Hem, M. H., Pedersen, R. (2016). Next of kin's experiences of involvement during involuntary hospitalisation and coercion. *BMC Medical Ethics*, 17(76), 1-9. DOI 10.1186/s12910-016-0159-4
- Gabrielsson, S. (2015). *A moral endeavour in a demoralizing context: psychiatric inpatient care from the perspective of professional caregivers*. Dissertation, Luleå University of Technology, Luleå. Last retrieved December 2019 from: http://pure_ltu.se/portal/files/103610457/sebastian_gabrielsson_webb.pdf.
- Gerson, L. D., & Rose, L. E. (2012). Needs of persons with serious mental illness following discharge from inpatient treatment: patient and family views. *Archives of Psychiatric Nursing*, 26(4), 261-271. doi: <https://doi.org/10.1016/j.apnu.2012.02.002>

- Gilburt, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: a qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Services Research*, 8, 92-110. <https://doi.org/10.1186/1472-6963-8-92>
- Gilburt, H., Slade, M., Rose, D., Lloyd-Evans, B., Johnson, S., & Osborn, D. (2010). Service users' experiences of residential alternatives to standard acute wards: qualitative study of similarities and differences. *The British Journal of Psychiatry*, 197(53), 26-31.
- Glasby, J., & Lester, H. (2005). On the inside: a narrative review of mental health inpatient services. *British Journal of Social Work*, 35(6), 863-879.
- Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. New York: Anchor Books.
- Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24(2), 105-112.
- Graneheim, U. H., Lindgren, B-M., & Lundman, B. (2017). Methodological challenges in qualitative content analysis: a discussion paper. *Nurse Education Today*, 56, 29-34.
doi:<https://doi.org/10.1016/j.nedt.2017.06.002>
- Grant, A., Biley, E., & Walker, H. (2011). *Our encounter with madness*. United Kingdom: PCCS Books Exeter.
- Hamann, J., Kruse, J., Schmitz, F. S., Kissling, W., & Pajonk, F-G. (2010). Patient participation in antipsychotic drug choice decisions. *Psychiatry Research*, 178(1), 63-67.
- Hamran, T. (1992). *Pleiekulturen-en utfordring til den teknologiske tenkemåten*. Oslo: Gyldendal norsk forlag.
- Hategan, A., Parthasarathi, U., & Bourgeois, J. A. (2014). Obtaining informed consent for research in an acute inpatient psychiatric setting. *Current Psychiatry*, 13(5), 39-40.
- Health Personnel Act (1999). 1999-07-02-64: The Act relating to Health Personnel, etc. Oslo: Norwegian Ministry of Health.
- Hem, M. H., Heggen, K., & Ruyter, K. W. (2007). Questionable requirement for consent in observational research in psychiatry. *Nursing Ethics*, 14(1), 42-53.
- Hem, M. H. (2008). *Mature care? An empirical study of interaction between psychotic patients and psychiatric nurses*. PhD dissertation, Institute of Nursing and Health Sciences, Faculty of Medicine. Oslo: University of Oslo.
- Hummelvoll, J. K. (2012). *Helt - ikke stykkevis og delt. Psykiatrisk sykepleie og psykisk helse*. Oslo: Gyldendal Akademisk.

- ICD-10 (2016). International Statistical Classification of Disease and Related Health Problems. World Health Organization. The Norwegian Directorate of e-health. Last retrieved December 2019 from: <https://finnkode.ehelse.no>
- Jacobsen, R. K., Sørgeard, J., Karlsson, B. E., Seikkula, J., & Kim, H. S. (2018). "Open Dialogue behind locked doors" – exploring patients', family members', and professionals' experiences with network meetings in a locked psychiatric hospital unit: A qualitative study. *Scandinavian Psychologist*, 5(5), 1-16. <https://doi.org/10.15714/scandpsychol.5.e5>
- Kaite, C. P., Karanikola, M., Merkouris, A., & Papatthanassoglou, E. "An ongoing struggle with the self and illness": A meta-synthesis of the studies of the lived experience of severe mental illness. *Archives of Psychiatric Nursing*, 29, 458-473.
- Karlsson, B., & Borg, M. (2013). *Psykisk helsearbeid*. Oslo: Gyldendal Akademisk.
- Karlsson, B., & Kim, S.H. (2015). *Sykepleie i kommunalt psykisk helse- og rusarbeid. En studie om sykepleierens ansvar, funksjon og faglighet i kommunalt psykisk helse- og rusarbeid*. Mental Health and Substance Abuse Centre, Buskerud University College.
- Katsakou, C., Bowers, L., Amos, T., Morriss, R., Rose, D., Wykes, T., & Priebe, S. (2010). Coercion and treatment satisfaction among involuntary patients. *Psychiatric Services*, 61(3), 286-292.
- Keen, N., George, D., Scragg, P., & Peters, E. (2017). The role of shame in people with a diagnosis of schizophrenia. *British Journal of Clinical Psychology*, 56(2), 1-15. doi:10.1111/bjc.12125.
- Kenyon, J. (2005). *Collected poems*. Minneapolis, MN: Greywolf Press.
- Koivisto, K., Janhonen, S., & Väisänen, L. (2004). Patients' experiences of being helped in an inpatient setting. *Journal of Psychiatric and Mental Health Nursing*, 11(3), 268-275.
- Kuosmanen, L., Hätönen, H., Jyrkinen, A. R., Katajisto, J., & Välimäki, M. (2006). Patient satisfaction with psychiatric inpatient care. *Journal of Advanced Nursing*, 55(6), 655-63.
- Lauveng, A. (2013). *A Road Back from Schizophrenia*. New York: Skyhorse Publishing.
- Leiviskä Deland, A.-C., Karlsson, G., & Fatouros-Bergman, H. (2011). A phenomenological analysis of the psychotic experience. *Human Studies*, 34(1), 23-42.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: SAGE Publications.
- Lindgren, B-M., Ringner, A., Molin, J., & Graneheim, U. (2018). Patients' experiences of isolation in psychiatric inpatient care: Insights from a meta-ethnographic study. *International Journal of Mental Health Nursing*, 1-15. Doi:10.1111/inm.12519

- Loch, A. A. (2014). Discharged from a mental health admission ward: is it safe to go home? A review of the negative outcomes of psychiatric hospitalization. *Psychological Research and Behaviour Management*, 7, 137-145. doi: <https://dx.doi.org/10.2147%2FPRBM.S35061>
- Looi, G. M. E., Gabriellson, S., Sävenstedt, S., & Zingmark, K. (2014). Solving the staff's problems or meeting the patients' needs: staff members' reasoning about choice of action in challenging situations in psychiatric inpatient care. *Issues in Mental Health Nursing*, 35(6), 784-792. <https://doi.org/10.3109/01612840.2013.879629>
- Loem, G., Steffensen, M., Frafjord, J. & Wang, C. E. A. Omsorg under tvang-En narrativ studie av pasienters fortellinger om tvang og psykisk helsevern. *Tidsskrift for psykisk helsearbeid* 02(11), 115-124.
- Lysnes, M. (1982). *Behandlere-voktere?: psykiatrisk sykepleies historie i Norge*. Oslo: Universitetsforlaget.
- Manuel, J., Hinterland, K., Conover, S., & Herman, D. (2012). "I hope I can make it out there": Perceptions of women with severe mental illness on the transition from hospital to community. *Community Mental Health Journal*, 48(3), 302-308.
- Marshall, M., & Rathbone, J. (2011). Early interventions for psychosis. *Cochrane Database System Review*, 6, doi:10.1002/146511858.CD004718.pub3
- Martinsen, K. (2000). *Øyet og kallet*. Bergen: Fagbokforlaget.
- Mathisen, J. (2006). *Sykepleiehistorie. Ideer-mennesker-muligheter*. Oslo: Gyldendal Akademiske.
- McCarthy-Jones, S., Marriott, M., Knowles, R., Rowse, G., & Thompson, R. T. (2013). What is psychosis? A meta-synthesis of inductive qualitative studies exploring the experience of psychosis. *Psychosis: Psychological, Social and Integrative Approaches*, 5(1), 1-16. doi:<https://doi.org/10.1080/17522439.2011.647051>
- McDaid, D., Park, A.-L., Iemmi, V., Adelaja, B., & Knapp, M. (2016). *Growth in the use of early intervention for psychosis services: an opportunity to promote recovery amid concerns on health care sustainability*. London: PSSRU, London School of Economics and Political Science.
- McGorry, P. D., Killackey, E., & Yung, A. R. (2008). Early intervention in psychosis: concepts, evidence and future directions. *World Psychiatry*, 7(3), 148-156.
- McGorry, P. M. (2015). Early intervention in psychosis. Obvious, effective, overdue. *The Journal of Nervous and Mental Disease*, 203(5), 310-318.
- McGrath, J. J., Saha, S., Al-Hamzavi, A. O., Alonso, J., Andrade, L., Borges, G.,...Kessler, R. (2016). Age of onset and lifetime projected risk of psychotic experiences: cross national data from the World Mental Health Survey. *Schizophrenia Bulletin*, 42(4), 933-941. doi:<https://doi.org/10.1093/schbul/sbw011>
- Melby, L., Ådnes, M., Kasting, F. (2017). Sykepleie i psykisk helsevern for voksne og tverrfaglig spesialisert rusbehandling (SINTEF Report A28053 2017).

- Mental Health Care Act (2001). 1999-07-02-62: The Act relating to the Establishment and Provision of Mental Health Care. Oslo: Norwegian Ministry of Health.
- Mishler, E. G. (1991). *Research interviewing: context and narrative*. Cambridge, MA: Harvard University Press.
- Molewijk, B., Hem, M. H., & Pedersen, R. (2015). Dealing with ethical challenges: a focus group study with professionals in mental health care. *BMC Medical Ethics*, *16*(4), 1-12.
<http://www.biomedcentral.com/1472-6939/16/4>
- Morse, J. (2000). Responding to the cues of suffering. *Health Care for Women International*, *21*(1), 1-9.
- Morse, J., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, *1*(2), 13-22.
- NAMI. (2011). National Alliance on Mental Illness. *First episode: Psychosis. Results from a 2011 NAMI survey*. Retrieved from NAMI US Website. Last retrieved Dec 2019. <https://www.nami.org/psychosis/report>.
- NICE. (2014). National Institute of Clinical Excellence. *Guidelines: Psychosis and Schizophrenia in Adults: Treatment and Management*. Last retrieved December 2019. National Institute of Clinical Excellence Website: <http://www.nice.org.uk/guidance/introduction>.
- Nightingale, F. (1860/1997). *Notater om sykepleie. Samlede utgaver*. Oslo: Universitetsforlagets Sykepleieklassikere.
- Norberg-Schulz, C. (1992). *Mellom himmel og jord. En bok om steder og hus*. Oslo: Pax Forlag A/S.
- Nordenfelt, L. (2007). The concepts of health and illness revisited. *Medicine, Health Care and Philosophy*, *10*(5), 5-10.
- Nordtvedt, F. (2014). Når sykepleie redder liv. *Sykepleien*, *12*, 44-49.
- Nordtvedt, P. (2019). Tilbake til Nightingale. *Sykepleien*, *01*, 66-69.
- Norvoll, R. (2007). *Det lukkede rom*. PhD dissertation, Department of Sociology and Human Geography, Faculty of Social Sciences. Oslo: University of Oslo.
- Norvoll, R., Ruud, T., Hynnekleiv, T. (2015). Skjerming i akuttpsykiatrien. *Tidsskrift for Norsk Legeforening*, *135*, 35-39.
- Norwegian Directorate of Health. (2013). Nasjonale retningslinjer for utredning, behandling og oppfølging av personer med psykoselidelser. Oslo: Directorate of Health.
- Norwegian Directorate of Health. (2014). IS-2076. Sammen om mestring. Veileder om lokalt psykisk helsearbeid og rusarbeid for voksne. Et verktøy for kommuner og spesialisthelsetjenesten. Oslo: Directorate of Health.

- Norwegian Directorate of Health. (2017). IS-1 Psykisk helsevernloven og psykisk helsevernforskriften med kommentarer. Oslo: Directorate of Health.
- Norwegian Directorate of Health. (2017). IS-2825. *Distriktpsikiatriske tjenester 2017*. Last retrieved December 2019. <https://helsedirektoratet.no/>
- Norwegian Directorate of Health. (2018). IS-2812. Tvang i psykisk helsevern. Utvikling i perioden 2013-2017. Last retrieved December 2019. <https://helsedirektoratet.no/>
- Norwegian Institute of Public Health. (2018). Psykisk helse i Norge. Last retrieved December 2019. [Fhi.no/2018/publ/psykisk-helse-i-norge](http://fhi.no/2018/publ/psykisk-helse-i-norge)
- Norwegian Ministry of Health and Care Services. (1997-1998). Parliamentary Proposition No 63. Opptappingsplan for psykisk helse 1999-2006.
- Norwegian Ministry of Health and Care Services. (2006). Report 15-1315. Brukermedvirkning-psykisk helsefeltet. Mål, anbefalinger og tiltak i Opptappingsplanen for psykisk helse.
- Nugteren, W., van der Zalm, Y., Hafsteinsdottir, T. B., van der Venne, C., Kool, N., & van Meijel, R. (2015). Experiences of patients in acute and closed psychiatric wards: A systematic review. *Perspectives in Psychiatric Care*, 52(4), 292-300.
- Nyvoll, H. R. (2008). *I ensomhetens verden*. Master's thesis. Tromsø: UiT The Arctic University of Norway.
- Øye, C., Bjelland, A. K., Skorpen, A., & Anderssen, N. (2009). User participation when using milieu therapy in a psychiatric hospital in Norway: a mission impossible? *Nursing Inquiry*, 16(4), 287-296.
- Patient Rights Act (1999). 1999-07-02-64: The Act relating to Patients' Rights. Oslo: Norwegian Ministry of Health.
- Pitkänen, A., Hätönen, H., Kuosmanen, L., & Välimäki, M. (2008). Patients' descriptions of nursing interventions supporting quality of life in acute psychiatric wards: a qualitative study. *International Journal of Nursing Studies*, 45(11), 1598-1606.
- Polit, D. F., & Beck, C. T. (2012). *Nursing research. Generating and assessing evidence for nursing practice*. Philadelphia: Lippincott Williams & Wilkins.
- Quirk, A., Lelliott, P., & Seale, C. (2006). The permeable institution: an ethnographic study of three acute psychiatric wards in London. *Social Science & Medicine*, 63(8), 2105-2117.
- Randall, J. R., Vokey, S., Loewen, H., Martens, P., Brownell, M., Katz, A.,... Chateau, D. (2015). A systematic review of the effect of Early Interventions for Psychosis on the usage of inpatient services. *Schizophrenia Bulletin*, 41(6), 1379-1386. doi:10.1093/schbul/sbv016.
- Rier, D. (2000). The missing voice of the critically ill: a medical sociologist's first-person account. *Sociology of Health and Illness*, 22(1), 68-93.

- Robinson, O. C. (2014). Sampling in interview-based qualitative research: a theoretical and practical guide. *Qualitative Research in Psychology, 11*, 25-41.
- Rundquist, C. & Barbosa da Silva, A. (2000). Relevansen av Martin Bubers dialogfilosofi för vårdvetenskap. *Vård i Norden, 3*(20), 49-54.
- Ruud, T., Gråwe, R. W., & Hatling, T. (2006). Akuttpsykiatrisk behandling i Norge-resultater fra en multisenter studie. (Sintef Report A310) Trondheim: SINTEF Helse.
- Salzmann-Erikson, M., & Söderqvist, C. (2017). Being subject to restrictions, limitations and disciplining: a thematic analysis of individuals' experiences in psychiatric intensive care. *Issues in Mental Health Nursing, 38*(7), 540-548. doi:<http://dx.doi.org/10.1080/01612840.2017.1299265>
- Sandelowski, M. (2011). When a cigar is not just a cigar: alternative takes on data and data analysis. *Research in Nursing and Health, 34*, 342-352.
- Sebergesen, K. (2002). *Det uforutsette, oversette og sette. En kvalitativ studie om å være ansvarsvakt i psykiatrisk akuttpost*. Thesis in Nursing and Health Science. Tromsø: University of Tromsø.
- Selder, F. (1989). Life transition theory: the resolution of uncertainty. *Nursing & Health Care, 10*(8), 449-451.
- Shattell, M. M., Andes, M., & Thomas, S. P. (2008). How patients and nurses experience the acute care psychiatric environment. *Nursing Inquiry, 15*(3), 242-250.
- Skorpen, A., Anderssen, N., Øye, C., & Bjelland, A. K. (2009). Treatment regimes in a psychiatric hospital and apparent contradictions: Report from field work in a lock-up ward illustrated with a constructed case. *International Journal of Mental Health Nursing, 18*(6), 409-416.
- Skorpen, A. & Øye, C. (2009). *Dagliglivet i en psykiatrisk institusjon: En analyse av miljøterapeutiske praksiser*. Department of Nursing and Department of Social Anthropology. Bergen: University of Bergen.
- Smith, L. J. (2008). How ethical is ethical research? Recruiting marginalized, vulnerable groups into health services research. *Journal of Advanced Nursing, 62*(2), 248-257.
- Stewart, D., Burrow, H., Duckworth, A., Dhillon, J., Fife, S., Kelly, S.,... Bowers, L. (2015). Thematic analysis of psychiatric patients' perceptions of nursing staff. *International Journal of Mental Health Nursing, 24*(1), 82-90. doi: 10.1111/inm.12107
- Svindseth, M. H., Nøttestad, J. A., & Dahl, A. A. (2010). A study of outcome in patients treated at a psychiatric emergency unit. *Nordic Journal of Psychiatry, 64*(6), 363-371.
- Szasz, T. S. (1961/2010). *The Myth of Mental Illness*. New York: Harper Collins Publisher.

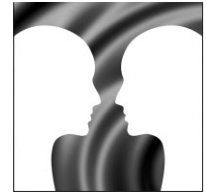
- Thornicroft, G., & Tansella, M. (2013). The balanced care model: the case for both hospital- and community-based mental healthcare. *The British Journal of Psychiatry*, *202*, 246-248. doi: 10.1192/bjp.bp.112.111377
- Thornicroft, G., Deb, T., & Henderson, C. (2016). Community mental health care worldwide: current status and further developments. *World Psychiatry*, *15*(3), 276-286. doi: 10.1002/wps.20349
- Toombs, S. K. (1990). The temporality of illness: Four levels of experience. *Theoretical Medicine*, *11*(3), 227-241.
- Topor, A., & Denhov, A. (2013). Helping relationships and time: Inside the black box of working alliance. *American Journal of Psychiatric Rehabilitation*, *15*(3), 239-254.
- Travelbee, J. (1999). *Mellommenneskelige forhold i sykepleie*. Oslo: Gyldendal.
- Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences*, *15*(3), 398-405. doi: 10.1111/nhs.12048
- Vatne, S. (2003). *Korrigere og anerkjenne: Sykepleierens rasjonale for grensesetting i en akuttpsykiatrisk behandlingspost*. PhD dissertation, Department of Nursing Science, Faculty of Social Sciences. Oslo: University of Oslo.
- Vatne, S. & Hoem, E. (2008). Acknowledging communication: a milieu-therapeutic approach in mental health care. *Journal of Advanced Nursing*, *61*(6), 690-698.
- Walsh, J., & Boyle, J. (2009). Improving acute psychiatric hospital services according to inpatient experiences. A user-led piece of research as a means of empowerment. *Issues in Mental Health Nursing*, *30*(1), 31-38.
- Weidmand, B., Hedelin, B., Hall-Lord, M-L., Sällström, C. (2011). "Left alone with straining but inescapable responsibilities:" Relatives' experiences with mental health services. *Issues in Mental Health Nursing*, *32*(11), 703-710.
- Wifstad, Å. (2018). *Vitenskapsteori for helsefagene*. Oslo: Universitetsforlaget.
- World Health Organization. (2001). *The World Health Organization Report 2001: Mental health – new understanding, new hope*. Last retrieved December 2019 from who.int/whr/2001/en/
- World Health Organization. (2007). *People-centred health care – a policy framework*. Last retrieved December 2019 from iris.wpro.who.int/handle/10665.1/5420
- World Health Organization. (2009). *Improving health systems and services for mental health*. Last retrieved December 2019 from who.int/mental_health/policy/services/mhsystems/en

World Medical Association (2013). *WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects*. Last retrieved December 2019 from www.wma.net/en/30publications/10policies/b3/

Wyder, M., Roennfeldt, H., Rosella, R. F., Stewart, B., Maher, J., Taylor, R.,...Barringham, N. (2018). Our sunshine place: A collective narrative and reflection on the experiences of a mental health crisis leading to an admission to a psychiatric inpatient unit. *International Journal of Mental Health Nursing*, 27, 1240-1249. Doi:10.1111/inm.12487

Wynn, R. (2018). Involuntary admission in Norwegian adult psychiatric hospitals: a systematic review. *International Journal of Mental Health Systems*, 12(10), 1-11. Doi.org/101186/s13033-018-0189-z.

Paper I



Being in a process of transition to psychosis, as narrated by adults with psychotic illnesses acutely admitted to hospital

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Accessible summary

- Early intervention to prevent and reduce new episodes of psychosis involves patients, relatives and mental health personnel recognizing the early signs of psychosis.
- Twelve participants with psychotic illnesses narrated how they experienced becoming psychotic before they were admitted to acute psychiatric wards.
- The results of this study demonstrate that participants and their close others who sensed, understood and articulated experienced changes as signs of psychosis established a dialogue with mental health personnel and initiated treatment and care. Participants who did not perceive the experienced changes as signs of psychosis articulated the experienced changes as an awareness of a poor health condition and illness. These participants, who had no other people to advocate for them, appeared to experience poor communication and coercion during intervention.

