International Journal of Mental Health Nursing (2008) *17*, 98–107 doi: 10.1111/j.1447-0349.2008.00517.x

FEATURE ARTICLE

The core characteristics and nursing care activities in psychiatric intensive care units in Sweden

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ABSTRACT: *Internationally, research on psychiatric intensive care units (PICUs) commonly reports results from demographic studies such as criteria for admission, need for involuntary treatment, and the occurrence of violent behaviour. A few international studies describe the caring aspect of the PICUs based specifically on caregivers' experiences. The concept of PICU in Sweden is not clearly defined. The aim of this study is to describe the core characteristics of a PICU in Sweden and to describe the care activities provided for patients admitted to the PICUs. Critical incident technique was used as the research method. Eighteen caregivers at a PICU participated in the study by completing a semistructured questionnaire. In-depth interviews with three nurses and two assistant nurses also constitute the data. An analysis of the content identified four categories that characterize the core of PICU: the dramatic admission, protests and refusal of treatment, escalating behaviours, and temporarily coercive measure. Care activities for PICUs were also analysed and identified as controlling – establishing boundaries, protecting – warding off, supporting – giving intensive assistance, and structuring the environment. Finally, the discussion put focus on determining the intensive aspect of psychiatric care which has not been done in a Swedish perspective before. PICUs were interpreted as a level of care as it is composed by limited structures and closeness in care.*

KEY WORDS: *coercion, critical incident technique, intensive care unit, psychiatric nursing.*

INTRODUCTION

There are several of psychiatric intensive care units (PICUs) in Swedish county hospitals, although the concept of PICU has not been specified by National Board of Health and Welfare as a public organisation. What exactly characterizes a PICU distinct from, for example, acute psychiatric care is relatively unexplored in Swedish health-care system. The aim of this paper is to describe the core characteristics and nursing care activities for a PICU in Sweden based on an empirical study of caregivers' experiences of nursing at a PICU in a county hospital.

Patients cared for in the PICU are admitted under either the Swedish law of Compulsory Mental Care Act named SFS 1991:1128, Health and Medical Service Act (SFS 1982:763) or the Forensic Mental Care Act (SFS 1991:1129). A patient's first contact with psychiatric care in acute situations is often the psychiatric emergency department. After being examined by a physician, the patient is usually transferred to a PICU or another inpatient ward. Patients may also be transferred to PICUs from other wards in cases when psychotic symptoms are not manageable by the referral ward. Either way, admission to a PICU is almost always traumatic to patient, family and staff.

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Accepted September 2007.

REVIEW OF EARLIER RESEARCH

Psychiatric intensive care units were first referred to in research literature by Rachlin (1973). In the early 1970s, there was a need for locked wards to treat patients who did not respond to treatment in open units whereas one-third of discharged patients were impulsive departures from the hospital. In the PICU described by Rachlin, the ratio of personnel per patient was three times higher than in other psychiatric wards. Patients differed significantly in two categories: domination of male patient and number of readmissions – 86% of the patients had previously been admitted. Rachlin addressed the lack of male staff as a problem as the unit also functioned as a backup unit for other wards in case of an emergency. Other research from PICUs has focused on the need for locked units (Brown & Bass 2004), criteria for admissions (Lehane & Rees 1996; Warneke 1986), as well as the occurrence of violence (Dawson *et al*. 2005). Demographic data of patients admitted to PICUs illustrate the PICU population as predominantly young men, single, unemployed, with a diagnosis of schizophrenia, bipolar disorder, and personality disorders (Bowers *et al*. 2003; Citrome *et al*. 1994; Goldney *et al*. 1985; Pereira *et al*. 2005; Wynaden *et al*. 2001). Drug misuse is common within the PICU population; Isaac *et al*. (2005) found that 71% ($n = 115$) of participants used cannabis, which intensified the psychosis and resulted in longer periods of treatment at the PICU before discharge. Goldney *et al*. (1985) stated that 72% were referred to the PICU from an outpatient facility and 28% were referred from other wards. In a study on reasons why patients were transferred from the psychiatric acute wards to PICU, Bowers *et al*. (2003) identified that the most common reason is the risk of harming oneself or others. Citrome *et al*. (1994) conclude that patients admitted to a PICU because of violent behaviour have significant longer length of stay than suicidal patients.