Abstract

To assist in improving early interventions for psychosis, this study explored how adult people narrated their experience of becoming psychotic, and how contact with mental health personnel was established. Narrative interviews were conducted with 12 participants with psychotic illnesses recruited from acute psychiatric wards. The interviews were content analysed. Participants described being in a process of transition to psychosis as follows: experiencing changes as well-known signs of psychosis, experiencing sudden unexpected changes as signs of psychosis and experiencing unidentified changes as signs of illness. Our results show that participants and their close others who knew the signs of psychosis established a dialogue with mental health personnel and were better equipped to prevent and mitigate the psychosis. Our results demonstrate that participants who did not perceive the signs of psychosis and did not have other people to advocate for them were at risk for delayed treatment, poor communication and coercive interventions. Furthermore, participants who did not know the signs of psychosis perceived these changes as deterioration in their health and awareness of illness. We suggest that participants' experiential knowledge of transitioning to psychosis and an awareness of illness can be used to improve the communication during interventions for psychosis.

Introduction

Psychoses are serious and can be lifelong conditions associated with appreciable levels of burden for the affected individuals and their families (Lopez *et al.* 2006). The severity of psychoses has led to the development of early interventions aimed at preventing and reducing new episodes of psychosis. In this paradigm, psychosis is viewed as a fluid syndrome that occurs in episodes, develops in stages that begin with early signs of psychosis and are defined by symptoms, including hallucinations, delusions and formal thought disturbances (McGorry *et al.* 2008). Preventing efforts are described in clinical guidelines for treatment and follow-up for people with psychotic illnesses in the following steps: (1) to reach people with psychosis by the detection and recognition of early signs of psychosis by patients and/or relatives and local mental health personnel; (2) to establish contact between patients and mental health service; and (3) to offer individual and stage-specific interventions. Interventions for people with psychosis are primarily offered in local mental health services and secondarily in acute psychiatric wards to people with acute psychosis (Norwegian Directorate of Health 2013). Early interventions include a variety of approaches as antipsychotic medication, cognitive therapy, family therapy, care, employment and social support to people in risk of new episodes of psychosis and their families (van Meijel *et al.* 2002, McGorry *et al.* 2008). The growing evidence from national studies for the effectiveness of early intervention approaches in preventing new episodes of psychosis (McGorry *et al.* 2008) supports that it is important to reach and access people with psychosis, not asking for or not wanting treatment (McGorry *et al.* 2010, Birchwood *et al.* 2013).

We reviewed previous literature with different qualities and approaches to broaden our insight about early interventions for people with psychosis. Studies investigating the effectiveness of early interventions confirmed that the early signs of psychosis are reliable markers that aid in the early identification of psychosis (Yung & McGorry 2007, Iyer *et al.* 2008). Other studies showed it is possible to treat young people with psychosis with fewer inpatient days and less use of medication with early approach combined with intense psychosocial treatment and support (Cullberg *et al.* 2002, 2006). Review studies reported that early interventions were effective for early psychosis and could reduce durations of untreated psychosis (Killackey & Yung 2007), furthermore, there was emerging but inconclusive evidence that people with prodrome could be helped with interventions, and support for the effectiveness of phase-specific treatments focused on employment and cognitive therapy for people with psychotic illnesses (Marshall & Rathbone

2011). Stafford *et al.* (2013) found no evidence for specific interventions to prevent psychosis, although findings supported the possibility to prevent transition to psychosis. Bosanac *et al.* (2010) showed that there was a lack of evidence that early interventions did much for people with illnesses associated with poor prognosis. A recent review study suggested community education and awareness campaigns related to the signs of psychosis to shorten delays in mental health services to reduce durations of untreated psychosis (Birchwood *et al.* 2013). Other researchers suggested improvements in outreach services to reach people with psychosis (Cotton *et al.* 2007, Hasselberg *et al.* 2011).

Researchers exploring people's subjective experiences of becoming psychotic described fundamentally changed perceptions of the world (Sass 1988), difficulties with articulating experienced changes and disturbances in the sense of self (Møller & Husby 2000, Parnas & Handest 2003), feeling lonely and hopeless (Barker *et al.* 2001) and becoming psychotic as a journey towards an uncertain future (Hardy *et al.* 2009). Psychosis changed people's perceptions, social behaviours and communication (MacDonald *et al.* 2005), their ability to advocate for themselves and prompted them to become suspicious (Leiviska Deland *et al.* 2011). Studies exploring people's help-seeking experiences reported their need for knowledge about psychosis and interventions by health professionals (Tanskanen *et al.* 2011) and their need for significant others as crucial in seeking help (Anderson *et al.* 2012). Published personal narratives, authored by patients themselves, gave detailed insight in what each of the narrators had to overcome in their 'journeys' in and out of psychosis and how psychosis changed their daily living (Grant *et al.* 2011, Lauveng 2013).

Our review showed support for the effectiveness of early interventions to prevent and reduce psychosis for some people with psychosis; however, with limited effects for people with psychotic illnesses associated with poor prognosis and people with psychosis not asking for treatment and care. The studies exploring people's experiences gave insight in how psychosis affected their social skills and their help seeking and the personal narratives deepened this understanding. These findings made us aware of the outlined steps of early intervention for psychosis: (1) to reach people becoming psychotic; (2) to establish contact between people becoming psychotic and mental health personnel; and (3) to offer and initiate treatment and care. We questioned how people experienced becoming psychotic and experienced their need for treatment and care prior to the steps of early interventions of psychosis; to address this question, we searched for research studies. The results were limited, but a study reviewing patients' and clinicians' different explanatory models about psychotic sickness and

treatment suggested that the difference in the models may impact durations of untreated psychosis and therefore should be further examined (Bhikha *et al.* 2012). We designed a study aimed at increasing the understanding of people’s experience of becoming psychotic to improve early interventions for psychosis. The theoretical framework of this study is based on the perspective of human experience in illness narratives to access people’s described processes of psychosis as well as their need for treatment and care (Kleinman 1988). Furthermore, narratives provided an understanding of the interplay between cognition, emotion, volition and action in the experience of becoming psychotic (cf. Tappan & Brown 1989).

People with psychosis who have been acutely voluntarily or involuntarily admitted to psychiatric wards, possess important knowledge regarding their experiences of becoming psychotic and their needs for treatment and care. Their experiences may increase the understanding about becoming psychotic and contribute to improve interventions for psychosis. The aim of our study was to explore the experiences of becoming psychotic among people with psychotic illnesses prior to interventions and admittance to acute psychiatric wards.

Methods

A qualitative exploratory design was chosen and narrative interviews (Mishler 1991) were used to assess participants’ illness experiences.

The setting for our study included four psychiatric wards in departments of general psychiatry in two hospitals in Norway providing treatment and care to people in the acute phases of psychosis. Participants were recruited among inpatients, and selection criteria for participants were as follows: acutely admitted to the hospital; involuntarily and voluntarily admitted; different psychotic disorders; and able to narrate their experiences regarding

psychotic illness and admittance to the hospital. The chief physician confirmed the patients’ participation in the study. Patients were informed about the study and were asked to participate and to sign an informed consent. The participants were eight women and four men, varying in age, from 18 to 64 years, who were being diagnosed with psychotic illnesses. Eight of the participants were involuntarily admitted for treatment and care. Participants were purposively recruited, and no further recruitment was conducted when the interviews no longer revealed any new information about the research topic.

The first author (KS) conducted interviews between December 2008 and May 2009 during the participants’ hospital stay. The opening statement was ‘Please tell me what brought you to the hospital’. An invitation to narrate about the experience of becoming psychotic ill followed, and K.S. encouraged the participants gently to narrate what seemed important to them of what happened. Participants described their experienced changes related to their psychotic illness and how the changes affected their daily lives. K.S. was attentive to participants’ use of terms about their illness experiences and was sensitive when asking clarifying questions and used their chosen words, such as, ‘How did you sense the strange impressions that intruded you? How did you interpret, understand, feel and act?’ The tape-recorded interviews lasted 50–90 min and were transcribed verbatim by K.S.

A qualitative content analysis (Graneheim & Lundman 2004) was applied. The total interview–text was read several times to understand the content as a whole. Sections of the text related to the participants’ narrated experiences of becoming psychotic were brought together into one text, a content area. This text was then divided into meaning units that were condensed and labelled with codes. These coded meaning units were compared and sorted into subcategories. Further comparison led to the construction of categories (Table 1). The underlying meaning of the

Table 1

Example of analysis

Meaning unit	Condensed meaning unit	Code	Sub-category	Category
It went slowly downhill. I noticed ‘mood’. A new day’s mood is not as yesterday’s mood (10)	Sensing known changes slowly growing in volume	Noticing changes Slowly changes	Noticing well-known changes directly related to time	Experiencing changes as well-known signs of psychosis
I sense when I am close to psychosis. I know the signs. First, I get worried, and then the voices become more aggressive. It is like the voices grow in volume inside me (12)	Sensing well-known changes which grow inside the body	Knowing changes Increasing intensity of changes	Sensing well-known changes	

Table 2
Categories and subcategories

Categories	Subcategories
A. Experiencing changes as well-known signs of psychosis	Noticing well-known changes directly related to time Sensing well-known changes Understanding well-known changes as signs of psychosis Dealing with well-known signs Articulating well-known signs
B. Experiencing sudden unexpected changes as signs of psychosis	Noticing sudden unexpected changes directly related to time Sensing sudden unexpected changes Understanding sudden unexpected changes as signs of psychosis supported by close others Dealing with signs of psychosis supported by close others Articulating signs of psychosis supported by close others
C. Experiencing unidentified changes as signs of illness	Noticing unidentified changes implicitly related to time Sensing unidentified changes Being aware of unidentified changes Dealing with unidentified changes without support Articulating unidentified changes without support

categories and subcategories was interpreted and formulated as the theme of 'being in a process of transition to psychosis' (Table 2).

Methodological considerations

To ensure the reliability, validity and thus trustworthiness of our approach, we considered methodological issues throughout the research process (Morse *et al.* 2002). We verified and confirmed the data during data collection by discussing the breadth, depth and nuances of the interviews within the research team; this gave K.S. the opportunity to modify subsequent interviews to ensure the sufficiency of the data. During the analysis, the second and third authors brought different perspectives from K.S. as well as additional questions. As a team, we discussed the chosen focus, coding strategy, creation of subcategories, categories and theme. This process provided the opportunity to explore and reflect upon the results and ensure that participants' voices were heard throughout the research.

Ethics

The study was approved by the Norwegian Social Science Data Service (15721/2006) and the Regional Committee for Medical and Health Research Ethics (110/2006). Participants were guaranteed confidentiality and anonymous presentation of the results. Participants' names and personal information were saved in secure computer files and were not used in the interview text. Participants were assured of their right to withdraw from the study before data were included in the analysis without stating a reason and with no consequences for their treatment and care.

Results

The theme 'Being in a process of transition to psychosis' linked the underlying meaning of three categories, each of which contained five subcategories (Table 2).

These categories of transitions to psychosis were as follows: experiencing changes as well-known signs of psychosis (A), experiencing sudden unexpected changes as signs of psychosis (B) and experiencing unidentified changes as signs of illness (C). The term 'sign' relates to the experienced changes noticed by participants, relatives and health personnel that may signal new episodes of psychosis (cf. Birchwood *et al.* 2000). All participants are quoted and labelled as 1–12. We use the term 'close others' to refer to participants' relatives, friends and mental health personnel who the participants reported having continuous contact with.

A. Experiencing changes as well-known signs of psychosis

The first category described participants' transitioning process as being familiar with their psychotic illness, and well-known signs of psychosis are expressed as important signals to seek treatment and care to prevent becoming psychotically ill.

Noticing well-known changes directly related to time

Participants noticed non-specific changes occurring slowly. They described the beginning and the length of time the changes lasted in terms of days, weeks and even months. One participant recounted:

It went slowly downhill. I noticed 'mood'. A new day's mood is not the same as yesterday's mood when you start getting ill. The changes lasted 2 or 3 months before I went to the hospital (10).

Sensing well-known changes

Participants described sensing different changes that increased in intensity. They recognized these changes as signs of psychosis based on earlier experiences. One participant described a restless body and an inability to concentrate on daily activities. Another participant described mood changes, nightmares and the feeling of being burned and falling down in the darkness. Participants expressed the experience of hearing voices that harassed them and/or tried to persuade them to do bad things; they also described increased anxiety. They adapted to the progression of signs by closely noticing them. One man described:

I sense when I am close to psychosis. I know the signs. First, I get worried, and then the voices become more aggressive. It is like the voices grow in volume inside me (12).

Understanding well-known changes as signs of psychosis

Participants understood the experienced changes as early signs of psychosis. They knew psychosis to be painful and wanted to prevent it. One participant recounted:

I know what becoming ill involves. This time it was easier for me to be in charge of my illness. I have more knowledge now (10).

Dealing with well-known signs

Participants used coping strategies to maintain control over the increasing changes. They described focusing on daily routines and paying attention to or ignoring the increasing voices they heard. Participants described taking antipsychotic drugs and other medications or alcohol to reduce disability; they reported contacting mental health services for support. Based on previous experiences, they knew they could reduce and/or stop psychosis with adequate efforts. This time, the signs evolved and made them aware of their need for help. One participant explained:

I had symptoms of mania. I started to spend money. I got problematic to read and do daily activities. I could not find peace in my apartment any longer. I walked down to the emergency clinic and talked with the nurse (5).

Articulating well-known signs

Participants contacted mental health personnel and described their experienced changes as signs of psychosis that indicated their need for treatment and care. One woman said:

I called the emergency clinic and got a nurse on the phone. I just said how it was. The voices I heard told me to harm my father. She understood it was serious and contacted the hospital (9).

B. Experiencing sudden unexpected changes as signs of psychosis

The second category described participants' transitioning process as the onset of sudden and unexpected changes that overwhelmed them and reduced their ability to deal with the changes on their own. Close others observed signs of psychosis and contacted mental health personnel, and the participants accepted treatment and care.

Noticing sudden unexpected changes directly related to time

Participants described sudden changes in their health condition and reported knowing the exact day this change occurred. One woman said:

I was home in my apartment and about to clean the bathroom. It was acute, like snapping my fingers. It happened from Thursday to Friday (1).

Sensing sudden unexpected changes

Participants reported overwhelming changes and described them as unexpected, intense sensations different from symptoms present in their daily lives. They described increasing energy, voices that suddenly became scary and demanding, situations where things in the environment took on special meanings and thoughts became twisted. Participants described intruding impressions and recalled hearing that relatives spoke with 'double voices'; they described being obsessed during activities and that impressions overwhelmed them and displaced their emotions. One woman explained:

It feels like I am closed or turned off. I do not think I love my children anymore (7).

Understanding sudden unexpected changes as signs of psychosis supported by close others

Participants described that changes occurred suddenly and unexpectedly. They reported not having the ability to think clearly and described an intense fear of losing control and/or of harming someone or themselves. They described having a vague understanding of being psychotic that became clearer when close others articulated their observations of psychosis; however, the intense changes took all of their attention, created fear and reduced their capacity to relate to people. One man recounted:

When you are in this situation, a paranoid psychosis, you only think that the worst will follow. You think someone will shoot you, strange things, and you draw the wrong conclusions, even if you know deep down in yourself everything will be as before (11).

Dealing with signs of psychosis supported by close others

Participants described their fight to maintain control over the changes. One man described himself as frozen when

trying to maintain control. Participants claimed to be unable to seek help. However, participants acknowledged they were lucky to have their close others who understood the signs of psychosis and contacted mental health personnel. One woman recalled:

Suddenly I thought, 'I am going to die anyway'. One nurse understood something was wrong with me; he came and found me in the garage. I was about to commit suicide. He saved me and got me to the hospital (4).

Articulating signs of psychosis supported by close others

Participants described being unable to articulate their condition and explained the feeling of being locked inside their body or that their speech was changed or blocked. Thus, it was necessary for their close others to speak on their behalf and to contact mental health personnel. They reported that close others described signs of psychosis to the mental health personnel and treatment and care were immediately offered. One participant said:

I was in a psychotic state, and it was difficult to distinguish between what was real and what was not. In that situation, I was not in a condition to do anything. Thanks to my parents, I got help. They decided to call for help (11).

C. Experiencing unidentified changes as signs of illness

The third category described the transitioning process to psychosis as unidentified changes participants sensed but struggled to understand, address and articulate. They described the absence of close others they related to that were concerned with their unidentified changes. They described the interventions from authorities (e.g. police, physicians and mental health personnel) as coercive.

Noticing unidentified changes implicitly related to time

Information about time was lacking in participants' narratives. Participants described unidentified changes experienced prior to hospital admittance and connected to events, places and people. When they were asked when the changes started, participants answered metaphorically. One participant related the changes to Good Friday. He expressed it like this:

I think about it as I restarted. It was on Good Friday. It was then that I started again on the school of life (6).

Sensing unidentified changes

Participants described sensing unidentified changes. One participant explained her face and body changed. Participants described the feeling of being weightless and that food began to taste bad; they expressed clearly seeing how

different events were chained together and having visions about the reality of situations. They described strange thoughts they could not control, intense anxiety, unpleasant sensations, feelings of illness, abundant energy or becoming fatigued. Participants recalled feeling insecure, of not belonging anywhere and having thoughts about changing their name and nationality. Some participants described positive changes. For example, one woman stated:

I heard my mother and father. I could hear them when it was quiet. They sat drinking their coffee, just as it was back then. It was good and cosy (3).

Being aware of unidentified changes

When participants recalled their experiences, they described neither knowing nor understanding what the changes meant. They described being in poor health and the awareness that something was wrong. Participants described searching for meanings and explanations for their experiences and contacted mental health personnel for treatment. One participant said:

I had intense pain in my arms and it was like a 'bird-nest'. I could not sleep, had a lot of energy and had problems at work. I told my general physician and got physiotherapy (2).

Dealing with unidentified changes without support

Participants described their fight to cope with the unidentified changes. They worked harder, travelled, stayed in bed, isolated themselves and/or stopped taking medication to reduce the discomfort. Some described their changes as being physically unwell. They contacted health personnel, but did not succeed in explaining their complaints and getting appropriate help. They did not talk with close others about the changes because they felt they would not understand them. At some point in time, they described that authorities (e.g. police, physicians and mental health personnel) intervened. In some cases, the interventions were made through physical coercion, which participants experienced as painful and shameful; the participants claimed they were treated with a lack of respect. One participant recounted:

I was squeezed against the wall, and the police held my arms very hard. I turned toward him and spat at him. I did not have anything else to do. They laid me down, and I got an injection. I felt I could not breathe (8).

Articulating unidentified changes without support

Participants explained they were afraid and confused about the changes and had problems articulating their condition to mental health personnel when the authorities intervened. They claimed the authorities ordered them to go to the hospital. When that situation occurred, participants

expressed a need to be connected with their close others. In some cases, they described acting out their frustrations and having the feeling of being isolated. When recalling the event, participants searched for words and used metaphors to express their experiences. They reported getting sad or angry and questioning the authorities' communication skills. One participant said:

They said I was to go to the hospital. I felt desperate and said, 'This cannot be true. You have to call my sister.' No! They took me out, and I got power and ran off to a store. I wanted someone to witness what was happening to me (2).

Discussion

The analysis and interpretation of participants' narratives about becoming psychotic revealed the following theme: being in a process of transition to psychosis. Transition means 'to go across', i.e. to pass or move from one state, condition or place to another (Reber *et al.* 2009). Transitions to psychosis are individual (Birchwood *et al.* 2000) and differ according to the specific psychotic disorder (Yung & McGorry 1996). Illness narratives differ according to the individual's illness, earlier experiences and ability to articulate his or her experiences. Moreover, the narratives differ according to whom the individual narrates and in what context (Frank 1995). This study is limited by the participants' abilities to recall their experiences of becoming psychotic and their willingness and ability to narrate. We do not know whether participants described exactly what happened; we know what the participants described. Participants' narratives about becoming psychotic are their unique way of expressing their illness experiences, their perceived symptoms and needs and their experiential accounts contribute to uncover differences in becoming psychotic, which are important for conducted interventions for psychosis.

Participants described different transitions through their experienced changes expressed as well-known signs of psychosis (A), sudden unexpected changes as signs of psychosis (B) and unidentified changes as signs of illness (C). These experiences reminded us of Toombs's (1988, p. 214) discussion that the illness precipitates changes in people's sense of self and body, both as the experiencing subject and the experienced object. In this perspective, the participants' awareness of changes can be predictable signs of psychosis (cf. Birchwood *et al.* 2000). Our results indicate the transitions were different based on how participants noticed changes related to time and how they sensed, understood, dealt with and articulated these changes. We also reported on the differences related to the participants contacting mental health personnel. Participants reported that they

themselves (A) or their close others articulated the experienced changes as signs of psychosis when contacting mental health personnel (B). Other participants articulated unidentified changes as a poor health condition that they described in metaphors when authorities intervened with coercion (C). These participants described the absence of close others to advocate for them. We discuss our results by highlighting these differences in the transitioning process.

Some participants expressed noticing changes over a period or at a specific moment in time (A, B). By stating when the changes began, participants distinguished these changes from ordinary health conditions and expressed some control over their illness. These results are consistent with studies reporting that some patients describe knowledge about the time related to the development of psychosis (Birchwood *et al.* 2000, Ruhrmann *et al.* 2009). Other participants associated the changes with events, places and people in their narratives (C). These results correspond with a report by Holma & Aaltonen (1998) that acute psychotic patients express an awareness of time through their narratives. Our study showed that all participants expressed an awareness of time when recalling their experiences about becoming psychotic but in different ways. Some participants (A, B) expressed time precisely related to when changes started and other participants (C) described time imbedded in their narratives expressed vaguely or in metaphors.

Participants described sensing changes as well-known signs of psychosis (A), as sudden unexpected changes (B) or as unidentified changes (C). They described changes that evolved in intensity and the fear of losing self-control due to the increased intensity of changes (A–C). Our results correspond with studies describing transitions to psychosis that begin with early non-specific signs of psychosis and progress to a psychotic state (Yung & McGorry 2007, Iyer *et al.* 2008) and disturb the patient's sense of self (Lysaker & Lysaker 2005, Roe & Davidson 2005). Our study provides insights into how participants describe psychotic signs physically and concretely. Moreover, we report on how these signs demand the participants' attention, threaten their sense of self, make it difficult for them to relate to other people and affect their perception of the world.

Participants demonstrated understanding changes in relation to their own and their close others' previous experienced psychosis as knowledge about the signs of psychosis (A, B). Participants who expressed unidentified changes described poor health and their search for an explanation for their condition (C). These results correspond with studies arguing that patients' insights into their psychoses encompass more than insights into the disorder and treatment; it also involves experienced changes and limitations in daily lives as an awareness of illness (David 1990, Roe *et al.* 2008). Researchers also argue that

patients' private perspectives on their situations can express their search for the meaning of their experience, not necessarily a lack of insight (Werbart & Levander 2005, Tranulis *et al.* 2008). Our study showed that participants describing unidentified changes as poor health conditions had difficulty articulating this understanding to mental health personnel.

Participants described dealing with changes as interventions initiated by them (A) or close others (B). These results are consistent with studies describing patients', relatives' and nurses' knowledge about psychosis and coping skills as significant factors related to the management of patients' psychoses (Mueser *et al.* 2006, Lincoln *et al.* 2007) and the role of significant others in reducing misunderstandings with mental health service (Anderson *et al.* 2012). Participants described interventions conducted by authorities (C) as being executed without consideration for the participants' awareness of their illness. They described these interventions as physical and traumatic. These results correspond with studies seeking to develop approaches to reduce coercion and to make treatment and care more secure for patients (Andreasson & Skärsäter 2012, Soininen *et al.* 2013). Our study shows that the physical aspect of the crisis interventions was an extra burden for people transitioning to psychosis.

Participants reported the process of articulating changes during transitioning as experiencing no changes in their language and speech (A), as blocked speech (B) and as having problems articulating unidentified changes which participants related to as feeling isolated (C). These results correspond with reported changes in language and speech as psychotic symptoms (Mould *et al.* 2010). Furthermore, our study shows how participants expressed the need for others to advocate for them and to communicate with them when changes in their language occurred. These results strengthen the arguments for a dialogical approach for patients with psychosis and their families during this phase of interventions for psychosis (cf. Seikkula *et al.* 2003).

To the best of our knowledge, we are the first to explore people's experience related to the phase of time prior to early interventions for psychosis, when people transition to psychosis. The new knowledge from our study can be highlighted as follows: Participants and their close others who understood and articulated experienced changes as signs of psychosis established a dialogue with mental health personnel about treatment and care. Participants who did not understand the experienced changes as signs of psychosis, but as poor health using metaphors in their explanations about their health, and had no one to advocate for them experienced poor communication during interventions. This new insight is revealed from the participants' narratives from the pre-interventional phase to enable

improvements in the interventions for psychosis. This insight can reasonably be transferred to other contexts where health personnel establish contact with people transitioning to psychosis.

Conclusions

Participants who knew and articulated the signs of psychosis on their own or who were supported by close others had an increased chance of getting treatment and care and preventing or reducing the critical phase of psychosis. Participants who expressed an awareness of unidentified changes as signs of illness, such as a poor health condition and not as signs of psychosis, used metaphors to articulate their health condition and had no support from close others were at risk for delayed treatment and/or coercive interventions. These results provide important information for improving communication during the three first steps of intervention for people transitioning to psychosis. Further research and clinical improvements are needed to develop approaches for interventions that take this experiential knowledge into serious consideration.

Implications for practice

The results in our study suggest there is a need for improvements to the communication during interventions for psychosis and that this communication should include participants' experiential knowledge of transitioning to psychosis. Mental health personnel, such as general physicians and mental health nurses/workers in the local mental health services, are often involved in interventions for people becoming psychotic. We suggest the development of guidelines for mental health personnel related to the three steps of early intervention for psychosis: to reach, to establish contact with, and to offer and start treatment and care for people transitioning to psychosis. Such guidelines can be supplemented with existing guidelines for the treatment and follow-up for people with psychotic illnesses.

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References

- Anderson K., Fuhrer R. & Malla A. (2012) 'There are too many steps before you get to where you need to be': help-seeking by patients with first-episode psychosis. *Journal of Mental Health* 22, 384–395.
- Andreasson E. & Skärsäter I. (2012) Patients treated for psychosis and their perceptions of care in compulsory treatment: basis for an action plan. *Journal of Psychiatric and Mental Health Nursing* 19, 15–22.
- Barker S., Lavender T. & Morant N. (2001) Client and family narratives on schizophrenia. *Journal of Mental Health* 10, 199–212.
- Bhikha A., Farooq S., Chaudhry N., et al. (2012) A systematic review of explanatory models of illness for psychosis in developing countries. *International Review of Psychiatry* 24, 450–462.
- Birchwood M., Spencer E. & McGovern D. (2000) Schizophrenia: early warning signs. *Advances in Psychiatric Treatment* 6, 93–101.
- Birchwood M., Conner C., Lester H., et al. (2013) Reducing duration of untreated psychosis: care pathways to early interventions in psychosis. *The British Journal of Psychiatry* 203, 58–64.
- Bosanac P., Patton G.C. & Castle D.J. (2010) Early interventions in psychotic disorders: faith before facts? *Psychological Medicine* 40, 353–358.
- Cotton M.A., Johnson S., Bindman J., et al. (2007) An investigation of factors associated with psychiatric hospital admission despite the presence of crisis resolution teams. *BMC Psychiatry* 7, 52.
- Cullberg J., Levander S., Holmqvist R., et al. (2002) One-year outcome for first episode psychosis patients in the Swedish Parachute project. *Acta Psychiatrica Scandinavica* 106, 276–285.
- Cullberg J., Mattsson M., Levander S., et al. (2006) Treatment costs and clinical outcome for first episode schizophrenia patients: a 3-year follow-up of the Swedish 'Parachute Project' and two comparison groups. *Acta Psychiatrica Scandinavica* 114, 274–281.
- David A.S. (1990) Insight and psychosis. *The British Journal of Psychiatry* 156, 798–808.
- Frank A.W. (1995) *The Wounded Storyteller: Body, Illness, and Ethics*. University of Chicago Press, Chicago, IL.
- Graneheim U.H. & Lundman B. (2004) Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today* 24, 105–112.
- Grant A., Biley F. & Walker H. (2011) *Our Encounter with Madness*. PCCS Books Exeter, United Kingdom.
- Hardy K.V., Dickson J.M. & Morrison A.P. (2009) Journey into and through an early detection of psychosis service: the subjective experience of persons at risk of developing psychosis. *Early Intervention in Psychiatry* 3, 52–57.
- Hasselberg N., Gråwe R., Johnson S., et al. (2011) An implementation study of the crisis resolution team model in Norway: are the crisis resolution teams fulfilling their role? *BMC Health Services Research* 11, 96.
- Holma J. & Aaltonen J. (1998) The experience of time in acute psychosis and schizophrenia. *Contemporary Family Therapy* 20, 265–276.
- Iyer S.N., Boekestyn L., Cassidy C.M., et al. (2008) Signs and symptoms in the pre-psychotic phase: description and implications for diagnostic trajectories. *Psychological Medicine* 38, 1147–1156.
- Killackey E. & Yung A. (2007) Effectiveness of early intervention in psychosis. *Current Opinion in Psychiatry* 20, 121–125.
- Kleinman A. (1988) *The Illness Narratives – Suffering, Healing and the Human Condition*. Basic Books, New York.
- Lauveng A. (2013) *A Road Back from Schizophrenia*. Skyhorse Publishing, New York.
- Leiviska Deland A.C., Karlsson G. & Fatouros-Bergman H. (2011) A phenomenological analysis of the psychotic experience. *Human Studies* 34, 23–42.
- Lincoln T.M., Wilhelm K. & Nestorluc Y. (2007) Effectiveness of psychoeducation for relapse, symptoms, knowledge, adherence and functioning in psychotic disorders: a meta-analysis. *Schizophrenia Research* 96, 232–245.
- Lopez A.D., Mathers C.D., Ezzati M., et al. (2006) Global and regional burden of disease and risk factors, 2001: systematic analysis of population health data. *The Lancet* 367, 1747–1757.
- Lysaker J.T. & Lysaker P.H. (2005) Being interrupted: the self and schizophrenia. *The Journal of Speculative Philosophy* 19, 1–21.
- MacDonald E., Sauer K., Howie L., et al. (2005) What happens to social relationships in early psychosis? A phenomenological study of young people's experiences. *Journal of Mental Health* 14, 129–143.
- Marshall M. & Rathbone J. (2011) Early interventions for psychosis. *Cochrane Database of Systematic Reviews*, Issue 15. Art. No. CD004718.
- McGorry P.D., Killackey E. & Yung A.R. (2008) Early intervention in psychosis: concepts, evidence and future directions. *World Psychiatry* 7, 148–156.
- McGorry P.D., Johannesen J.O., Lewis S., et al. (2010) Early intervention in psychosis: keeping faith with evidence-based health care. *Psychological Medicine* 40, 399–404.
- van Meijel B., van der Gaag M., Kahn R.S., et al. (2002) The practice of early recognition and early intervention to prevent psychotic relapse in patients with schizophrenia: an exploratory study. Part 2. *Journal of Psychiatric and Mental Health Nursing* 9, 357–363.
- Mishler E.G. (1991) *Research Interviewing. Context and Narrative*. Harvard University Press, Cambridge, MA.
- Morse J., Barret M., Mayan M., et al. (2002) Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods* 1, 1–19.
- Mould T.J., Oades L.G. & Crowe T.P. (2010) The use of metaphor for understanding and managing psychotic experiences: a systematic review. *Journal of Mental Health* 19, 282–293.
- Møller P. & Husby R. (2000) The initial prodrome in schizophrenia: searching for naturalistic core dimensions of experience and behaviour. *Schizophrenia Bulletin* 26, 217–232.
- Mueser K.T., Meyer P.S., Penn D.L., et al. (2006) The illness management and recovery program: rationale, development, and preliminary findings. *Schizophrenia Bulletin* 32, 32–43.
- Norwegian Directorate of Health (2013) *National Guidelines for Diagnosis, Treatment and Follow-Up of Individuals with Psychotic Disorders*. Anvord Grafisk AS, Oslo, Norway.
- Parnas J. & Handest P. (2003) Phenomenology of anomalous self-experience in early schizophrenia. *Comprehensive Psychiatry* 44, 121–134.
- Reber A.S., Rhiannon A. & Reber E. (2009) *The Penguin Dictionary of Psychology*. Clays Ltd, St Ives, England.
- Roe D. & Davidson L. (2005) Self and narrative in schizophrenia: time to author a new story. *Medical Humanities* 31, 89–94.
- Roe D., Hasson-Ohayon I., Kravetz S., et al. (2008) Call it a monster for lack of anything else: narrative insight in psychosis. *The Journal of Nervous and Mental Disease* 196, 859–865.
- Ruhrmann S., Schultze-Lutter F. & Klosterkötter J. (2009) Intervention in the at-risk state to prevent transition to psychosis. *Current Opinion in Psychiatry* 22, 177–183.
- Sass L.A. (1988) The land of unreality: on the phenomenology of the schizophrenic break. *New Ideas in Psychology* 6, 223–242.
- Seikkula J., Arnkil T.E. & Erikson E. (2003) Postmodern society and social networks: open and anticipation dialogues in network meetings. *Family Process* 42, 185–203.
- Soininen P., Välimäki M., Noda T., et al. (2013) Secluded and restrained patients' perception of their treatment. *International Journal of Mental Health Nursing* 22, 47–55.
- Stafford M., Jackson H., Mayo-Wilson E., et al. (2013) Early interventions to prevent psychosis: systematic review and meta-analysis. *British Medical Journal* 346, f185.
- Tanskanen S., Morant N., Hinton M., et al. (2011) Service users and carer experience of seeking help for a first episode of psychosis: a UK qualitative study. *BMC Psychiatry* 11, 157.

- Tappan M. & Brown L.M. (1989) Stories told and lessons learned: toward a narrative approach to moral development and moral education. *Harvard Education Review* 59, 182–205.
- Toombs S.K. (1988) Illness and the paradigm of lived body. *Theoretical Medicine* 9, 201–226.
- Tranulis C., Corin E. & Kirmayer L.J. (2008) Insight and psychosis: comparing the perspectives of patient, entourage and clinician. *International Journal of Social Psychiatry* 54, 225–241.
- Werbart A. & Levander S. (2005) Understanding the incomprehensible: private theories of first-episode psychotic patients and their therapists. *Bulletin of the Menninger Clinic* 69, 103–136.
- Yung A.R. & McGorry P.D. (1996) The prodromal phase of first-episode psychosis: past and current conceptualizations. *Schizophrenia Bulletin* 22, 353–370.
- Yung A.R. & McGorry P.D. (2007) Prediction of psychosis: setting the stage. *The British Journal of Psychiatry* 191, 1–8.

Paper II

RESEARCH ARTICLE

Open Access



Confirming mental health care in acute psychiatric wards, as narrated by persons experiencing psychotic illness: an interview study

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Abstract

Background: It is important that mental health nurses meet the safety, security and care needs of persons suffering from psychotic illness to enhance these persons' likelihood of feeling better during their time in acute psychiatric wards. Certain persons in care describe nurses' mental health care as positive, whereas others report negative experiences and express a desire for improvements. There is limited research on how persons with psychotic illness experience nurses' mental health care acts and how such acts help these persons feel better. Therefore, the aim of this study was to explore, describe and understand how the mental health nurses in acute psychiatric wards provide care that helps persons who experienced psychotic illness to feel better, as narrated by these persons.

Method: This study had a qualitative design; 12 persons participated in qualitative interviews. The interviews were transcribed, content analysed and interpreted using Martin Buber's concept of confirmation.

Results: The results of this study show three categories of confirming mental health care that describe what helped the participants to feel better step-by-step: first, being confirmed as a person experiencing psychotic illness in need of endurance; second, being confirmed as a person experiencing psychotic illness in need of decreased psychotic symptoms; and third, being confirmed as a person experiencing psychotic illness in need of support in daily life. The underlying meaning of the categories and of subcategories were interpreted and formulated as the theme; confirming mental health care to persons experiencing psychotic illness.

Conclusion: Confirming mental health care acts seem to help persons to feel better in a step-wise manner during psychotic illness. Nurses' openness and sensitivity to the changing care needs of persons who suffer from psychotic illness create moments of confirmation within caring acts that concretely help the persons to feel better and that may enhance their health. The results show the importance of taking the experiential knowledge of persons who have experienced psychotic illness seriously to develop and increase the quality of mental health care in acute psychiatric wards.

Keywords: Acute psychotic illness, Confirmation, Mental health nursing care, Narrative, Qualitative research

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Background

Psychosis affects about 1 % of the population worldwide once in a life time. The incidence of new cases of psychosis is estimated to 15–20 per 100 000 inhabitants a year [1, 2]. This means 750–1000 new cases of persons suffering from psychosis in Norway a year, and in the Nordic countries the total of 3900–5200 new cases. Most persons recover from psychosis, although experience vulnerabilities to new phases of psychosis, and/or some persons have long-lasting psychotic illness [1]. In the last decade, there has been a new emphasis in the global community on developing and offering the best possible mental health care to prevent psychosis, and to reduce persons suffering from psychotic illness and to support their daily life [3].

Psychosis is defined by certain symptoms, such as hallucinations, delusions and disturbed behaviour, and refers to psychotic illnesses [4]. Persons experiencing psychotic illness describe a changeable phenomenon with risks of developing acute phases of psychosis [1, 2]. The acute phase of psychotic illness can be characterized by increased distress and psychotic symptoms that include distortions in emotions, thinking, perceptions, sense of self and behaviour [1, 2]. Being acute psychotic ill is metaphorically described as being adrift from one's own body and self, from other people and from the environment (cf. [5]). Persons may express severe mental distress and suffering from psychotic illness as complex and challenging mental health care needs [6]. Clinical mental health care guidelines recommend a range of clinical approaches to the various phases of psychosis within different care settings and specific mental health care adjusted for each person [1, 2].

In most Western countries, mental health care for persons experiencing psychotic illness is primarily offered in the community and secondarily in acute psychiatric wards in hospitals. Mental health professionals in acute psychiatric wards seek to diagnose, treat and provide intensive care for persons to reduce their psychotic symptoms and enhance their health [7]. Research studies have reported growing evidence of the potential to prevent psychosis and/or decrease psychotic symptoms to improve persons' health with treatment and care in different care settings [4, 8]. Researchers have recommended that mental health nursing care should be person-centred, meaning that care acts should be provided within the interpersonal relationship between the nurse and the person in care, based on how the person in care understands his/her situation and needs and in accordance with what the nurse understands is the person's care needs [5, 9].

The main task for mental health nurses in acute psychiatric wards is to meet the person's emergent needs for safety and security and his/her physical and mental

needs while he/she experiences psychotic illness [10, 11]. This requires trained mental health nurses with specific knowledge about and skills in mental health care for the person, social interaction and communication [12–14]. The interpersonal interaction between the nurse and the person in care is considered as a cornerstone of mental health care [15]. It is important to be aware that the efficiency demands in acute psychiatric wards may prevent nurses from interacting with persons in their care [16, 17]. To better understand mental health care acts, we reviewed the literature on how persons with psychosis experience and describe the mental health care they receive in acute psychiatric wards as a help to feel better. Mental health nurses' responsibility is to help and support the person who experiences psychotic illness to "get going again" and "feel better" [9]. The goal of mental health nurses care is what is possible for the person in care. This can be "to feel better" which is the expression nurses relate to when providing mental health care (cf. [18]).

Some studies report positive experiences in acute mental health care. One ethnographic study described that nurses' regulation and control of the admitted persons' behaviour were intended to meet their needs for safety and security during acute mental illness [19]. Interview studies have highlighted that persons receiving acute mental health care experience the acute psychiatric ward as a refuge from self-destructiveness [20] and as a safe place [21] that frees them from daily chaos and stress [22]. Furthermore, persons described nurses as trustworthy and fair [21, 23] and reported that the nurses confirmed them as persons [24]. The relationships with nurses increased the perceived quality of care to persons in care [25], and they appreciated that nurses were available to them on the ward [26]. The quality of life for persons increased when nurses supported their physical health, and helped them to cope with symptoms and daily life problems, and when nurses supported contact with their families [27]. The persons in care were helped when their psychosis were alleviated by nurses who tried to understand their vulnerability and helped them to be empowered [20]. The interpersonal relationship with nurses was described as important in improving the mental health to persons receiving mental health care [28, 29], and being involved in medical treatment and care decisions helped them feel in control [30–32].

Other studies have described persons' experiences with acute mental health care in negative terms. In two different ethnographic studies, researchers reported that mental health care lacks interaction between nurses and persons in care because nurses spend most of their time working at nursing stations [33, 34]. These results are similar to those of two review studies [35, 36]. Other persons who experience psychotic illness reported that

staying in an acute ward was meaningless and was similar to being in a prison because of the sense of intimidation and control and the long waits to see nurses. They doubted the effectiveness of the care they received during their acute psychotic illness [37]. Still others described dissatisfaction with their care because of restrictions such as compulsion and confinement, which increased their mental distress [38, 39], and because they felt they were humiliated and disrespected [40]. A survey study revealed that a controlling, angry and aggressive atmosphere on the ward decreased the quality of care provided [41].

Studies have also shown that persons in acute psychiatric wards want to interact with nurses [25] who are trained and understanding and have good social skills; furthermore, care recipients want to be perceived as ill persons who need care [23, 40]. Some involuntarily admitted persons desired more communication with the staff about their care [39]. Persons receiving care wanted to discuss and negotiate with nurses how their care could be provided [42], desired to be engaged in their treatment [23], and longed for deeper connections with nurses to share their inner world [20].

The reviewed studies described that some persons experienced mental health care as positive and helpful when their care needs were met within the context of a positive interpersonal relationship with nurses, such as being helped when protected from vulnerabilities and empowered during psychotic illness [20]. However, mental health care was also described in negative terms when persons experienced a lack of interpersonal relationships and interaction with nurses and when the care included confinement and restrictions. Persons in care in psychiatric wards wanted to be acknowledged and respected as a person by the nurse. There is limited research on how persons with psychotic illness experience care acts in their relationships with nurses, and whether that care helps them to feel better. Nursing care comprises two aspects: one is the issue/matter act and the other is the interpersonal relationship between the nurse and the person in care that strengthens the quality of the care act (cf. [5, 43, 44]). These two aspects of nursing are interwoven. Mental health nursing care in acute psychiatric wards is intended to provide a safe haven through interpersonal relationships between the nurses and the persons in care by addressing the latter's care needs and supporting their recourses. Within this perspective and to the little known about how nurses' mental health care acts help persons to feel better, we designed a study to assess the care experiences of persons who suffer from psychotic illness. The aim of this study is to explore and describe how the mental health care provided by nurses was experienced as help to feel better, as

narrated by persons with psychotic illness in acute psychiatric wards.

We employed Martin Buber's [45] concept of confirmation to understand the mental health care act as a confirming act. According to Buber [45], confirmation happens in events of confirming acts; it is not the event itself, but rather what happens between people. Confirmation happens when one person apprehends the other as a different and unique person, and meets him/her as an independent other able to enter relationships in which they confirm each other as persons. Confirmation is fundamental to the formation of a person's self and identity [45]. The concept of confirmation has been used in mental health nursing research to understand the relationships between the person in care and the nurse [24, 46].