Violence in psychiatric care

Violence is a common problem in psychiatric acute and intensive wards (Dawson *et al*. 2005; Gillig *et al*. 1998; Owen *et al*. 1998; Wynaden *et al*. 2001), although Vaaler *et al*. (2006) suggest there are significantly lower incidents of violence in a PICU compared with an acute psychiatric ward. Saverimuttu and Lowe (2000) studied violence in a PICU and could not find a correlation between violence and specific diagnoses. Davis (1991) points out that violence is not solely a result of pathology and it must also be considered by individual and situational impacts. Although the explanation for violence is not confined to one perspective, for example, in a study by Duxbury (2002), staff and patients' explanations regarding the causes of violence differed. Staff connected patient violence to their mental illness, while patients said that violence was a result of the staff's lack of communication skills.

Management of violence

Several ways to manage patients expressing verbal aggression and violent behaviour have been utilised. Hyde and Harrower-Wilson (1996) favour the pharmacological intervention, *rapid tranquilization*, as an intervention to manage patients experiencing mental disturbance. Wynaden *et al*. (2001) focused on the use of seclusion rooms and suggested seclusion as a preferable intervention to manage violent patient in PICUs. However, seclusion in acute psychiatric wards and PICUs is frequently used (Baxter *et al*. 1989; El-Badri & Mellsop 2002; LeGris *et al*. 1999; Tunde-Ayinmode & Little 2004) despite that the practice has been strongly criticized because it lacks evidence-based research. Other researchers emphasize the importance of interpersonal relationships (Olsen 2001) and caregivers' knowledge and ability to understand underlying processes of aggressive behaviour to achieve a psychotherapeutic conduct (Dawson *et al*. 2005). Ryan and Bowers (2005) suggested 'talk-down' interventions as a preferable alternative to physical coercive measures. Similarly, Lowe (1992) emphasizes that giving time, being honest and maintaining personal control are essential skills in managing patients with challenging behaviours. Environmental factors are also discussed in previous research. Dix and Williams (1996) suggested special designs of PICUs with single rooms, low stimuli, a garden, safe door and windows, and plenty of space.

AIM OF THIS STUDY

From the above literature review, different and sometimes contradictory perspectives in caring for people with destructive behaviour can be seen. Although demographic data and the problem of managing violent behaviour in psychiatric care are important areas for research, few studies describe specific nursing care activities of the PICUs. Because the quality of care also depends on nursing staff's interventions, it is of interest to describe what characterizes a PICU. Given that psychiatric units can differ internationally, the study conducted in Sweden may generate results that can be useful in comparative studies. Thus, the aim of this study is to describe the core characteristics of a PICU in Sweden as well as to describe

which care activities are practiced by registered nurses and assistant nurses at the PICU.

METHOD

As it was important for this study to relate care activities to typical situations in the PICU, the critical incident technique (CIT) was chosen as an appropriate research method. CIT was introduced and outlined by Flanagan (1954) as a systematic process to collect important situations experienced by practitioners in order to study effective/ineffective ways of doing something and helping/hindering factors. To identify such situations, informants were asked to describe a specific situation where their care made a significant difference to the outcome of the situation. Criteria for an incident are clarified by Butterfield *et al*. (2005) including information concerning what led up to a situation, detailed description of the experience and description of the outcome. Since CIT was introduced, it has become an important research method in nursing research when the interest is in gaining consensus in a problematic area from experience-based practice (Bailey 1956; Benner 1984; Clamp 1980; Cormack 1983, 2000; Dachelet *et al*. 1981; Grant *et al*. 1993; Norman *et al*. 1992; Rimon 1979; Ryback 1967; Sims 1976). In this study, CIT is used to collect, distinguish and verbalize the care activities practiced at a PICU. Five methodological steps, as described by Flanagan (1954), have been applied in this study: (i) Determination of the general aim; (ii) Development of plans for collecting incidents regarding the activity; (iii) Collecting the data; (iv) Analysis of the data; and (v) Interpreting and reporting.

Ethical approval was obtained by the research ethical committee at Mälardalens University (CF33-522/06), and approval to recruit participants was received from the administrative chief and the medical chief of PICU within a regional psychiatric clinic in Sweden. In the psychiatric clinic, there were two PICUs, one of them focused their treatment on detained patients and was excluded because it was a forensic unit. The other PICU treated patients with acute psychiatric needs and was therefore included. All registered nurses and assistant nurses working at the PICU were invited to participate in the study. Twenty-one caregivers consented to participate after they had received written and verbal information about the study by the main author (M.S.E.). However, three of these did not return the questionnaire without any explanation given. Thus, the study comprises 18 informants, nine women and nine men aged between 23 and 56 years. Their length of employment at the selected PICU was between 1 and 7 years.