Methods

To address the aim of this study, we used a qualitative, explorative and descriptive study design. Qualitative interviews we found suitable for assessing persons' narrated experiences of psychotic illness were used [47]). To analyse the interview texts, we chose a qualitative content analysis that allows description of the manifest content of the data, interpretation of the underlying meaning of subcategories and categories, and formulation of a theme [48]. Through the qualitative content analysis, the multifaceted and sensitive phenomenon of nursing care can be uncovered, explored and described (cf. [49]).

Ethics

The Regional Committee for Medical and Health Research Ethics (2012/1319) approved the study. Key research ethical principles were followed: the participants received written and oral information about the study and on the voluntary nature of participation. They signed an informed consent form prior to participation; confidentiality and the anonymous presentation of the results were guaranteed; and the participants were assured of their right to withdraw from the study without any explanation at any time before the analysis with no consequences for their treatment or care. The researchers were aware of the vulnerability of persons who are hospitalized for psychotic illnesses, possible limitations in their ability to understand and sign the informed consent form, and the risk that they may feel coerced to participate (cf. [50, 51]). According to the study procedure, the local project contact person on each ward contacted the participants after the interviews. This contact person ensured that the primary nurse followed up the participants if the interview had evoked bad memories that they strived to cope with.

Setting

For the past 10–15 years in Norway, mental health care has been offered in acute psychiatric wards of hospitals to persons experiencing acute phases of psychotic illness when community mental health care is insufficient. The setting for this study was four acute psychiatric wards at two general hospitals. The hospitals located in mid-sized cities are responsible for providing acute mental health services to large geographical areas, which implies relatively long distances between the hospitals and the admitted persons' homes. Each 10- to 12-bed ward provides short-term treatment and care (for a mean of 10 days) to women and men experiencing acute mental illness. Each ward reported admitting approximately 400 people per year. The nursing staff members are mental health nurses, nursing assistants and registered nurses who are educated and trained in acute mental health care. Together with the persons in care and, often, the latter's family members, the multi-professional team on the ward is involved in developing a mental health care plan for each person in care on the ward.

Recruitment procedure

The participants were purposively recruited from among admitted persons on four acute wards during a five-month period and were selected based on voluntary or involuntary admission, psychotic illness, and their willingness to narrate their experiences of mental health care in acute psychiatric wards. The chief physician and the responsible nurse on the ward selected persons in care to be asked about participation after the acute phase of psychosis. In cooperation with the person selected; the physician and nurse ensured that he/she understood what it means to participate in the research; including narrating his/her experiences of psychotic illness (cf. [51]). Those 20 persons selected for recruitment received written and oral information from a local project contact person at each hospital who did not work in mental health care on the ward. Fourteen persons provided informed consent for participation; however, two persons discharged from hospital before an interview could be arranged. The number of participants and the variation in the sample appeared sufficient to describe the nuances and variations in experience and were small enough to allow a thorough analysis of the data (cf. [48]).

Participants

Eight women and four men aged 18 to 64 years participated. Eight of the participants were involuntarily admitted, and four were voluntarily admitted according to the Norwegian Mental Health Act [52]. The participants reported they had been diagnosed with psychosis during an earlier hospital stay. They described their number of

stays in acute wards as ranging from two to approximately 40. This period of admission to the acute psychiatric wards was related to a phase of psychotic illness. The stays during which the interviews were conducted lasted from one to approximately eight weeks. All of the participants reported having contact with their family members. Eight of them lived together with partners or other family members, and four lived alone in their own flat or house.

Interviews

Only the first author (KS) and the interviewee were present during the interview, which was conducted in the hospital in a quiet room outside the ward. Before the interview began, KS introduced herself, provided information about the research study and discussed everyday matters, such as place of residence. KS then repeated the information about the study, the interview, and audio recording and began a conversation about how the participants experienced the interview situation. The qualitative interview [47] began with an opening question inviting the participants to speak freely about and narrate the mental health care they received. Additional and exploratory questions followed, such as "Please describe what happened during your care"; "Please tell me what you felt, thought, wished for during your care"; "How did you experience that the mental health care helped you feel better?" An interview guide was used to ensure that various aspects of the topic were covered. The interviews lasted 50–90 minutes, not counting the time taken for breaks, and were audio recorded and transcribed verbatim by KS. When the twelfth interview did not reveal any new information on the study topic, no further interviews were conducted (cf. [53]).

Analysis

A qualitative content analysis inspired by Graneheim & Lundman [48] was used in a step-wise manner:

- It should be noted that the interview text included descriptions of mental health care that the participants regarded as either helping or not helping them feel better. In the present study, the interview text from all interviews that describes the mental health care that helped the participants feel better constitutes the unit of analysis. This interview text was read and reread in an open-minded manner to gain a sense of the whole according to the aim of the study. In this reading, we recognized elements of person-centred mental health care (cf. [5]) in the interview text that described care that responded to each participant's personal care needs when psychotically ill. These descriptions reminded us of Martin Buber's [45] concept of confirmation.

- The interview text was divided into meaning units consisting of one or more sentences or a paragraph containing one meaning that described helping mental health care.
- Each meaning unit was condensed and labelled with codes via reflecting upon the following questions: What does the text describe as helping mental health care? How was the care helping feel better? To whom did the participants relate during care and how?
- The research team compared, contrasted and explored the commonalities and differences between the coded meaning units, which then were sorted and organized into subcategories and categories and validated by relating the subcategories. We then searched for uniformities to reduce the number of categories.
- The categories and subcategories were labelled with regard to confirmation (Tables 1 and 2).
- The underlying meaning of the subcategories and categories was interpreted in the context of the whole of all interviews, answering the question of how the participants experienced mental health care that helped them feel better. The interpretation of the underlying meaning of the subcategories and categories constructed from the total interview text was formulated as a theme: *Confirming mental health care to persons experiencing psychotic illness.*

Results

The results present how the participants in this study experienced the mental health care in acute psychiatric wards provided by nurses, helped them feeling better while they experienced psychotic illness. The theme, “confirming mental health care to persons experiencing psychotic illness”, links subcategories and categories together. Each of the three categories describes how the participants were approached by nurses and describe the nurses’ confirming mental health care acts. These

confirming acts help the participants in a step-by-step movement towards to feel better. The movement of confirming care acts can also go back and forward, as well move into new circles of confirming mental health care. A schematic presentation of the results is illustrated in Fig. 1. The following presentation of the results consists of the theme, categories and subcategories and includes quotations from the interviews, numbered from 1–12, to verify the results.

Confirming mental health care to persons experiencing psychotic illness

The results regarding confirming mental health care that involved the participants and the nurses in various mental health care acts during the participants’ acute psychotic illness illustrate how they were helped to feel better. The participants described that the mental health care helped them and confirmed their personal changing needs during their psychotic illness and that the confirming way in which the nurses provided mental health care helped them to feel better. The confirmation that occurred within the various confirming mental health care acts helped the participants feel better in a step-by-step manner during their psychotic illness by helping them become aware of their own care needs, increasing their self-respect, and strengthening their self-esteem as a person who matters to others. The various ways of being confirmed within mental health care acts are described further below.

Being confirmed as a person experiencing acute psychotic illness in need of endurance

The participants described their experience during the first phase of psychotic illness as critical. The nurses’ unconditional mental health care confirmed their immediate need for care and helped them to endure the critical phase of psychotic illness. These confirming mental health care acts increased the participants’ awareness of their own needs.

Table 1 Example of the analysis process

Meaning unit	Condensed meaning unit	Subcategory	Category
The physician asked repeatedly if I accepted the treatment, as if to persuade me and I got stressed. (.) I said no, because I thought this treatment could be a danger to my body. When the nurse heard this, she said, “This is not the way it should be – I will talk with the Physician A”. Then, A stopped (...)	The participant talks about being supported and respected by the nurse and the physician.	Being in relationships with nurses and physicians	Being confirmed as a person experiencing psychotic illness in need of decreased psychotic symptoms
We talk about the psychosis and how it was when I injured myself. We talk about what happened before and put labels on a board to look at it. In this way, it gets easier for me and for them to understand (4).	The participant described how she and the nurse/physician can discuss symptoms to understand how she experiences them.	Being in discussion with nurses and physicians	

The example of the analysis may seem linear from meaning units to categories. Note that in the analysis, each category implies several subcategories, and each subcategory implies several condensed meaning units

Table 2 Interpreted theme, categories and subcategories

Theme	Confirming mental health care to persons experiencing psychotic illness		
Categories	Being confirmed as a person experiencing acute psychotic illness in need of endurance	Being confirmed as a person experiencing psychotic illness in need of decreased psychotic symptoms	Being confirmed as a person experiencing psychotic illness in need of support in daily life
Subcategories	Being understood by nurses as a person experiencing critical psychotic illness	Being understood by nurses and physicians as a person experiencing psychotic symptoms	Being understood by nurses as a vulnerable person feeling better
	Being in peaceful communication with nurses	Being in discussion with nurses and physicians	Being in dialogue with nurses
	Being in an unconditional relationship with nurses	Being in a relationship with nurses and physicians	Being in a partnership with nurses

Being understood by nurses as a person experiencing critical psychotic illness

The participants described that it was difficult to articulate their suffering and their care needs to nurses during this phase of psychotic illness. However, they knew that the nurses understood their suffering based on how the nurses’ mental health care acts addressed their immediate

needs for safety, security and care. They described how the nurses remained with them, consoled them and assured them that their acute psychosis would pass. Without questioning their needs, the nurses provided nursing care, offered them medication and care to help them rest and sleep and to decrease their suffering, and limited their behaviour to prevent them from harming themselves or

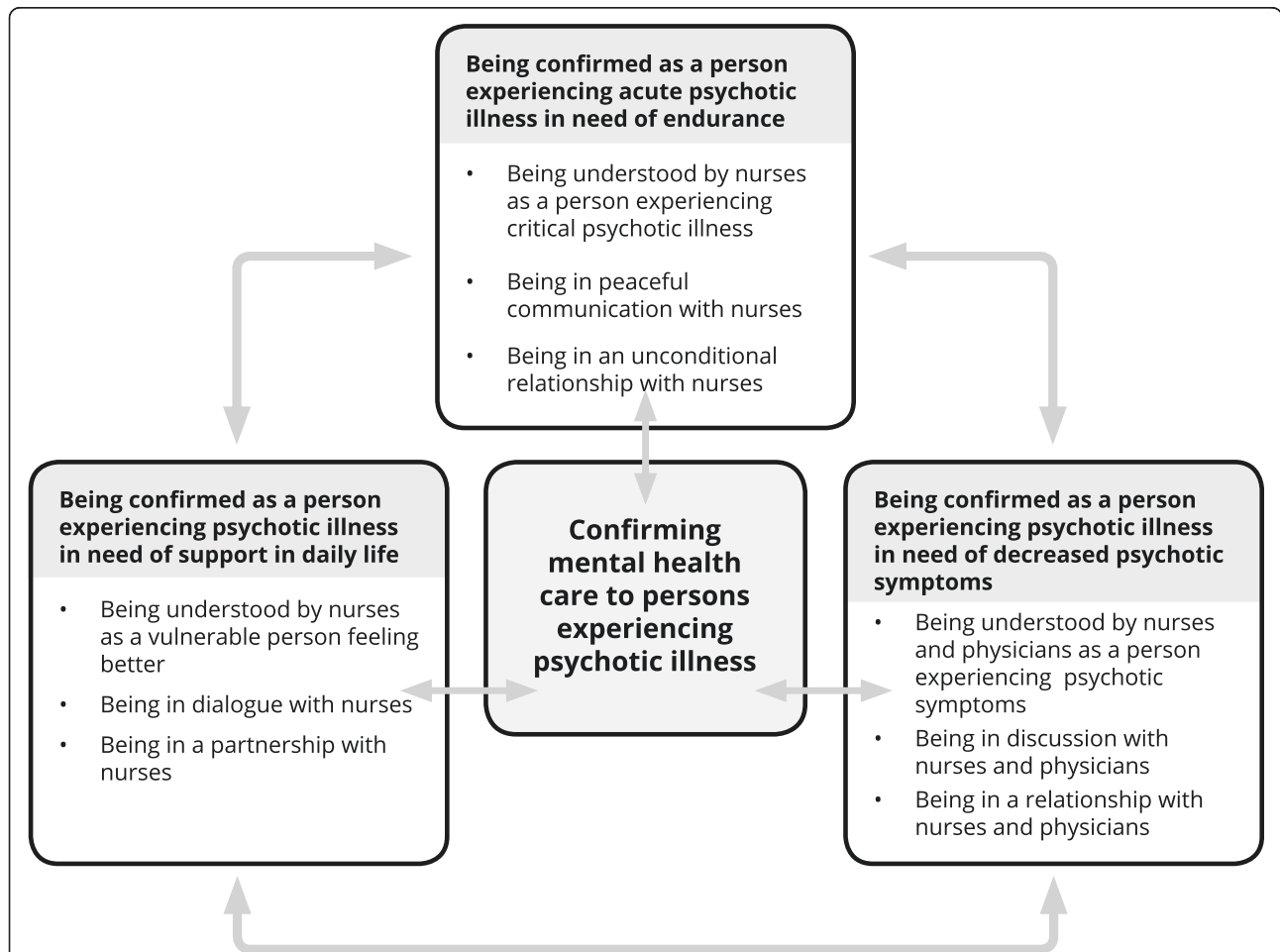


Figure 1 Confirming mental health care to persons experiencing psychotic illness. Confirming mental health care to persons experiencing psychotic illness links the three categories of nurses confirming acts: being confirmed as a person experiencing acute psychotic illness in need of endurance; being confirmed as a person experiencing psychotic illness in need of decreased psychotic symptoms; being confirmed as a person experiencing psychotic illness in need of support in daily life. These confirming acts help the person in a step-by-step movement towards to feel better. The movement of confirming care acts can also go back and forward, as well move into new circles of confirming mental health care

others. Being understood and receiving confirming mental health care in this way helped the participants endure the critical phase of their psychotic illness and helped them become aware of their own needs, as one participant articulated:

I was desperately anxious about Nurse A sitting there as if blocking the door, and I wanted out of the wardroom. Then, Nurse B offered to be with me. He did his best to ensure that everything would be OK. (...) He listened to how it really was for me and tried to understand me as well as possible (...), and maybe I only needed to be cared about (8).

Being in peaceful communication with nurses

The participants expressed that while they were critically psychotically ill, they were intensely mentally distressed and afraid of losing control over their behaviour. The nurses' peaceful non-verbal and verbal communication helped them feel safer and find some peace, and the participants described how the nurses sat quietly with them and read the newspaper or completed their chores in the wardroom. The nurses used few words and did not demand any conversation. Furthermore, peacefulness was communicated through the nurses' silent movement, silence, compassionate words and/or the use of a sensitive voice when providing care, limiting participants' behaviour and/or explaining to the participants why care was needed. One participant illustrated this peaceful communication when describing how Nurse C approached her:

When I was psychotic, (...) I sometimes needed limitation. Nurse C, whom I have met several times, limited me in a very good and helpful manner. He used his body to stop me, and he murmured quietly, such as "hum-hum", and did not argue with me... It made me feel safe (11).

Being in an unconditional relationship with nurses

The participants recalled being anxious during the critical phase of psychotic illness; they were anxious about being left alone and about being with people, and sometimes they rejected the nurses. The participants described the nurses who stayed with them, despite the participants' hostility, as "special". They described how these nurses acted with sensitivity to them and respected their personal space when providing care, such as when the participants were held and controlled and/or given personal care. They expressed that the nurses were physically close to their bodies without intruding, and one participant described the nurse's sensitivity by making small, nearly imperceptible movements with her fingers. The participants expressed their gratitude for an emotional connection with the nurses who unconditionally

provided mental health care in accordance with participants' needs and sensitively balanced the participants' needs for distance and closeness during nursing care in a way that felt safe and good. One participant described how Nurse D approached her:

It is very difficult to ask for help when you are this ill. Nurse D came and knocked on the door to the wardroom and asked to come in; I said, "No". She said she would come back in five minutes. She returned, came in, and sat down and held her arms around me for a long time without saying much. I cried and told her I was about to harm myself. Her actions stopped me from harming myself (4).

Being confirmed as a person experiencing psychotic illness in need of decreased psychotic symptoms

The participants described their suffering from psychotic symptoms. The nurses' and physicians' mental health care helped them decrease their suffering, and these confirming mental health care acts were expressed in terms of strengthening the participants' self-respect and their relationships with nurses and physicians.

Being understood by nurses and physicians as a person experiencing psychotic symptoms

The participants stated that both nurses and physicians understood that their psychotic symptoms affected their daily activity and well-being. This understanding led the participants to trust the nurses' and physicians' competence and their desire for the participants to be well, and the participants accepted the invitation to be involved in planning their treatment and care. They described that the physicians were engaged in understanding how they experienced symptoms and the medical treatment they were offered and strove to determine the medication and doses that would effectively decrease their symptoms. The participants expressed that it was important to them that the nurses involved in planning their treatment and mental health care focused on and understood that they were afraid of the antipsychotic medications and that the medications could make them uncomfortable and/or hurt them. The participants appreciated the nurses' support as they expressed these fears and experiences. One participant described the nurses' understanding approach as follows:

Nurse F asked me about how the medication was for me, and I said: "It helps to reduce the big ups and downs, but has changed my daily life into grey days". When hearing this, the physician suggested finding a new medication, and we sat together – me, the physician and the nurse, and I asked about everything, and they explained. They understood how important it was for me to feel better (2).

Being in discussion with nurses and physicians

The participants expressed that the nurses and physicians heard them during discussions about medication, and this made participants feel more in control. The participants raised questions and voiced opinions and desires, and they agreed, disagreed and negotiated with the physicians until they reached agreements and/or solutions about their treatment. The participants appreciated that nurses and physicians considered their accounts of the medications' effects important and allowed disagreement. This increased the participants' self-respect and encouraged them to express themselves and listen to the nurses' and physicians' opinions about medications. One participant described a discussion with the nurse and the psychiatrist as follows:

Regarding antipsychotic and sleeping medications, we had an uncompromising disagreement, but we agreed about our disagreement. However, I was heard, and they respected my opinion, and the psychiatrist took the initiative and offered me sleeping medication (11).

Being in a relationship with nurses and physicians

The nurses' and physicians' engagement in finding common solutions for the participants' treatment and mental health care strengthened the participants' relationships with the nurses and physicians and encouraged them to trust that the nurses/physicians cared about them. They appreciated that the nurses and physicians took the time to listen to them and respected their knowledge and opinions about medications, and they appreciated informal talks that allowed all of parties to get to know one another. They stated that their relationships with the nurses and physicians were different; they and the nurses knew one another more personally because they spent more time together and had more personal conversations. They valued their relationships with the nurses and the support that the nurses offered when they disagreed with the physicians about their treatment. The participants believed that the nurses' support made a difference, as one participant described:

The physician repeatedly asked if I accepted the treatment, as if to persuade me, and I got stressed. (...) I said no, because I believed this treatment could be a danger to my body. When the nurse heard this, she said, "This is not the way it should be – I will talk with Physician A". Then, A stopped. I think the nurse's intervention made the physician stop (3).

Being confirmed as a person experiencing psychotic illness in need of support in daily life

After being on the ward for some time, the participants felt better and were able to concentrate again. They

described that at that point of time, the nurses involved them in plans for their discharge and further support in daily life at home. This approach confirmed the participants and strengthened their self-esteem.

Being understood by nurses as a vulnerable person feeling better

The participants noted that they were involved in planning their discharge and the support that they and their family members would need at home. They articulated that the nurse responsible for planning the discharge understood their vulnerability, their concerns about becoming psychotically ill again and their limitations at home due to the risk of psychosis. Together with the nurse and the team on the ward, the participants' family members and local mental health professionals were invited to participate in planning the further support. The participants described how the nurses understood their vulnerability to stigmatization and the nurses' trusted their competence to represent their needs. The following participant statement captures this experience:

Yesterday, my nurse and my team on ward invited the local treatment team to a meeting, and I suggested one important and useful theme to be discussed: the stigmatization of me at home (11).

Being in dialogue with nurses

Regarding meetings with family members and local mental health professionals, which were arranged at the hospital or as phone/video conferences, the participants described that the nurse asked what they wished to talk about. The participants expressed their worries about future support and medication, and their family members asked questions about what to do if the participants needed acute help. They also discussed disagreements between family members and participants that could occur at home, and the participants found it easier to discuss this topic when the nurses and the team were present and supported the conversation. The participants were emotionally affected when family members expressed their love for them despite their concerns. These dialogues reminded the participants that they and their family members mattered to one another, and they viewed their family members in a new way, as one participant described:

When I heard my mother speak, I heard she was afraid of losing me or not knowing where I was. Not for control, but to know. (...) I understand more of my mother's worries about me now (4).

Being in a partnership with nurses

Cooperating with the nurse on the ward to plan the discharge and find solutions for mental health care at home

strengthened the participants' relationship with the nurse as a partner. The participants described how they used their knowledge of their own mental illness and care needs in the cooperation with the nurse and how the nurse used his/her nursing knowledge about psychosis and planning the discharge. Some participants expressed feeling ashamed about their illness and dependence and appreciated the nurses' sensitive behaviour, honesty and acceptance of their care needs. The participants cared about the nurses who approached them in this manner, as one participant described:

Nurse G and me have known each other for years during several admissions. She was the one who helped me receive benefits and keep in contact with my children. She supports me by trusting my needs and helps me figuring out about further treatment. I am still weak and need support. We are a kind of a team (9).

Discussion

Our results indicate that it is important for persons experiencing psychotic illness to receive confirming mental health care to help them to feel better. Confirming mental health care includes three approaches that address and confirm participants' personal changing needs for mental health care during psychotic illness. We do not know whether the participants described exactly what happened, but we know that they described their experiences of confirming mental health care. The participants' narratives help uncover differences in confirming approaches and in how the confirmation occurred during interactions between the nurses and the participants in mental health care acts. We seek to understand how confirming mental health care were received and how the confirming mental health care acts helped persons with psychotic illness feel better, step-by-step, in acute psychiatric wards. The results are discussed with respect to previous research and Buber's [45] concept of confirmation.

The nurses' confirming mental health care acts addressed the participants' immediate needs for safety, security and care to help them to endure the critical phase of psychotic illness. This result corresponds to those of other studies that indicate that nurses' presence, caring and interactions with the person in care are important for providing safety and security [20, 21, 23, 27]. Our results concerning how nurses' confirming mental health care acts helped the participants feel better are partially consistent with Koivisto *et al.*'s [20] study, which showed that nurses expressed an understanding of persons' needs for care and a sensitivity to their needs for distance and space while empowering them to cope with everyday life [20]. Our results also describe how nurses

employed peaceful communication within their relationships with the participants to convey understanding and support for the participants, who had difficulties articulating their care needs. According to Buber [45], to be understood is to be confirmed, and to understand another person is to confirm him/her as a unique person with true expression within a confirming act. Our results show that the nurses responsible for providing care concretely used their ability to reflect upon who the person in care is and consider his/her needs and how to provide the best care. We interpret nurses' provision of care from the perspective of Buber's [45] concept of confirmation, akin to taking a bold swing of thought into what another person might wish, feel, perceive and think in an attempt to understand the other person, with doing so leading to the confirming act.

The nurses provided mental health care in a way that led the participants to feel understood. In other words, the confirming mental health care act happened within a mutual understanding between the two of them, with few words and a peaceful manner. The participants described this approach as responsive to their need for care. According to Buber [45], the creation of mutual understanding happens in dialogue. The dialogue between the participant and the nurse was constituted by sensitive caring, gestures, and the use of few words (cf. [45]).

Nurses' confirming mental health care acts, conveyed through their peaceful approach, demonstrated the nurses' knowledge of the participants' needs by allowing them to be critically psychotically ill and by meeting their specific mental health care needs in a sensitive way. This result corresponds to previous research [13, 17, 20] describing the sensitive care that nurses provides for persons suffering from psychotic illness. However, our results show the nurses' assurance and unconditional mental health care, which implied knowledge and the hope that the participants would get better with the time (cf. [45]). Confirmation occurs between persons in care and nurses through mutual understanding, dialogue and interpersonal relationships and within an on-going movement between distance and closeness between the two partners. These new results are important because they contribute to improve our understanding of how to help psychotically ill persons whose abilities to articulate their needs and enter relationships are limited for a while (cf. [13, 14]). The confirming mental health care seem to contribute to the participants' ability to feel better and become aware of their needs when nurses help them express and/or articulate what they want and need through confirming mental health care act.

The nurses and physicians strove to decrease the participants' psychotic symptoms. The participants described this act as being heard, listened to and

understood. The discussions among the nurses, physicians, and participants allowed for agreement about how to decrease the participants' symptoms through medical treatment and care. These results are consistent with those of other studies reporting that involvement in treatment and care planning helps patients feel more in control [23, 25, 38] and involved in a positive process of becoming better [30]. However, other studies have shown that some persons find it difficult to participate in discussions about medical treatment [31], especially when they perceive a paternalistic attitude from the physician when physicians and persons in care disagree [32]. In our study, the disagreements between the nurses/physicians and the participants were described as a confirming mental health care act and as occurring in an atmosphere that permitted exchanges of opinions and a willingness to find solutions and agreements about how medical treatment and care decisions should be made. According to Buber [45], a discussion is a dialogical exchange of understanding that is not intended to change another's opinion; instead, the aim is to speak and listen with a willingness to understand one another's perspectives and develop a common understanding. This confirming mental health care act seemed to help increase the participants' self-respect. This result corresponds with results that describe the importance of patients feeling respected and maintaining their integrity in discussions with professionals [20] if nurses are to develop helping relationships [29] and persons in care become better from psychosis [28]. However, our results clarify the complex nature of creating agreement in shared decision-making processes when the professionals and persons in care do not have a mutual understanding of the situation. Our results reflect the support that nurses gave the participants during disagreements; such moments were important to the development of the discussion, and contributed to the participants' engagement in the decision-making process.

Together with the nurses, the participants, their family members and local mental health professionals were involved in planning discharge and further support. By allowing the participants to participate in the planning, the nurses confirmed them as valuable persons. Through this confirming mental health care act, the participants engaged in dialogue and partnership with the nurse to make plans for further support and care for themselves and their family members at home. Our results are in line with those of studies describing how professionals' cooperation with the family members of persons receiving mental health care improved these persons' relationships with their family [27]. It increased persons' quality of life [25] and decreased their mental health problems [54]. Furthermore, our results indicate that family members who confirmed the participants through love and

concern changed the participants' perceptions of their family members and themselves as persons who matter to one another. According to Buber [45], simply confirming individuals in their social roles, such as "patient", reduces their image of themselves as unique persons. Because personal confirmation happens between persons in a dialogue, a common understanding of a "we" can arise. From this perspective, our results show that the joint development of the discharge plan represents a confirming mental health care act arising from a partnership among the nurses, the participant and their family members. It creates a common understanding of the need for further support to maintain the participant's mental health and to prevent new phases of psychotic illness (cf. [55]). It appears that this confirming mental health care act helps the person receiving care feel better and strengthens her or his self-esteem.

The new knowledge gained from our study indicates that confirmation occurs between the participants and the nurses through reciprocal confirming mental health care acts. These acts appear to help participants feel better in a step-by-step manner. Moreover, as a result of the confirming mental health care acts, the participants become aware of their own needs, their self-respect increases, and their self-esteem as a person who matters to other people is strengthened. According to Buber [45], confirmation is essential to the formation of a person's self and self-esteem, and it requires the continuous repetition of confirming acts that include mutual understanding and dialogue.

Other studies have described confirming mental health care with a focus on the narrative interviews of persons who have experienced psychotic illness. These studies followed a theoretical perspective that corresponds to elements of person-centred care (cf. [5, 9, 56]). However, our results describe how confirming mental health care acts are experienced by participants with acute psychotic illness, and it appears that confirming acts are important for helping them feel better during care in acute psychiatric wards and may enhance their health. Our results, describing the confirming mental health care that helps persons experiencing psychotic illness to feel better, correspond with studies describing an open verbal dialogue-based approach to persons with acute psychosis and their families receiving psychological therapy [54, 57]. However, our results uncover nurses' confirming mental health care acts that contain care, such as nurses' silence, gestures and peaceful communication with persons in care in acute psychiatric wards.

Methodological considerations and limitations

The trustworthiness of qualitative studies depends on rich and well-saturated data and a valid analysis that demonstrates the connection between the data and the

results [48, 53]. To ensure trustworthiness of our results, we performed verification strategies at every step throughout the research process (cf. [53, 58]). The data were verified and confirmed during the data collection by discussing the breadth, depth and nuances of the interviews within our research team. This gave KS the opportunity for self-reflection and self-awareness regarding her own pre-understanding of the topic explored and for modification of subsequent interviews to ensure sufficient data collection. As a team, we discussed the analysis based on critical questions about the chosen focus and the coding strategy and sought to achieve agreement on the constructions of the categories (cf. [48, 58]). The codes and categories were compared in several turns with the whole interview text to ensure that the categories covered data. We paid special attention to the possibility that we may have described the results in an idealized manner, and we sought to balance this possibility through a critical discussion of our interpretation and evaluation of the results.

To facilitate the transferability of our results, the context, the participants, the data collection and the analysis are described carefully. Furthermore, the results are presented via rich descriptions, including quotations from the interviews, to increase the ability of readers to evaluate the transferability of our results to other contexts or groups of persons [48]. Our report adheres to criteria for reporting qualitative research [59]. Aspects of our study results are also consistent with results from previous research [24, 46] and provide new knowledge.

Our results are limited due to the small sample size. However, our aim was not to generalise our findings, but rather to describe and understand the topic explored. The aspects of interpersonal interactions in confirming mental health care should be further explored and described based on narratives to mental health nurses providing care to persons experiencing psychotic illness and by the family members of the persons in care.

Conclusions

Our results emphasize that confirming mental health care acts provided by nurses in acute psychiatric wards help persons experiencing psychotic illness to feel better. Three confirming mental health approaches were identified: 1) Nurses' confirming mental health care conveyed through understanding of the participants' critical illness, peaceful communication and unconditional relationships with the participants helped the participants to endure the critical phase of psychotic illness and to become aware of their own care needs. 2) Nurses'/physicians' confirming mental health care conveyed through understanding of the participants' suffering, discussion and interpersonal relationships with the participants helped the participants to experience decreased psychotic symptoms and increased self-respect. 3) Nurses' confirming

mental health care conveyed through understanding of the participants' vulnerability, dialogue and partnership with the participant helped the participants to feel safe by ensuring that further support would be available at home and strengthened the participants' self-esteem as persons who mattered to other persons. The nurses' confirming mental health care is attuned to the participant as a person and to her/his specific, changing needs during psychotic illness. Our results indicate that each confirming approach helps the participants feel better in a step-by-step manner throughout the process of becoming in better health.

Clinical situations involving persons in acute phases of psychotic illness who express changing needs demand special knowledge, sensitivity, skills and responsibilities from nurses beyond the standardized guidelines because each person experiencing psychotic illness is both unique and universal. This means that some experiences are common among people experiencing psychotic illness, while other experiences are genuine and differ from the experiences of others, even others with the same diagnosis. A confirming mental health care act is not the event itself (cf. guidelines) but the attuned interaction between the mental health nurse and the person in care as the caring act can generate an on-going cycle of personal confirmation.

We suggest that nurses seriously consider the participants' experiential knowledge of confirming mental health care to improve mental health care in acute psychiatric wards. It is necessary for nurses to be present and open to the expressions of the changing needs of persons experiencing psychotic illness and to adjust their care to that persons' current clinical situation. This openness to the other persons' expressions creates moments of confirmation that concretely help the persons feel better and thereby support their use of their personal and interpersonal resources in the process of becoming in better health. We also believe that knowledge of confirming mental health care should be included in education and training programmes for nurses meaning learning and training regarding how mental health care confirm the person in care. Such training programs can be provided both at hospitals and in educational settings and supervised by trained mental health nurses. The supervision can also be in cooperation with persons who have experienced psychotic illness themselves and are willing and able to share their knowledge for the education of nurses and increase the quality and competence of mental health nurses.

Abbreviations

KS: Karina Sebergesen; AN: Astrid Norberg; AGT: Anne-Grethe Talseth.

Competing interest

The authors declare that they have no competing interests.

Authors' contributions

All authors contributed in the design of this study. Data collection was performed by KS with supervision from AN and AGT. KS, AN, AGT contributed to the analysis and interpretation of the data. KS was responsible for drafting the manuscript. All authors revised the manuscript critically and made a substantial contribution in revising the manuscript. All authors read and approved the final manuscript.

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References

- National Institute of Clinical Excellence (NICE). Psychosis and schizophrenia in adults: treatment and management. <http://www.nice.org.uk/guidance/cg178> (2014). Accessed 27 Aug 2015.
- Norwegian Directorate of Health. National guidelines for diagnosis, treatment and follow-up of persons with psychotic disorders. Oslo: Anvend Grafisk AS; 2013.
- World Health Organisation (WHO). Psychosis and bipolar disorders. www.who.int/mental_health/mhgap/evidence/psychosis/en/ (2014). Accessed 27 Aug 2015.
- McGorry PD, Killackey E, Yung A. Early intervention in psychosis: concepts, evidence and future directions. *World Psychiatry*. 2008;7:148–56.
- Barker P. The Tidal Model: developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *J Psychiatr Ment Health Nurs*. 2001;8:233–40.
- Simpson A. The acute care setting. In: Barker P, editor. *Psychiatric and mental health nursing: the craft of caring*. London: Hodder Arnold; 2009. p. 403–7.
- Thornicroft G, Tansella M. The balanced care model for global mental health. *Psychol Med*. 2013;43:849–63.
- Alanen YO. Towards a more humanistic psychiatry: development of need-adapted treatment of schizophrenia group psychoses. *Psychosis*. 2009;1:156–66.
- Barker P, Buchanan-Barker P. The tidal model of mental health recovery and reclamation: application in acute care settings. *Iss Ment Health Nurs*. 2010;31:171–80.
- Cleary M. The realities of mental health nursing in acute inpatient environments. *Int J Ment Health Nurs*. 2004;13:53–60.
- Bowers L, Simpson A, Alexander J, Hackney D, Nijman H, Grange A, et al. The nature and purpose of acute psychiatric wards: the Tompkins acute ward study. *J Ment Health*. 2005;14:625–35.
- Deacon M, Warne T, McAndrew S. Closeness, chaos and crisis: the attractions of working in acute mental health care. *J Psychiatr Ment Health Nurs*. 2006;13:750–7.
- Hem MH, Heggen K, Ruyter KW. Creating trust in an acute psychiatric ward. *Nurs Ethics*. 2008;15:777–88.
- Bowers L, Brennan G, Winship G, Theodoridou C. Talking with acutely psychotic people: communication skills for nurses and others spending time with people who are very mentally ill. London: City University; 2009. www.kcl.ac.uk/ioppn/depts/hspr/research/ciemh/mhn/projects/Talking.pdf. Accessed 27 Aug 2015.
- Cleary M, Hunt GE, Horsfall J, Deacon M. Nurse-patient interaction in acute adult inpatient mental health units: a review and synthesis of qualitative studies. *Iss Ment Health Nurs*. 2012;33:66–79.
- Hummelvoll JK, Severinsson E. Coping with everyday reality: mental health professionals' reflections on the care provided in an acute psychiatric ward. *Aust N Z J Ment Health Nurs*. 2001;10:156–66.
- Björkdahl A, Palmstierna T, Hansebo G. The bulldozer and the ballet dancer: aspects of nurses' caring approaches in acute psychiatric intensive care. *J Psychiatr Ment Health Nurs*. 2010;17:510–18.
- Elstad I. *Sjukesleietenkning*. (Nursing thought). Oslo: Gyldendal Akademisk; 2014. p. 16–35.
- Quirk A, Lelliott P, Seale C. The permeable institution: an ethnographic study of three acute psychiatric wards in London. *Soc Sci Med*. 2006;63:2105–17.
- Koivisto K, Janhonen S, Väisänen L. Patients' experiences of being helped in an inpatient setting. *J Psychiatr Ment Health Nurs*. 2004;11:268–75.
- Gilburt H, Rose D, Slade M. The importance of relationships in mental health care: a qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Serv Res*. 2008;8:92.
- Thomas SP, Shattell M, Martin T. What's therapeutic about the therapeutic milieu? *Arch Psychiatr Nurs*. 2002;16:99–107.
- Stewart D, Burrow H, Duckworth A, Dhillon J, Fife S, Kelly S, et al. Thematic analysis of psychiatric patients' perceptions of nursing staff. *Int J Ment Health Nurs*. 2015;24:82–90.
- Talseth AG, Lindseth A, Jacobsson L, Norberg A. The meaning of suicidal psychiatric in-patients' experiences of being cared for by mental health nurses. *J Adv Nurs*. 1999;29:1034–41.
- Längle G, Baum W, Wollinger A, Renner G, U'Ren R, Schwärzler F, et al. Indicators of quality of in-patient psychiatric treatment: the patients' view. *Int J Qual Health Care*. 2003;15:213–21.
- Sørgård KW. Satisfaction and coercion among voluntary, persuaded/pressured and committed patients in acute psychiatric treatment. *Scand J Caring Sci*. 2007;29:214–29.
- Pitkänen A, Hätönen H, Kuosmanen L, Välimäki M. Patients' descriptions of nursing interventions supporting quality of life in acute psychiatric wards: a qualitative study. *Int J Nurs Stud*. 2008;45:1598–606.
- Schön UK, Denhov A, Topor A. Social relationships as a decisive factor in recovering from severe mental illness. *Int J Soc Psychiatry*. 2009;55:336–47.
- Denhov A, Topor A. The components of helping relationships with professionals in psychiatry: users' perspective. *Int J Soc Psychiatry*. 2012;58:417–24.
- Deegan PE. The lived experience of using psychiatric medication in the recovery process and a shared decision-making program to support it. *Psychiatr Rehabil J*. 2007;31:62–9.
- Stewart DC, Anthony GB, Chesson R. "It's not my job. I'm the patient not the doctor": patient perspectives on medicines management in the treatment of schizophrenia. *Pat Educ Couns*. 2010;78:212–17.
- Hamann J, Kruse J, Schmitz FS, Kissling W, Pajonk FG. Patient participation in antipsychotic drug choice decisions. *Psychiatry Res*. 2010;178:63–7.
- Skorpen A, Anderssen N, Oeye C, Bjelland AK. The smoking-room as psychiatric patients' sanctuary: a place for resistance. *J Psychiatr Ment Health Nurs*. 2008;15:728–36.
- Skorpen A, Anderssen N, Oye C, Bjelland AK. Treatment regimes in a psychiatric hospital and apparent contradictions: report from field work in a lock-up ward illustrated with a constructed case. *Int J Ment Health Nurs*. 2009;18:409–16.
- Quirk A, Lelliott P. What do we know about life on acute psychiatric wards in the UK? A review of the research evidence. *Soc Sci Med*. 2001;53:1565–74.
- Sharac J, McCrone P, Sabes-Figuera R, Cspike E, Wood A, Wykes T. Nurse and patient activities and interaction on psychiatric inpatients wards: a literature review. *Int J Nurs Stud*. 2010;47:909–17.
- Shattell MM, Andes M, Thomas SP. How patients and nurses experience the acute care psychiatric environment. *Nurs Inq*. 2008;15:242–50.
- Kuosmanen L, Hätönen H, Jyrkinen AR, Katajisto J, Välimäki M. Patient satisfaction with psychiatric inpatient care. *J Adv Nurs*. 2006;55:655–63.
- Katsakou C, Bowers L, Amos T, Morriss R, Rose D, Wykes T, et al. Coercion and treatment satisfaction among involuntary patients. *Psychiatr Serv*. 2010;61:286–92.
- Olofsson B, Jacobsson L. A plea for respect: involuntarily hospitalized psychiatric patients' narratives about being subjected to coercion. *J Psychiatr Ment Health Nurs*. 2001;8:357–66.
- Rössberg JI, Melle I, Opjordsmoen S, Friis S. Patient satisfaction and treatment environment: a 20-year follow-up study from an acute psychiatric ward. *Nord J Psych*. 2006;60:176–80.

42. Alexander J. Patients' feelings about ward nursing regimes and involvement in rule construction. *J Psychiatr Ment Health Nurs*. 2006;13:543–53.
43. Peplau HE. Interpersonal techniques: the crux of psychiatric nursing. *Am J Nurs*. 1962;62:50–4.
44. Talseth AG. Psychiatric care of people at risk of committing suicide. Narrative experiences with registered nurses, physicians, patients and their relatives. <http://www.diva-portal.org/smash/get/diva2:769190/FULLTEXT01.pdf> (2001). Accessed 27 Aug 2015.
45. Buber M. The knowledge of man. A philosophy of the interhuman. New York: Harper & Row Publishers; 1966.
46. Larsson P, Nilsson S, Runeson B, Gustafsson B. Psychiatric nursing care of suicidal patients described by the sympathy-acceptance-understanding-competence model for confirming nursing. *Arch Psychiatr Nurs*. 2007;21:222–32.
47. Mishler EG. Research interviewing: context and narrative. Cambridge, MA: Harvard University Press; 1991.
48. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today*. 2004;24:105–12.
49. Vaismoradi M, Turunen H, Bondas T. Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nurs Health Sciences*. 2013;15:398–405.
50. Hem MH, Heggen K, Ruyter KW. Questionable requirement for consent in observational research in psychiatry. *Nurs Ethics*. 2007;14:41–53.
51. Hategan A, Parthasarathi U, Bourgeois JA. Obtaining informed consent for research in an acute inpatient setting. *Cur Psychol*. 2014;13:39–40.
52. Norwegian Department of Health. Mental health act 1999-07-02-62: act relating to the establishment and provision of mental health care. Oslo: Norwegian Department of Health; 2001.
53. Elo S, Kääriäinen M, Kanste O, Pölkki T, Utriainen K, Kyngäs H. Qualitative content analysis: a focus on trustworthiness. Open: Sage Publishing House; 2014.
54. Seikkula J, Alakare B, Aaltonen J. The comprehensive open-dialogue approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care. *Psychosis*. 2011;3:192–204.
55. Sebergesen K, Norberg A, Talseth A. Being in a process of transition to psychosis, as narrated by adults with psychotic illnesses acutely admitted to hospital. *J Psychiatr Ment Health Nurs*. 2014;21:896–905.
56. Andersson EK, Willman A, Sjöström-Strand A, Borglin G. Registered nurses' descriptions of caring: a phenomenographic interview study. *BMC Nurs*. 2015;14:16.
57. Seikkula J. Becoming dialogical: psychotherapy or a way of life? *Austral New Zealand J Fam Therapy*. 2011;32:179–93.
58. Morse JM, Barret M, Mayan M, Olson K, Spiers J. Verification strategies for establishing reliability and validity in qualitative research. *Int J Qual Meth*. 2002;1:13–22.
59. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007;19:349–57.

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Paper III

Note to reader

This article has an error on page 1, second column. Last sentence should be:

Below, we review previous research papers on how persons in acute psychiatric inpatient care experience transitional care related to their discharge from acute psychiatric wards.

"I Want to Go Home, but I Need to Stay": The Transition to become Ready for Discharge from Acute Psychiatric Wards, as Narrated by Persons Who Experienced Acute Psychotic Illness

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Abstract

Background: Discharge planning for persons with psychotic illness who are admitted to acute psychiatric wards is critical for decreasing the well-known risk of new phases of psychosis and early readmissions after discharge from the ward. There is limited knowledge about admitted persons' experience of their readiness for discharge from acute psychiatric wards. This study aims to describe and understand how persons with psychotic illness experience to become ready for discharge during their stay on an acute psychiatric ward.

Method: During their hospital stay, 12 persons who recently had acute psychotic illness were interviewed about their experiences related to their upcoming discharge. The recorded interviews were transcribed and content analysed.

Results: The results describe the participants experienced three phases of transition to become ready for discharge after their acute psychosis had decreased: 1) Being affected by wounds following acute psychotic illness, 2) Being in need for strength to feel better before discharge, and 3) Being ready for discharge.

Conclusion: This experiential knowledge informs the transitional care that mental health nurses provide to persons during the discharge process. In addition to developing plans for discharge and for further mental health care in the community together with persons in care, nurses must seriously consider persons' mental health care needs following psychosis to support the best of outcome of the transition to become ready for discharge.

Background

In most Western countries, persons who experience acute psychotic illness and whose acute care needs are not sufficiently met by community mental health care services, are offered short-term mental health care in acute psychiatric wards [1] to provide safety and security and decrease their psychotic symptoms and enhance their health [2]. In Norway, the specialist physician or psychologist in psychiatry, who is responsible for the person's inpatient mental health care, makes the decision about the discharge from acute psychiatric ward in cooperation with mental health personnel and the person in care. The basement for the decision before the discharge includes considering that the person's acute psychotic symptoms have decreased, and further that the person's medical, social and mental health care needs will be met in the community after discharge [3]. In the early period after psychosis, persons' vulnerability to the risk of experiencing new phases of psychosis is heightened [4]. To reduce this risk, clinical guidelines recommend community mental health care adjusted to each person's care needs following discharge [3,5]. From this perspective, the planning of the person's discharge from the acute psychiatric ward and his/her further mental health care in the community acknowledges and mirrors in national guidelines that recommend personal mental health care plans [6,7]. A person's discharge from an acute psychiatric ward to home is viewed as a transition [8, 9], and the discharge plan is an important component of the transition between the different care settings [10].

Before persons are discharged from acute psychiatric wards, nurses must provide transitional mental health care, including discharge planning [11]. Discharge planning requires nurses to make

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multifaceted decisions and the discharge planning is considered a method, a function, a solution [12] and an approach to accessing how each person in care views discharge [11]. Furthermore, it is an indicator of quality of care after hospital discharge [10]. This means that nurses who provide the discharge planning must consider and adjust a person's needs in terms of care and medical services, housing, finances and plans for immediate care if a new acute psychotic illness occurs at home. Furthermore, transitional care on the ward includes decisions about when and how the discharge will occur, and it is provided by nurses on the ward in partnership with the person in care, his/her significant others and community mental health nurses [11]. Mental health nurses' transitional care is critical to supporting and improving persons' engagement in follow-up treatment and care plans supported by community mental health nurses at home [13,14].

Given that mental health care in acute psychiatric wards tends to be short term [1], the time available for the mental health nurses and the person in care to plan and prepare for discharge from acute psychiatric wards is limited [9,15]. Below, we view previous research papers on how persons in acute mental health inpatient psychiatric wards?

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Some research has reported that following discharge from acute psychiatric wards, persons are at risk of experiencing negative outcomes. The results of a review study showed that persons' risks of increased psychiatric symptoms and early readmissions were related to their vulnerability linked to homelessness, poor housing facilities, broken appointments or non-cooperation with community mental health care, and noncompliance with recommended medication. Furthermore, suicide attempts, suicide and violence increased significantly in the first month after persons were discharged from the hospital [16]. Loch's [16] findings address and illustrate, on the one hand, persons' need for further support and mental health care after discharge and, on the other hand, the potential for nurses' transitional care to minimize the risks of increased psychotic symptoms and early readmissions. As Noteworthy et al. [17] thoroughly described, mental health nurses' care may bridge the gap in the quality of different mental health care settings.

Qualitative studies have reported persons' experiences with hospital discharge. One interview study found that nurses did not consider persons' opinions about the timing of discharge, for example, discharge before the weekend when community mental health care services are less available and the risk of loneliness and of misusing alcohol and drugs increases for some persons [18]. In a review study, Glasby and Lester [19] reported poor timing in terms of both delayed and early discharge of persons in care. Persons in care wished that nurses provided specific information about their needs after discharge, such as where they could go and whom they could contact if a new crisis occurred after discharge [18]. Another study showed that nurses' discharge planning was mostly positive but that some areas should be improved. Persons wished that nurses better prepared them for discharge by introducing them to peers who had experienced discharges from acute psychiatric wards so that they could receive more information about health problems that may occur, medication treatment and the prevention of mental illness relapses [20]. Manuel et al. [21] explored the discharge experiences of women with severe mental illness after a long-term stay in psychiatric institutions and reported that these women were concerned that the community mental health care would be insufficient to meet their needs of safety, security and support in entering social relationships with other people. Gerson and Rose [22] reported similar results, and found that persons with severe mental illness were unsure whether community mental health nurses care could meet their illness-related needs and needs of support in daily activities.

Several quantitative studies evaluated the effect of transitional care interventions and discharge planning. A statistical study [23] focused on pre-discharge planning in hospitals, including recommendations for post-discharge care in the community. This study did not find significant decrease in persons' psychotic symptoms or rates of readmissions to the hospital or an increase in their quality of life. Two review studies examined pre-discharge transitional care interventions, including discharge plans, appointments for further care, and cooperation with the person in care and his/her family, nurses on the ward and personnel in community care settings [24,25]. These approaches improved persons' mental health and were cost effective for the mental health care services [24,25]. Other studies described that transitional care that included the establishment of relationships between community mental health nurses and persons in care before discharge shortened the persons' length of hospital stay, increased their daily functioning and quality of life after discharge, and decreased their hospital readmissions [13,14]. Persons in care who also participated

in education about coping with psychosis reported an increased ability to engage in self-care after discharge [26]. Researchers utilised questionnaire tool (RDQ) to measure persons' readiness for discharge from acute psychiatric wards following severe mental illness. The results showed that the tool helped psychiatrists make decisions about discharge based on persons' ability to engage in daily activities and to control their aggression, impulsivity and risk of suicide [27].

Our literature review shows that discharge planning characterized by cooperation between the person in care, his/her family members and the mental health personnel in the hospital and community decreased the risks of psychotic illness and early hospital readmissions. Some researchers used qualitative methodology and focused on the persons' experiences of poor timing of discharge and lack of attention to their opinions about timing, and to their other wishes, needs and personal circumstances such as housing, finances and knowledge of who to contact during crisis. A study conducted by Potkin et al. [27] reported persons' readiness for discharge based on a tool measuring their mental health status before discharge. We identified no studies on persons' experience of becoming ready for discharge from acute psychiatric wards following an acute psychotic illness. The attention to and knowledge of how persons in care experience becoming ready for discharge remains limited in mental health nursing research.

Mental health nurses have the responsibility of providing transitional care by planning the discharge and care adjusted to persons' needs and ensuring that the discharge is as smooth, safe and secure as possible to decrease persons' risks of experiencing new phases of psychotic illness (cf. [11, 28]). We reflected on the following question: how do persons' experience and describe the process of becoming ready for discharge from acute psychiatric wards? We designed a study to access persons on acute psychiatric wards who recently experienced an acute psychotic illness to narrate their experiences of becoming ready for discharge from the ward.

The aim of this study is to explore, describe, and understand how persons' experience becoming ready for discharge from acute psychiatric wards, as narrated by persons who recently suffered from an acute psychotic illness.

Methods

Study design

Given the aim of this study, we employed a qualitative, explorative and descriptive study design. To access persons' experiences of becoming ready for discharge from acute psychiatric wards following psychotic illness, we conducted qualitative interviews [29]. A qualitative content analysis, which allows describing the manifest content of the persons' narrated experiences, was performed and interpretations of the underlying meaning of the results, subcategories and categories, were conducted [30]. Content analysis is well suited to analyse multifaceted, sensitive and important phenomena in nursing, especially when there is limited knowledge about the topic explored [31].

Ethics

The Regional Committee for Medical and Health Research Ethics (2012/1319) approved the study, and the research followed ethical principles for research [32]. The participants received information

about the study, the purpose of the study and the interviews in both written and oral forms. Furthermore, they received information about that their participation was voluntary, the presentation of the results would ensure their confidentiality and anonymity, and they had the right to withdraw from the study at any time before the analysis of the data started without explanation and with no consequences to their treatment and care. Then, the participants signed the informed consent form to participate.

Informed consent is a cornerstone in health care research. Interviews with a person in acute inpatient mental health care raise ethical challenges and special concerns regarding the person's vulnerability and ability to provide informed consent [33, 34]. We ensured that the persons who were approached about participation obtained adequate information about the research study and had the opportunity to ask questions to better understand the information and the impact of participation (cf. [34, 35]). To avoid possible risks of evoking bad memories that the person may strive to cope with alone following the interview, the local project contact person on each ward contacted the participants after the interviews to ensure that their primary nurse on ward was meeting their needs. No participants reported experiencing bad memories after participating in the interviews. At the time of data collection, the current authors were not employed in the acute psychiatric wards.

Setting

In Norway, the national mental health service is organised in three service levels: the first level is the community mental health service including general physicians and mental health care services in each municipality; the second level is community mental health centres with mental health care wards and acute ambulatory services; and the third level is psychiatric wards in general hospital, including acute psychiatric wards who are responsible for the emergency short-term mental health services to persons with acute mental illness with complex care needs [4,36]. In Norway, the acute psychiatric wards provide the intensive care to persons experiencing acute psychotic illness (cf. [36]). The mean length of stay in acute psychiatric wards for persons admitted with acute mental illness is 9, 5 days in Norway, and persons with schizophrenic psychosis and affective psychosis have longer stays on ward, with a mean of 10 days [36].

We conducted this study in four acute psychiatric wards in two hospitals located in mid-sized cities. These wards provide services to people in large geographical areas, implying long distances between the admitted persons' home and the hospitals. Acute mental health care is conducted by the nursing staffs, which includes enrolled nurses, nursing assistants, mental health nurses and registered nurses. Multi-professional teams on the ward, plan for discharge in cooperation with the person in care, his/her family members and local mental health professionals. According to the law, persons in care have the right to be involved in the planning of their mental health care and to include their family members in this planning [37]. In Norway, the nurses on ward have to ensure before the discharge that the person in care has a home to come to, and if not, nurses have to cooperate with the community service which is responsible for housing facilities to homeless persons [38].

Recruitment

The participants were purposively recruited from the population of persons admitted to acute psychiatric wards. The participant selection criteria in this study were as follows: being acutely admitted to the

ward, having severe mental illness, displaying a decrease in acute symptoms and exhibiting the ability to narrate experiences about the process of discharge from acute psychiatric wards.

In cooperation with the physician and the nurse in charge of each ward, a local project contact selected 20 admitted adults, provided them with verbal and written information about the study and requested their participation. Of these 20 persons, 14 signed the informed consent for participation. Two persons discharged from the ward before the interviews were arranged, and six persons did not provide their informed consent for participation. Before the interviews began, the first author KS invited each participant to meet her and to obtain further information about the study. KS met two participants before the interviews face-to-face, and scheduled an interview appointment with them during this meeting. KS contacted the other participants via telephone to schedule the interview appointments.

Participants

Eight women and four men aged from 18 to 64 years participated in the study. Eight of the participants lived with partners or other family members, and four of them lived alone. Eight of them had children and grandchildren. The participants reported that they had experienced psychotic symptoms for two to 40 years and had received the diagnosis of psychosis during previous hospital stays. This time they were admitted to the experience of a phase of acute psychotic illness. Eight of the participants informed being involuntarily admitted to the wards and was formal patients under the Norwegian Mental Health Care Act; in other words, they had to remain in hospital care for a set period to undergo assessment by mental health personnel and/or to receive treatment (cf. [39]). The person's formal status under the Mental Health Care Act [39] is considered by specified criteria by specialist physicians or psychologists in psychiatry during the person's stay on ward. The purpose is to evaluate the person's state of mental health to limit the length of the status as a formal inpatient [39].

Interviews

At the point of time for the interviews, the participants had been admitted the acute psychiatric ward since one to about eight weeks. Only KS and the participant were present during the interview, which was conducted in a quiet room that was in the hospital but outside the ward. First, KS informed the participants that she was not in possession of any of their personal or medical information. Then, the interviewer and the interviewee engaged in introductions. KS repeated information about the study and described the interview and the interviewer's role and responsibility during the interview. The participant asked the interviewer questions, such as whether they could take breaks during the interview. This study focused on the participants' experiences of their upcoming discharge from the acute psychiatric ward. They were encouraged to speak freely about their feelings, thoughts, worries and wishes in relation to the discharge. The interviewer asked additional questions, such as "What do you mean? What happened? Could you please describe how you felt in more detail?" Multifaceted narratives concerning participants' experiences in regards to their readiness for discharge from the acute psychiatric ward emerged during the audio-recorded interviews, which lasted from 50 to 90 minutes. KS transcribed the audio-recorded interviews. The twelfth interview did not reveal any new information on the studied topic; therefore, the researcher did not conduct further interviews (cf. [40]).

Content analysis

We performed a qualitative content analysis of the interview text in a stepwise manner [30]. In the first step, we read and re-read the interview text regarding the participants' discharge experiences with an open mind to gain a sense of the whole text. Based on this reading, we understood the participants' descriptions of their discharge to message: "I want to go home, but I need to stay". In the second step, we identified meaning units in the text, of words, sentences or paragraphs containing aspects related to each other in terms of content and context [30]. The meaning units were condensed and labelled with codes relevant to the study's aim. We discussed the coding thoroughly to identify codes that covered the content of the meaning units. In the third step of the analysis, we created categories. A category answers the question "what?" and mainly describes the manifest content of a text [30]. In this step, we examined how the coded meaning units described the discharge; the participants' wish to go home, and their need to stay on the ward. We compared, contrasted and collected the coded meaning units into different sub-categories until we reached a consensus about the constructed subcategories and categories (Table 1). With the aim of understanding the participants' experiences, we conducted the final and fourth step of the analysis, i.e., the interpretation of the underlying meaning linking the subcategories and categories. We interpreted the participants' experiences of becoming ready for discharges a transition. Inspired by Afaf Meleis and research colleagues [8,41,42], we used the perspective of the experienced transitions in a person's illness and health to interpret and reflect on the underlying meaning of the subcategories and categories formulated as a theme. The theme, answering the question of how the participants experienced to become ready for discharge from an acute psychiatric ward, we formulated as follows: Being in transition to become ready for discharge from acute psychiatric wards. Table 2 shows the theme, categories and subcategories.

Meaning unit	Condensed meaning unit	Sub-category	Category
I can return home when I am able to be a mother, a grandmother, a wife and can sit in my living room and enjoy a good cup of coffee or maybe a glass of wine (12).	Describes feeling better when able to be what the homely social roles and daily life requires.	Noticing signs of feeling better	Ready for discharge
I have a special nurse, nurse B, at home and we have regular contact. She comes to me and she knows my family, my serious complaints and my critical psychotic illness. (...) She was the one who asked the local mental health ward for an open door and free bed for me. (...) I can go there, anytime I need to. This has saved me (1).	Describes the importance of the special nurse's care to cope with the severe mental illness, also in critical phases.	Being confident in the ability of living home	

Table 1: Examples from the content analysis.

Theme	Being in transition to become ready for discharge from acute psychiatric wards		
Categories	Being affected by wounds following acute psychotic illness	Being in need for strength to feel better before discharge	Being ready for discharge
Sub-categories	Being physically wounded Being mentally wounded Being in wounded relationships with family members	Needing time on ward Needing time at home	Noticing signs of feeling better Being confident in the ability of living home

Table 2: Theme, categories and subcategories.

Results

The results of being in transition to become ready for discharge from acute psychiatric wards describe the participants' experienced changes in their psychotic illness and in their mental health care needs during a period of time. This period is limited from the point in time when the participants' acute psychotic illness symptoms decreased and they stated that they were not ready for discharge to the point in time when the participants expressed their readiness for discharge. The participants described the changes they experienced during this time from being psychotic ill to feeling better characterized by an unstable and insecure movement in transition phases. Persons' descriptions of the transition occurring during the discharge process inform us of how persons in care in an acute psychiatric ward define becoming ready for discharge.

We present the results, illustrated in Table 2, below and use quotations from the different interviews, labelled from number 1 to 12, to verify the results.

Being affected by wounds following acute psychotic illness

After the acute psychotic illness diminished, the participants felt wounded physically, mentally and in their relationship with their family members. At the same time, the nurses on ward actualized the participants' discharge from the acute psychiatric ward. The participants expressed that they wanted to go home but were anxious about being discharged prematurely because they still needed nurses' care on the ward to feel better.

Being physically wounded

The participants reported that they had physical wounds from the acute psychotic illness. Their body felt as though it had been beaten up; their muscles ached and felt fragile and stiff; and they were tired and exhausted. They had trouble in getting out of bed in the morning, their appetite for food was reduced, and they were too weak to engage in activities. Furthermore, some of them felt sick. It seems as though some nurses did not take note of participants' physical health. The participants felt stressed and frightened that nurses would discharge them before they felt better and had the ability to perform daily

activities at home. Other nurses sensed and understood participants' physical health problems and supported and encouraged them to maintain daily routines, to eat and drink and to go outside in the fresh air. These nurses informed the participants about discharge planning but waited to engage them in the planning. One participant described how nurses encouraged her to eat and drink, as follows:

I was ill and I could not eat. (...)The nurses were attentive and kind. They supported me patiently to eat and drink. They brought me food and explained that I did not have to eat much, just a little, but enough to become better (6).

Being mentally wounded

The participants described that the acute psychotic illness had left mental wounds, stating that the psychosis was as directly under their skin and only covered with an easily broken film. Participant's expressed doubt about being their ordinary self again, and some participants even checked in the mirror or questioned nurses to determine if their faces had changed. They described bad memories from psychosis, such as hallucinating voices that threatened them, and from the pre-psychosis period, such as evoked memories of violence. They expressed painful and shameful memories of their own behaviour during psychosis, such as disrespecting family members and nurses. The participants were anxious about the possibility of becoming acutely psychotically ill again and struggled to forget and control their memories. Some mental health nurses were sensitive to and understanding of the participants' mental wounds, inviting the participants to open up and talk with the nurses. One participant described this experience as follows:

These memories are difficult to share, and it is a choice if you are going to or not. (...)Nurse A, who I related to and I opened up to, knows what is going on in my world. (...) She understands what I am saying. Sometimes, I have to explain some extra. She asks, I explain, I explain and she asks in a two-way communication. (...) This helped me to get better (2).

Being in wounded relationships with family members

The participants described feeling guilty about their behaviour towards their family members during the acute psychotic illness, such as their use of threatening words and irresponsible actions. Participants feared that they had harmed or scared their family, especially their children, and wondered if their family members could trust them again. They attempted to restore their relationships and reconcile with their family during telephone calls or family members' visits to the wards. The participants appreciated nurses who helped them contact their families and invite them to the hospital. The nurses supported and guided the participants in addressing problems in conversations with their families when the participants experienced feelings of chaos and difficulties in sharing their opinions with family members. The participants also stated that contact with family members without support from nurses was a lonely responsibility, causing the participants mental distress and, in some cases, reducing their vitality for life. One participant described her thoughts about her contact with her children as follows:

I am afraid this illness has harmed and frightened my children. I know they need to talk about this. However, I cannot talk with them alone about everything; it will frighten them, you know, such as I told you about my longing for death (10).

Being in need for strength to feel better before discharge

After the participants experienced a decrease in their acute psychotic symptoms, they described their need to stay on the ward for a longer period and to visit home before discharge to gain strength to feel better before discharge.

Needing time on the ward

The participants stated that they felt weak, feared becoming acutely psychotically ill again and needed more time on the ward to feel better physically, mentally and socially before discharge. They explained their weakness, stating that they still cried and became anxious, frustrated or suspicious easily. The participants wanted to feel safer and more secure before discharge, for example, by receiving more information about their new medical treatment, and help to socialize with other persons on the ward before returning home. The participants felt safer because they were on the ward and knew that they could reach the nurses day and night and receive help with situations that they could not cope with alone. They stated that their influence on the timing of discharge was limited and that it was difficult to argue with the nurses. The participants understood nurses' demands to provide short-term care and that other persons needed inpatient mental health care as well. They stated that some nurses did not understand their need for a longer stay on the ward. One participant articulated this need as follows:

My opinion is that the patients need to influence the time for the stay on ward based on how they feel. The hospital personnel decide the stay based on what they think is right, but the hospital personnel do not always know the truth. Therefore, time is an important factor in patients' recovery, but this is difficult to argue and "to sell" to the nurses. When you do, it feels as though you do not want to go home (3).

Needing time at home

The participants expressed their longing for to go home and limitations in their ability to cope with home life. Participants expressed the following limitations in coping with everyday life: feeling too weak to be a responsible parent; to take care of children and to be a partner; to perform household chores such as shopping, preparing meals, and cleaning the house; and to find solutions to life problems such as problems regarding finances. Some nurses understood the participants' personal life situation and helped them visit home, for shorter or longer periods, to meet their family. These home visits were critical to the participants' feeling of improved health and allowed them to evaluate how they could cope with everyday life. The home visits were a basic fundament for the participants to determine when they were ready for discharge. It was difficult for the participants to articulate when and how they felt better and their readiness for discharge, as one of them expressed:

"It is a change, like a threshold you have to pass. Then, you know!" (3).

Being ready for discharge

The participants stated that they were ready for discharge when they noticed well-known signs of feeling better and were confident about the mental health care they would receive at home.

Noticing signs of feeling better

The participants described feeling a sense of relief when they noticed signs of feeling better and that their state of health was similar to that before the psychotic illness occurred. They recognized themselves again, their wellbeing increased and they felt better as demonstrated by more stable emotions, expressions of love and happiness with life and the ability to care for others. The participants' descriptions of their everyday life and health widely varied; some coped with symptoms such as hearing voices during daily living and others expressed that they had no symptoms but experienced anxiety about the acute psychosis returning. They looked forward to returning home, spending time alone or with their loved ones, and engaging in activities that they had longed for, such as drinking coffee in the morning or taking a walk outdoors. They described the ability to concentrate on activities, work and studies and the feeling of being a whole person and ready for discharge. One participant articulated this ability as follows:

I can return home when I am able to be a mother, a grandmother, a wife and can sit in my living room and enjoy a good cup of coffee or maybe a glass of wine (12).

Being confident in the ability of living home

The participants reported that the psychotic illness affected them in various ways. They explained their feared their needs of assistance from mental health care professionals in the days, weeks and months following discharge would be too complex for nurses at home to meet. These needs included assistance managing daily activities, having a trusted person to talk with, addressing daily problems, keeping appointments to follow up the medication treatment, and having knowledge of how to react if they needed immediate care in phases of acute psychosis. The participants also expressed the need for support to become better from psychotic illness. With these needs of support and care, the participants wanted to meet or at least know the name of the nurse contact at home before discharge to ease the contact with the nurse when they returned home. Some nurses understood that participants felt safer and more secure when they received these details before their discharge from the wards. Participants reported that it was important for the nurses on the ward to understand the participants' views of mental health care at home. One participant expressed this view as follows:

I have a special nurse, nurse B, at home and we have regular contact. She comes to my home, and she knows my family, my serious complaints and my critical psychotic illness. (...) She was the one who asked the local mental health ward for an open door and free bed for me. (...) I can go there anytime I need to. This has saved me (1).

Discussion

Psychoses are viewed as severe, fluid and changeable mental illnesses [4]. The mental health care in the different care settings intends to follow and adjust to persons' changing care needs during phases of acute psychotic illness [28]. The nurses plan the discharge in cooperation with the persons in care, their family members and local mental health professionals intending to ensure the discharge as smooth, safe and secure as possible.

The aim of our study is to explore, describe, and understand how persons experience becoming ready for discharge from acute

psychiatric wards based on the narratives of persons who recently suffered from acute psychotic illness. The participants' narratives represent their unique way of articulating their experiences about discharge from acute psychiatric wards. The participants' narratives about their psychotic illness and the mental health care they received differ according to personal circumstances, and earlier experience with illness and care, and including when they narrate and to whom [43]. We do not know the details of the interactions between the nurses and the participants during the discharge process; however, we know how the participants described the transition to become ready for discharge from the acute psychiatric ward.

The results of our study show that being in transition to become ready for discharge involves movement between three different phases of the transition: being affected by wounds following acute psychotic illness, being in need for strength to feel better before discharge, and being ready for discharge. Transition is defined as a passage or movement from one state, condition or place to another [41]. The concept of transition in nursing includes developmental, situational, health-illness and organizational transitions [8]. Persons experience transitions caused by a change decided by others, such as a discharge from hospital to home, and by a change in their health during a period of illness [42]. Nurses have special concern for transitions pertaining to a person's health and illness [42] because such transitions are mostly beyond a person's control. For each person, an illness and health transition is a personal, complex and diverse experience characterized by discontinuity in his/her life span. In other words, the person moves between fairly stable states of illness and health, which involve instability, insecurity and worries that their illness and health will worsen or the future will be unpredictable. A nurse's responsibility is to provide opportunities to enhance a person's health and decrease his/her risk for illness, even though the complexity of a person's needs may challenge a nurse to better understand and provide care to meet these care needs [42].

Our results address that mental health nurses should understand, care for and care about participants' needs during the time of transition to become ready for discharge. We discuss our results in light of previous research and the concept of transition in nursing described by Chick and Meleis [41] and Meleis et al. [42].

Our results show that after the acute psychotic illness had diminished, the participants experienced wounds that affected their health. When nurses initiated the plan to discharge participants from acute psychiatric wards, the participants expressed both their wish to go home and their need to stay on the ward because they needed to feel better before leaving. These results correspond with those of previous studies reporting that persons want to adjust the timing of discharge based on their experience of the illness, care needs and social needs related to their personal circumstances [18, 19, 21]. In addition, our results show that the participants' awareness of the transition was related to their experience of the changes in their acute psychotic illness and insight about their need of mental health nursing care on the ward before the discharge. The participants' awareness of being in a state of transition seems to elicit hope related to becoming better and returning home when ready. This finding corresponds to Chick and Meleis's [41] finding that a person's awareness of being in transition is critical to their experience of the transition and for the outcome of the transition.

Being in transition to become ready for discharge brings attention to the phase of time after the acute psychotic illness has decreased. The participants expressed suffering and vulnerability related to

physical and mental wounds and fragile or broken relationships with family members. Previous research has also highlighted the phase of time following acute psychotic illness as critical, demonstrating that the risk of new phases of psychosis increases during this time [4,9,16]. Furthermore, the risk of new phases of psychosis can decrease when nurses and persons in care plan the discharge and community care together to ensure the continuation of care at home [24-26].

The participants in our study did not primarily focus on their risk of new psychosis; rather, they focused on their suffering from the wounds following acute psychotic illness, which differs in time and quality from their suffering from acute psychotic symptoms. The suffering from the wounds, which are described as marks left on their bodies following the psychotic symptoms, occurs after the acute psychotic symptoms had decreased. The participants expressed their silent suffering as sickness, tiredness, bad memories and disconnectedness from their loved ones. These wounds are difficult to articulate, and the participants attempted to express their care needs to the mental health nurses. Similar to Meleis et al. [42], we understand the expression of wounds following acute psychotic illness as a person's response to his/her experienced changes in the psychotic illness, which may be observable or unobservable and viewed as functional or dysfunctional by mental health nurses. These personal expressions are not random, and nurses must address these expressions to ensure that the person in care experiences the best outcome of the transition. Nurses' care can enhance persons' health and reconnect persons in transition with family members they feel safe with following disruption in the relationships (cf. [42]).

Researchers have reported that the time that a person experiences illness differs from the time of disease as determined by the physician through observable signs of the disease [43, 44]. Thus, a person can suffer from an illness long before the disease is diagnosed based on observed objective signs [43], and an illness can continue after the disease even if the disease is cured and the objective signs of the disease are no longer observable [44]. In our study, it seems that participants' acute psychosis is cured or diminished; however, the participants continue to suffer from the psychotic illness. Mental health nurses are educated and trained to sense symptoms, observe signs of acute mental illness, provide the best care to decrease symptoms and suffering and provide sensitive, attentive and adjusted care based on the persons' need for both closeness and distance when receiving care (cf. [45,46]). Some nurses in this study noticed and understood the participants' silent expressions of suffering from the wounds following the acute psychotic illness, which differ from expressions of suffering from acute psychotic symptoms, and met the participants' mental health care needs. Such care was critical for the participants in this phase of transition to feel better.

The participants described the need to feel better before discharge. They expressed that their sense of self and emotions were unstable and that their health was too poor and limited to cope with daily life at home. Other researchers have described that some persons with severe mental illness report care needs that are too serious and complex for community mental health nurses to sufficiently meet them [19, 22]. Furthermore, Manuel et al. [21] described persons' pre-discharge worries about community mental health nurses' availability and ability to meet their safety, security and social support needs. Our results show that participants know that they need to feel better before discharge as a fundament to cope with daily life at home. The participants stated that they required more time on the ward to feel better and that frequent visits home allowed them to evaluate the

strength that they would need to engage in daily living and reconnect with family. This result is reminiscent of the transitional discharge model described by Reynolds et al. [13] and Forchuc et al. [14]. This model focuses on bridging the relationships between nurses in the hospital care and the community care settings, which increases persons' safety before discharge from the hospital. However, our results report that participants were aware of their need for additional time, on the ward and at home, to feel better. In other words, they were aware that they must be in a state of health to be discharged from the hospital and to cope with the daily living at home. According to Meleis et al. [42], transitions may challenge a change in persons' self-concept and self-esteem, which some persons in care expressed as distress, irritability or anxiety. The participants in our study expressed frustration to the mental health nurses who did not understand their need for more time on the ward and time at home to become better before discharge. Our results show that the participants' wish for more time on the ward was based on both available day and night nursing care on ward and visits home, which seem to give the participants the strength needed to feel better and better able to cope at home. The participants articulated their need of time for transition, as a threshold to pass to become ready for discharge.

Our results show also that the participants' need more time on ward; even if nurses' discharge planning intends to ensure the continuity between the hospital care and the community care for each person after discharge (cf. [11]). It seems that the participants' stays on ward were too short for relieving their psychotic illness after the acute psychotic symptoms had decreased, and they did not feel ready for discharge. This may address their needs of safety, security and to be cared for in the specialised mental health inpatient care provided by nurses present day and night (cf. [28,47]). Other authors have also reported that persons with severe mental illness express feeling unsafe and insecure before discharge about if the community mental health care can meet their care needs [9,20-22]. Community mental health service that is provided by appointments primarily at daytime seems at this period of time after the acute psychotic illness not to be sufficient to the participants' needs of safety to manage their daily life at home.

Transition is characterized by its entry, passage and exit [41]. The participants in our study described being ready for discharge when the intense and overwhelming acute psychotic symptoms decreased (cf. [47]) and when they noticed and recognized the well-known signs of feeling better, such as the same state of health as before the acute psychotic illness occurred. For the participants, feeling better represents familiarity with their state of health and social abilities and confidence to live at home with the help and support of community mental health nurses. Our results are significantly different from the results reported by Potkins et al. [27], who described a tool for psychiatrist to measure persons' statements related to symptoms of psychosis to assess their mental health status and their readiness for discharge. Our results are in line with Fenwick's [48] definition of readiness for discharge as a balance between a person's physical, mental and social resources and limitations in support at home. Other nursing researchers have reported similar results in studies investigating readiness for hospital discharge following heart, hip or cancer surgery [49-51]. These studies highlight that persons' readiness for discharge relies on feeling safe in terms of the nurses' knowledge and information about the persons' illness, risks and care needs; the need for medical equipment after surgery; and further safe and secure community nursing care. These results partially correspond to the results of our study.

According to Meleis et al. [42], transitions represent adaptations to a new state of health, life, or environment and the perception that one has the ability to live with the illness. Nurses must understand the transitions between illness and health as opportunities to enhance persons' health and decrease risks of illness and vulnerabilities during these transitions [42]. Our results show that participants express awareness of their readiness for discharge from acute psychiatric wards. Their awareness is based on feeling better and feeling safe and secure in regards to their psychotic illness, to their need for care from the community mental health nurses to cope with daily life at home with family members and the need be observed and understood as ill to receive support and care if new phases of acute psychosis occur.

Our results describe how the participants experienced being in transition to become ready for discharge. Models of transitional mental health care (cf. [11,13,14]) recommend the transitional care adjusted to persons' narrated experiences about their situation and care needs, and provided within partnership and cooperation between the person in care and the mental health nurses. We know that the nurses and the persons in care may have different understanding about the time for discharge, and about their medical and care needs [18,19]. We also know that some persons who suffer from severe mental illness and substance abuse may have limited economy, bad housing facilities or being homeless which must be considered by the nurse during the discharge planning [17]. Noseworthy et al. [17] described in a study that smooth transition from the acute ward to community care for a person requires trusting relationships between the person in care and the nurse, sharing knowledge and respecting each other's knowledge, even the lack of resources in the communities and work for the best of solutions for the person in care. These circumstances show some of the complexity of planning the discharge from acute psychiatric ward and the challenge for both mental health nurses and persons in care when to provide the best of transitional mental health care.

The results of our study highlight that participants are aware of their mental health care needs and the time needed for transition to become ready for discharge from the acute psychiatric ward. The participants reported the following care needs: nurses' sensitivity to the participants' care needs associated with their physical and mental wounds and wounded relationships following the acute psychotic illness; the need for a combination of nursing care on the ward and visits home to feel better before discharge; the need for nurses, together with the person in care, to access the person's experienced readiness for discharge based on his/her experienced signs of feeling better and opinions about the quality of care provided at home to confidently live at home.

Methodological considerations and limitations

To ensure the trustworthiness of our approach, we used specific verification strategies throughout the research process [30, 40]. The sample includes persons in care who reported suffering from psychotic illness, which might elicit questions about the reliability of the study. However, previous studies have found that persons' self-report of signs of psychotic illness are generally reliable [52]. The number of participants and the variation in the sample appeared sufficient to describe the nuances and variations in their experiences and was small enough to allow a thorough analysis of the data [30]. We discussed the breadth, depth and nuances of the interviews during the data collection, which allowed the interviewer to modify interviews to

ensure sufficient data [40]. During the content analysis, we critically viewed our chosen focus, coding, the constructions of subcategories and categories and the interpretation of the underlying meaning from different perspectives. This strategy allowed us to explore and reflect on the results and to ensure that our presentation of the results fully captures the participants' narrated experiences.

Our study is limited by the sample size; however, our intention was to present rich descriptions of the topic explored, resulting in a high degree of content validity [40]. The rich detailed descriptions presented in our results allow the reader to consider the transferability of the results to other contexts and may, thus, contribute to the development of nurses' transitional care to help persons for discharge and return home. Aspects of our results are consistent with previous research describing transitions in persons' psychotic illness experiences [53, 54] and provide new knowledge. The new knowledge informs about the transitional period when persons psychotic symptoms decreased and about their needs of nurses transitional care.

Conclusion

Nurses' transitional care activities that seem to be most important for persons with psychotic illness are planning for discharge together with the persons in care and following up with the persons' care at home. However, the new results of our study indicate that only to meet the persons' medical, social and nursing care needs when planning for discharge from an acute psychiatric ward is not sufficient. Persons who recently suffered from acute psychotic illness highlighted the need for time to transition to become ready for discharge from the acute psychiatric ward and the need for care from nurses on the ward and visits home during the transition to become ready for discharge. Mental health nurses need seriously to consider this experiential knowledge as a contribution to improve the transitional mental health care that they provide to persons who recently experienced acute psychotic illness discharged from acute psychiatric wards.

Competing Interest

The authors declare that they have no competing interests.

Author Contributions

All authors contributed in the design of this study. KS performed the data collection guided by AGT. All authors contributed to the analysis and interpretation of the data. KS was responsible for drafting the manuscript. All authors revised the manuscript critically and made a substantial contribution in revising the manuscript. All authors read and approved the final manuscript.

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References

1. Thornicroft G, Tansella M (2013) The balanced care model: the case for both hospital- and community-based mental healthcare. *Br J Psychiatry* 202: 246-248.
2. Bowers L, Simpson A, Alexander J, Hackney D, Nijman H, et al. (2005) The nature and purpose of acute psychiatric wards: the Tompkins acute ward study. *J Ment Health* 14: 625-635.
3. Norwegian Directorate of Health (2013) National guidelines for diagnosis, treatment and follow-up of persons with psychotic disorders. Oslo: Anword Grafisk AS.
4. McGorry PD, Killackey E, Yung A (2008) Early intervention in psychosis: concepts, evidence and future directions. *World Psychiatry* 7: 148-156.
5. NICE (2014) National Institute of Clinical Excellence Guidelines: psychosis and schizophrenia in Adults: Treatment and Management.
6. Mental Health Commission Scotland (2012) Guidance document on individual care planning mental health services.
7. Norwegian Directorate of Health (2015) Rehabilitation, habilitation, individual care plan and coordinator. Guideline. Oslo: Anword Grafisk AS.
8. Schumacher KL, Meleis AI (1994) Transitions: a central concept in nursing. *Image J Nurs Sch* 26: 119-127.
9. Tomita A, Herman DB (2012) The impact of critical time intervention in reducing psychiatric rehospitalization after hospital discharge. *Psychiatr Serv* 63: 935-937.
10. Mistiaen P, Francke AL, Poot E (2007) Interventions aimed at reducing problems in adult patients discharged from hospital to home: a systematic meta-review. *BMC Health Serv Res* 7: 47.
11. Barker P, Buchanan-Barker P (2010) The tidal model of mental health recovery and reclamation: application in acute care settings. *Issues Ment Health Nurs* 31: 171-180.
12. Rock BD (1987) Beyond discharge planning. *Hosp Community Psychiatry* 38: 529-530.
13. Reynolds W, Lauder W, Sharkey S, Maciver S, Veitch T, et al. (2004) The effects of a transitional discharge model for psychiatric patients. *J Psychiatr Ment Health Nurs* 11: 82-88.
14. Forchuk C, Martin ML, Chan YL, Jensen E (2005) Therapeutic relationships: from psychiatric hospital to community. *J Psychiatr Ment Health Nurs* 12: 556-564.
15. Lien L (2002) Are readmission rates influenced by how psychiatric services are organized? *Nord J Psychiatry* 56: 23-28.
16. Loch AA (2014) Discharged from a mental health admission ward: is it safe to go home? A review of the negative outcomes of psychiatric hospitalization. *Psychol Res Behav Manag* 7:137-145.
17. Noseworthy AM, Sevigny E, Laizner A, Houle C, La Ricca P (2014) Mental health care professionals' experiences with the discharge planning process and transitioning patients attending outpatient clinics into community care. *Arch Psychiatr Nurs* 28: 263-271.
18. Walsh J, Boyle J (2009) Improving acute psychiatric hospital services according to inpatient experiences. A user-led piece of research as a means to empowerment. *Issues Ment Health Nurs* 30: 31-38.
19. Glasby J, Lester H (2005) On the inside: a narrative review of mental health inpatient services. *Br J Soc Work* 35: 863-879.
20. Cleary M, Horsfall J, Hunt GE (2003) Consumer feedback on nursing care and discharge planning. *J Adv Nurs* 42: 269-277.
21. Manuel J, Hinterland K, Conover S, Herman D (2012) "I hope I can make it out there": perceptions of women with severe mental illness on the transition from hospital to community. *Community Ment Health J* 48: 302-308.
22. Gerson LD, Rose LE (2012) Needs of persons with serious mental illness following discharge from inpatient treatment: patient and family views. *Arch Psychiatr Nurs* 26: 261-271.
23. Puschner B, Steffen S, Volker KA, Spitzer C, Gaebel W, et al. (2011) Needs-oriented discharge planning for high utilizers of psychiatric services: multicenter randomized controlled trial. *Epidemiol Psychiatr Sci* 20: 181-192.
24. Vigod S, Kurdyak P, Dennis CL, Leszcz T, Taylor VH, et al. (2013) Transitional interventions to reduce early psychiatric readmissions in adults: systematic review. *Br J Psychiatry* 202: 187-194.
25. Steffen S, Kösters M, Becker T, Puschner B (2009) Discharge planning in mental health care: a systematic review of the recent literature. *Acta Psychiatr Scand* 120: 1-9.
26. Khankeh H, Rahgozar M, Ranjbar M (2011) The effects of nursing discharge plan (post-discharge education and follow-up) on self-care ability in patients with chronic schizophrenia hospitalized in Razi psychiatric Center. *Iran J Nurs Midwifery Res* 16: 162-168.
27. Potkin SG, Gharabawi GM, Greenspan AJ, Rupnow MF, Kosik-Gonzalez C, et al. (2005) Psychometric evaluation of the Readiness for Discharge Questionnaire. *Schizophr Res* 80: 203-212.
28. Barker P (2001) The Tidal Model: developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *J Psychiatr Ment Health Nurs* 8: 233-240.
29. Mishler EG (1991) *Research Interviewing: Context and Narrative*. Cambridge, MA: Harvard University Press.
30. Graneheim UH, Lundman B (2004) Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today* 24: 105-112.
31. Vaismoradi M, Turunen H, Bondas T (2013) Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nurs Health Sci* 15: 398-405.
32. WMA Declaration of Helsinki (2013) Ethical Principles for Medical Research Involving Human Subjects.
33. Hem MH, Heggen K, Ruyter KW (2007) Questionable requirement for consent in observational research in psychiatry. *Nurs Ethics* 14: 41-53.
34. Hategan A, Parthasarathi U, Bourgeois JA (2014) Obtaining informed consent for research in an acute inpatient psychiatric setting. *Cur Psychiatry* 13: 39-40.
35. Carpenter WT Jr, Gold JM, Lahti AC, Queem CA, Conley RR, et al. (2000) Decisional capacity for informed consent in schizophrenia research. *Arch Gen Psychiatry* 57: 533-538.
36. Ruud T, Grawe R, Hatling T (2006) Akuttpsykiatrisk behandling i Norge - resultater fra en multisenterstudie (Acute psychiatric treatment in Norway - results from a multicenter study). Oslo: SINTEF.
37. (2001) Patients and Users Rights Act 1999-07-02-64: Act Relating to Patients and User Right. Oslo: Norwegian Department of Health.
38. Norwegian Directorate of Health (2008-2009) The reform of cooperation - The right treatment - in right care-setting - to the right time. Oslo: 07 Gruppen AS.
39. (2001) Mental Health Act 1999-07-02-62: Act Relating to the Establishment and Provision of Mental Health Care. Oslo: Norwegian Department of Health.
40. Elo S, Kaariainen M, Kanste O, Polkki T, Utriainen K, et al. (2014) Qualitative content analysis: a focus on trustworthiness. *SAGE Open* 2014: 1-10.
41. Chick N, Meleis A (1986) Transitions: a nursing concern. In: Chinn PL (Ed) *Nursing Research Methodology*, Aspen Publishers; Boulder, CO, pp. 237-257.
42. Meleis AI, Sawyer LM, Im EO, Hilfinger Messias DK, Schumacher K (2000) Experiencing transitions: an emerging middle-range theory. *ANS Adv Nurs Sci* 23: 12-28.
43. Frank AW (2001) Can we research suffering? *Qual Health Res* 11: 353-362.
44. Toombs SK (1990) The temporality of illness: four levels of experience. *Theor Med* 11: 227-241.

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45. Delmar C, Bøje T, Dylmer D, Forup L, Jakobsen C, et al. (2005) Achieving harmony with oneself: life with a chronic illness. *Scand J Caring Sci* 19: 204-212.
 46. Helene Hem M, Heggen K, Ruyter KW (2008) Creating trust in an acute psychiatric ward. *Nurs Ethics* 15: 777-788.
 47. Sebergesen K, Norberg A, Talseth AG (2016) Confirming mental health care in acute psychiatric wards, as narrated by persons experiencing psychotic illness: an interview study. *BMC Nurs* 15: 3.
 48. Fenwick AM (1979) An interdisciplinary tool for assessing patients' readiness for discharge in the rehabilitation setting. *J Adv Nurs* 4: 9-21.
 49. Heine J, Koch S, Goldie P (2004) Patients' experiences of readiness for discharge following a total hip replacement. *Aust J Physiother* 50: 227-233.
 50. Lapum J, Angus JE, Peter E, Watt-Watson J (2011) Patients' discharge experiences: returning home after open-heart surgery. *Heart Lung* 40: 226-235.
 51. Lithner M, Klefsgard R, Johansson J, Andersson E (2015) The significance of information after discharge for colorectal cancer surgery-a qualitative study. *BMC Nurs* 14: 36.
 52. Jorgensen P (1998) Early signs of psychotic relapse in schizophrenia. *Br J Psychiatry* 172: 327-330.
 53. Sebergesen K, Norberg A, Talseth AG (2014) Being in a process of transition to psychosis, as narrated by adults with psychotic illnesses acutely admitted to hospital. *J Psychiatr Ment Health Nurs* 21: 896-905.
 54. Uttinger M, Koranyi S, Pappmeyer M, et al. (2015) Early detection of psychosis: helpful or stigmatizing experience? A qualitative study. *Early Interv Psychiatry* .

Appendix I

Documentation of permission I

Karina Sebergesen
Psykiatrisk senter for Tromsø og Karlsøy
UNN
9291 TROMSØ

Deres ref.:

Vår ref.: 200604741-5/MRO/400

Dato: 16.11.2006

**P REK NORD 110/2006 PSYKISTRISK PLEIE OG BEHANDLING TIL PASIENTER
INNLAGT I VOKSEN PSYKIATRI AKUTTPOST. NARRATIVE INTERVJUER MED
SYKEPLEIERE, LEGER, PASIENTER OG DERES PÅRØRENDE -
SLUTTIVURDERING - KOMITEEN HAR INGEN INNSENDINGER MOT AT
PROSJEKTET GJENNFØRES**

Vi viser til prosjektleders brev av 28.10.2006 med vedlegg.

Prosjektleders tilbakemelding på komiteens merknader til prosjektet i møte 31.08.06 tas til etterretning.

Forespørsellinformasjonsskriv/samtykkeerklæring

For pasienter og andre i et avhengighetsforhold må det opplyses at det ikke får innvirkning på deres forhold til behandlerne eller andre, dersom de ikke deltar i studien. Opplysning om dette bør føyes til etter opplysningen om at det er frivillig å delta.

Setningen om at det kun er pasienten som kjenner identiteten til pårørende bør strykes eller endres til at det kun er pasienten og prosjektleder som kjenner identiteten.

Komiteen ber om å få tilsendt revidert skjema til orientering.

Regional komité for medisinsk forskningsetikk, Nord-Norge (REK Nord) har ingen innvendinger mot at prosjektet gjennomføres.

Det forutsettes at prosjektet er godkjent av aktuelle formelle instanser før det settes i gang.

Det forutsettes at prosjektet forelegges komiteen på nytt, dersom det under gjennomføringen skjer komplikasjoner eller endringer i de forutsetninger som komiteen har basert sin avgjørelse på.

REGIONAL KOMITÉ FOR MEDISINSK FORSKNINGSETIKK, NORD-NORGE

Regional komité for medisinsk forskningsetikk, Nord

Universitetet i Tromsø, No-9037 Tromsø, tlf 77 64 40 00, e-post postmottak@uit.no, <http://uit.no>
førstekonsulent May Britt Rossvoll, tlf 77 64 48 76, faks , e-post May.Rossvoll@fagmed.uit.no

Komiteen ber om å få melding dersom prosjektet ikke blir slutført.

Vennlig hilsen

May Britt Rossvoll
førstekonsulent

Anne-Grethe Talseth
Avdeling for helsefag
Høgskolen i Tromsø
9293 Tromsø

Deres ref.:

Vår ref.: 200604741-7/MRO/400

Dato: 29.04.2008

**P REK NORD 110/2006 BRUKERMEDVIRKNING VED INNLEGGELSE I
AKUTTPSYKITATRISK SENGEPOST - PROTOKOLLENDRING GODKJENNES**

Vi viser til skjema for protokolltillegg og endringer, datert 15.04.2008 med vedlegg.

Endringen består i skifte av prosjektleder fra Karina Sebergsen til Anne-Grethe Talseth, samt endring av prosjektittel og en ”spissing” av prosjektet.

Etter fullmakt har komiteens leder fattet slikt

vedtak: *prosjektendringen godkjennes.*

Det forutsettes at prosjektet er godkjent av andre aktuelle instanser før det settes i gang. Prosjektet må forelegges komiteen på nytt, dersom det under gjennomføringen skjer komplikasjoner eller endringer i de forutsetninger komiteen har basert sin avgjørelse på. Komiteen ber om å få melding dersom prosjektet ikke blir slutført.

Vedtaket oversendes til Sosial- og helsedirektoratet for behandling av søknad om oppretting av forskningsbiobank.

Vedtaket kan påklages av en part eller annen med rettslig klageinteresse i saken jf. fvl. §28. Klagefristen er tre uker fra det tidspunkt underretning om vedtaket er kommet fram til vedkommende part, jf. fvl. § 29. Klageinstans er Den nasjonale forskningsetiske komité for medisin og helsefag, men en eventuell klage skal rettes til Regional komité for medisinsk og helsefaglig forskningsetikk, Nord Norge. Det følger av fvl. § 18 at en part har rett til å gjøre seg kjent med sakens dokumenter, med mindre annet følger av de unntak loven oppstiller i §§ 18 og 19. Se også <http://www.etikkom.no/REK/klage>.

**REGIONAL KOMITÉ FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK, NORD-NORGE
REK NORD**

Postadresse: Det medisinske fakultet, Universitetet i Tromsø, N-9037 Tromsø
telefon sentralbord 77 64 40 00 telefon ekspedisjon 77649180 e-post rek-nord@fagmed.uit.no
www.etikkom.no

Vennlig hilsen

May Britt Rossvoll
rådgiver
77644876

Kopi: karina,sebergsen@unn.no

Region: REK nord	Saksbehandler: Monika Rydland Gaare	Telefon: 77620756	Vår dato: 09.03.2016	Vår referanse: 2012/1319/REK nord
			Deres dato: 19.02.2016	Deres referanse:

Vår referanse må oppgis ved alle henvendelser

Anne-Grethe Talseth

2012/1319 Brukermedvirkning ved innleggelse i akuttpsykiatrisk sengepost

Forskningsansvarlig: Universitetet i Tromsø
Prosjektleder: Anne-Grethe Talseth

Vi viser til søknad om prosjektendring datert 19.02. 2016.

Det søkes om å få endret sluttdato for prosjektet og innlevering av sluttrapport til 31.12.16.
Pr. telefon 14.3. 2016 har prosjektmedarbeider Karina Sebergsen opplyst at koblingsnøkkel og lydfiler er slettet.

Datasettet er anonymt så man trenger derfor ikke godkjenning for videre oppbevaring.

Komiteen imøteser sluttrapport ved prosjektslutt 31.12.2016.

Med vennlig hilsen

May Britt Rossvoll
sekretariatsleder

Monika Rydland Gaare
rådgiver

Appendix II

Documentation of permission II



Karina Sebergsen
Psykiatrisk senter for Tromsø og Karlsøy
Universitetssykehuset Nord-Norge
Postboks 6124
9291 TROMSØ

Vår dato: 10.12.2006

Vår ref: 15721/PB

Deres dato:

Deres ref:

TILRÅDING AV BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 01.11.2006. Meldingen gjelder prosjektet:

15721 *Psykiatrisk pleie og behandling til pasienter innlagt i voksenpsykiatrisk
akuttpost*
Behandlingsansvarlig Universitetssykehuset Nord-Norge HF, ved institusjonens øverste leder
Daglig ansvarlig Karina Sebergsen

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, eventuelle kommentarer samt personopplysningsloven/-helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/endringskjema>. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://www.nsd.uib.no/personvern/register/>

Personvernombudet vil ved prosjektets avslutning, 01.02.2011 rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

for
Bjørn Henrichsen

Pernilla Bollman
Pernilla Bollman

Kontaktperson: Pernilla Bollman tlf: 55 58 24 10

Vedlegg: Prosjektvurdering



I prosjektet vil det bli registrert sensitive personopplysninger om helseforhold (jf. POL § 2 pkt. 8 c).

Personvernombudet finner prosjektet meget godt gjennomtenkt mht. både rekruttering, førstegangskontakt, informasjon som gis til utvalget og informasjonssikkerhet.

Et år etter prosjektslutt (01.02.2011) vil datamaterialet anonymiseres. Dette innebærer at koblingsnøkkel og lydopptak må slettes og at alle indirekte personidentifiserbare opplysninger som foreligger i intervjuutskrifter slettes eller kategoriseres i vide kategorier.

REK har i følge brev datert 16.11.2006 tilrådet at prosjektet gjennomføres.



Karina Sebergesen
Psykiatrisk senter for Tromsø og Karlsøy
Universitetssykehuset Nord-Norge
Postboks 6124
9291 TROMSØ

Dato: 09.04.2008

Vår ref: 15721 JE/RF

Deres dato:

Deres ref:

OVERFØRING AV OPPFØLGINGSANSVAR TIL NYTT PERSONVERNOMBUD FOR UNIVERSITETSSYKEHUSET NORD-NORGE HF

Viser til tidligere korrespondanse i forbindelse med prosjektmelding for forskningsprosjektet:

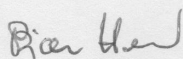
15721 Psykiatriske pleie og behandling til pasienter innlagt i voksenpsykiatriske akuttpost

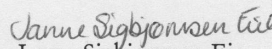
Universitetssykehuset Nord-Norge (UNN) har, med virkning fra 31. mars 2008, sagt opp avtalen om at NSD skal fungere som personvernombud for forskningsprosjekter ved institusjonen. UNN har etablert en egen ordning med internt personvernombud for behandling av personopplysninger. Personvernombudet ved UNN har overtatt ansvaret for videre oppfølging av ovennevnte prosjekt. NSD har oversendt opplysninger om prosjektet til ombudet ved UNN.

Spørsmål om prosjektet eller personvernombudsordningen ved UNN kan rettes til:

Per Bruvold
Sikkerhetssjef IKT/Personvernombud UNN
Universitetssykehuset Nord-Norge
9038 Tromsø
Tlf: 77626119, mob: 97539771
E-post : Per.Bruvold@unn.no

Vennlig hilsen


Bjørn Henrichsen


Janne Sigbjørnsen Eie

Avdelingskontorer / District Offices:

OSLO: NSD, Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no

TRONDHEIM: NSD, Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel: +47-73 59 19 07. kyrre.svarva@svt.ntnu.no

TROMSØ: NSD, SVF, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. nsdmaa@sv.uit.no



UNIVERSITETSSYKEHUSET NORD-NORGE
DAVVI-NORGGÁ UNIVERSITEHTABUOHCCVIESSU



PERSONVERNOBUD

Karina Sebergesen
Psykiatrisk senter for Troms og omegn
9038 Tromsø

Deres ref.:

Vår ref.:
2008/3732

Saksbehandler/dir.tlf.:
Per Norleif Bruvold, 77626119

Dato:
25.07.2008

ANBEFALING AV BEHANDLING AV PERSONOPPLYSNINGER

Viser til melding om behandling av personopplysninger, mottatt 05.05.08.
Meldingen gjelder prosjektet/registeret:

0089 *Psykiatrisk pleie og behandling til pasienter innlagt i voksenpsykiatrisk akuttpost, ref. NSD melding nr 15721*

Formål: Utvidelse av opprinnelig formål. Temaet som nå skal undersøkes er: Brukermedvirkning ved innleggelse i akuttpsykiatrisk sengepost. Beskrive og gi økt forståelse gjennom brukernes erfaring om det å være bruker i akuttpsykiatrisk sengepost, og hvilken mening/betydning det har for den enkelte bruker.

Prosjektet er opprettet i 2006 og godkjent av Personvernombudet for Norsk samfunnsvitenskapelig datatjeneste AS (NSD) pr. 10.12.2006.

Personvernombudet for forskning ved UNN HF har fra 01.01.2008 overtatt NSDs rolle og vil ha den videre oppfølging og godkjenning av prosjekter ved UNN HF.

Personvernombudet har vurdert prosjektet, og finner at utvidelsen av formålet ikke er i uoverensstemmelse med det grunnlag som NSD har basert seg på ved sin godkjenning.

Personvernombudet ved UNN HF tilrår at meddelt endring i prosjektet gjennomføres.

Personvernombudets anbefaling forutsetter at prosjektet gjennomføres i tråd med de opplysningene som er gitt i selve meldingen, i øvrig korrespondanse og samtaler samt i henhold til Personopplysningsloven og Helseregisterloven med forskrifter.

Det gjøres oppmerksom på at det skal gis ny melding (remelding) dersom registeret ikke er slettet eller ikke ferdig innen 3 år og som ligger til grunn for Personvernombudets anbefaling.

Personvernombudet gjør oppmerksom på at dersom registeret skal brukes til annet formål enn det som er nevnt i meldingen må det meldes særskilt i hvert enkelt tilfelle.

Personvernombudet ber om tilbakemelding når registret er slettet.

Med hjemmel etter Personopplysningslovens forskrift § 7-12 godkjenner Personvernombudet at behandlingen av personopplysningene kan settes i gang med de forutsetninger som er nevnt i dette skriv.

Med vennlig hilsen
UNIVERSITETSSYKEHUSET NORD-NORGE HF

Per Bruvold
Sikkerhetssjef IKT/Personvernombud

Postadresse:
UNN HF
9038 TROMSØ

Avdeling:
Besøksadr.:
Fakturaadr:

Direktøren
UNN HF, c/o Fakturamottak, Postboks 4220, Vika, 8608 Mo i Rana

Telefon: 77 62 60 00
Internett: www.unn.no
E-post: post@unn.no

Appendix III

Information about the research project

Forespørsel

Forespørsel om deltakelse i et forskningsprosjekt

BRUKERMEDVIRKNING I AKUTTPSYKIATRISK SENGEPOST I
SPESIALISTHELSETJENESTEN

Dette er en forespørsel til deg om å delta i et forskningsprosjekt som skal undersøke og lære mer om hvordan det er å være pasient (bruker) og mottager av pleie- og behandling i akuttpsykiatrisk sengepost. Det finnes en god del kunnskap om det akuttpsykiatriske behandlingstilbudet, men mindre om hvordan pasienter og pårørende erfarer oppholdet og tilbudet. Pasienters og pårørendes erfaring med det akuttpsykiatriske behandlingstilbudet er betydningsfull kunnskap. Hensikten med prosjektet er å få innsikt i denne kunnskapen, som kan utvikle og kvalitetssikre tilbudet i de akuttpsykiatriske sengeposter i spesialisthelsetjenesten. Deltagere i prosjektet vil være pasienter innlagt ved akuttpsykiatriske sengeposter i Nord – Norge og deres pårørende. Du er en av de **pasienter** jeg vil spørre om å delta i prosjektet for intervju.

Psykiatrisk sykepleier/forsker Karina Sebergsen gjennomfører prosjektet, jeg er tilsatt ved Universitetssykehuset Nord Norge og doktorgradsstudent ved Universitetet i Tromsø. Prosjektet ledes av Anne-Grethe Talseth, psykiatrisk sykepleier og I.amanuensis ved Høgskolen i Tromsø, og vitenskapelig veileder er professor II Astrid Norberg, Universitetet i Tromsø. Prosjektet er finansiert av Helse Nord HF. Prosjektperioden er fra høst 2008 til vår 2011.

Deltakelse i prosjektet innebærer at du vil bli intervjuet av forskerkandidat. Intervjuet vil være på et egnet rom på sykehuset. Jeg ønsker å samtale med deg om dine erfaringer med å være pasient i akuttposten, hvordan du opplever at dine erfaringer og ønsker blir tatt hensyn til, hvordan egen deltakelse i utforming av pleie- og behandlingstilbudet erfares og hvilken betydning deltakelsen har for deg. Du beskriver situasjonen slik du ønsker og opplever det. Underveis vil jeg stille deg spørsmål for å være sikker på at jeg (intervjuer) har forstått det du har fortalt meg. Du velger selv hva du ønsker å svare på. Samtalen vil ha en varighet på ca. 1 time. Jeg innhenter ingen opplysninger om deg fra pasientjournalen. Dersom du samtykker til å delta, ber jeg om tillatelse til å ta samtalen opp på bånd. Slik kan jeg være sikker på å få med alt du forteller. Etterpå skriver jeg ut intervjuet, ord for ord, fra lydbåndet og bruker det skriftlige materialet videre i prosjektet.

Det forventes ikke at det vil medføre noe ubehag eller risiko for deg å delta i prosjektet. Deltagelsen vil ikke gi deg noen nytte eller fordeler i form av honorering.

Det er frivillig å delta i prosjektet. Det vil ikke ha noen konsekvenser for ditt behandlingstilbud, for forholdet til dine behandlere eller til annet personell dersom du ikke ønsker å delta. Du kan trekke deg fra å delta i prosjektet på et hvilket som helst tidspunkt uten begrunnelse og konsekvenser. Dersom intervjuet er gjennomført vil de innsamlede opplysninger bli slettet umiddelbart.

Intervjuene med deg brukes kun slik som beskrevet i hensikten med prosjektet. Lydbåndene og de skrevne intervjuene vil bli behandlet uten navn og fødselsnummer. En kode knytter intervjuene til en navneliste. Kode og navneliste blir forsvarlig låst ned. Intervjuopplysningene vil bli behandlet konfidensielt og kan ikke tilbakeføres til deg. Opplysninger vil bare være tilgjengelig for meg og prosjektleder, som begge har taushetsplikt. Lydbåndene, utskrift av disse og kodelister vil bli slettet/makulert 1 år etter prosjekt slutt.

Denne forespørselen får du fra en prosjektkontakt i akuttposten. Du har 2 dagers betenkningstid før du bestemmer om du skal delta i prosjektet. Dersom du velger du å delta, fyller du ut samtykket for å delta, legger den i vedlagt konvolutt og leverer den til prosjektkontakten som melder fra til meg. Du beholder ditt eget eksemplar av informasjon og samtykkeerklæringa. Jeg tar kontakt med deg og avtaler tid og sted for intervju. Dersom du ønsker mer informasjon om prosjektet før du bestemmer deg for å delta, så melder du fra til prosjektkontakten eller direkte til meg, og vi avtaler et informasjonsmøte.

Prosjektleder og forskerkandidat har ingen økonomiske interesser i prosjektet. Resultatene av prosjektet vil danne grunnlag for artikler som vil bli offentliggjort i internasjonale vitenskapelige tidsskrift og nasjonale tidsskrift om psykisk helse. Dersom du ønsker å få tilgang til prosjektets konklusjon, vil du få det tilsendt.

For spørsmål, ta kontakt pr. telefon: 979 71 949 eller e-post karina.sebergsen@unn.no

Hilsen

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Boks 6124,
9291 Tromsø

Samtykke til deltakelse i forskningsprosjekt

Jeg har mottatt skriftlig og muntlig informasjon om prosjektet” Brukermedvirkning i akuttpsykiatrisk sengepost i spesialisthelsetjenesten” og ønsker å delta i prosjektet.

Navn:
Adresse:
Telefon:

Dato:

Underskrift:

Fyll ut og legg skjemaet til vedlagt konvolutt. Samtykket innhentes av prosjektkontakt. Kopi av forespørsel og samtykke beholder du.

Appendix IV

Interviewguide

SAMTALEGUIDE INTERVJU MED INNLAGT PASIENT

Faktaopplysninger

- Kjønn Alder
- Har du vært innlagt på akuttpost tidligere?
- Hvor lenge har du vært innlagt nå?
- Er du her frivillig eller ufrivillig?

Områder i intervjuet:

Innleggelsen

- Hva var det som brakte deg hit?
- Hvordan kom du til sykehuset?

I akuttposten

- Hvordan vil du beskrive dine problemer og plager når du kom til sykehuset?
- Hvordan opplever du å få hjelp med dine problemer og plager?
- Dersom ikke, hvordan opplever du det?

- Snakker du med sykepleier/lege om dine tanker/følelser knyttet til problemene og plagene dine?
Hva er det som gjør at du får til å snakke med dem?
Hva er det som gjør at du ikke snakker med dem?
- Når du snakket med lege/sykepleier, opplever du at de/den forstår deg og det du snakket om?
Hva er det som gjør at du fikk opplevelsen av at de/den forsto?
Hva er det som gjør at du fikk opplevelsen at de ikke forsto?

- Når du er sammen med lege/sykepleier/andre får du følelsen at de bryr seg om deg?
Hvordan viste de/den at de bryr seg om deg?
Hvordan viste de/den at de ikke bryr seg om deg?

- Hvordan får du bruke egne erfaringer om det å være syk/være i krise under innleggelsen?
Dersom ikke, hvordan kunne du tenkt deg å bruke egne erfaringer?
På hvilken måte har dine pårørende kunne bidra med sine erfaringer som har vært til hjelp for deg? Dersom ikke, hvordan kunne du tenke deg at de kunne bidra under innleggelsen?

Om utskrivelse

- Har personalet og du begynt å snakke om utskrivelse?
- Hvordan opplever du det?
- Hva tenker du skal til for at du blir klar for utskrivelse?

Til slutt:

- Er det noe du vil ha formidlet som du ikke har fått sagt noe om?