The informants were instructed to answer a semistructured questionnaire consisting of three questions: (i) incidents involving patients that were typical in the PICU; (ii) their perceptions of patients' caring needs; and (iii) their views on what kind of skills that are needed in the situations that they have described. In order to gain more in-depth data, interviews with five informants (two women and three men) were conducted. These five were selected, after a discussion with the head nurse of the PICU because of their long experience of working in the PICU. Four of these five had also completed the questionnaire. The interviews were held during the caregivers' shift, yet away from the PICU and began with the question 'What is it like to care for a patient in the PICU?'. The focus was on the informants' personal experiences of situations working at a PICU as well as their care activities. The interviews lasted 20–50 min and were audio-taped and transcribed verbatim.

Data analysis

The transcribed protocol from the semistructured questionnaires and interviews were thereafter analysed using the procedures of CIT described by Flanagan (1954). First, the analysis involved perceiving the situations in the text from the questionnaires and transcribed audiotapes. Next, we isolated situations by assembling those that gave the characteristic sense of the PICU and placed them in different categories according to their disparities. For example, in the questionnaires one informant wrote about a situation in which the patient was 'getting more and more aggressive'. This situation exemplifies the origin of the category 'Escalating behaviour'. In the same way, we isolated nursing acts and their outcomes in order to conceptualize the main care activities. As in the procedure described previously, we analysed the content of these situations by searching for similarities and differences, and finally formed different categories describing care activities. In order to substantiate the categories, quotations from the interview data are presented in the results; for example, in one interview the caregiver experience was categorized as supportive: '. . . they (patients) afterwards are often aware of what they have done, and to keep the patient from feeling ashamed, which often occurs, you need to be there for them to help them overcome their shame. This is an important task for a caregiver'.

RESULTS

The results are presented in two parts, *the core*, which describes the characteristics of PICU and *the care*, which describes the care activities of PICU.

The core of psychiatric intensive care units

The identification of the core of PICU in this study is based on critical incidents that highlight the dynamics of caring for person who have the need for such care and treatment. Four categories are integrated in the core of the PICU: the dramatic admission, protests and refusal of treatment, escalating behaviour, and temporary coercive measures.

The dramatic admission

The reasons for admitting patients at the PICU are commonly psychosis or a manic illness, and/or the patients had stopped taking their medication or begun using drugs. Also, aggressive behaviour was a common cause in the admission process. One informant described an acute admission situation:

> A patient was brought to the psychiatric emergency department by police because he had been aggressive in the city and threatened people. The patient was agitated and psychotic. The patient was admitted to the ward 77 [the PICU]. The patient became violent and was physically restrained at the ward and was given a calming injection.

A main characteristic for the PICU was that admissions were acute and patients were often admitted as a result of dramatic situations in society. The patient was first brought to the psychiatric emergency department and thereafter admitted to the PICU where treatment takes place (i.e. sedative medications). Patients were in some situations also admitted from other wards; one informant described a dramatic situation where a patient started to 'kick the walls and threw a cup'. The referral ward was then unable to manage to care for the patient and he was therefore admitted to the PICU. Another informant described a situation when an aggressive patient arrived by police to the psychiatric emergency department. The PICU staff were then called on and served as a rescue team to provide support in the admission process.

Protests and refusal of treatment

A second characteristic of caring for patients admitted to the PICU is the patients' disputes with the staff and protests or refusal of treatment. An informant gives an example of this when a patient could not understand why he was admitted and asked several times to be discharged; he was angry at the police, the doctors and the situations as a whole. According to the informants, the majority of patients admitted to the PICU are 'verbally and physically abusive' and lack the capacity to understand information and the necessity of care activities.

> The staff tries to calm the patient down and offers an oral sedative. At the same time, the patient becomes more aggressive and throws the medicine on the floor, kicks the wall and screams 'You better take the medicine yourself, you sick bastards'.

It could trigger aggression when patients did not understand the nursing staff. Another informant mentioned that because of psychosis, it can be difficult 'getting to' the patient. Also, during a psychosis, bodily needs were often neglected and situations have been related about patients who did not care for their bodies, which could involve excessive smoking and eating as well as refusal to shower.

Escalating behaviour

The informants portrayed situations in which people who are cared for at the PICU express threatening behaviours and violence. In some of the situations that were told, the informants talked about an escalating aspect of the patients' behaviours; verbal aggressive patients were likely to be physically violent.

> On the ward, the patient keeps acting out, screaming and being threatening, insulting staff and other patients with improper words. Calming conversation does not work. The patient becomes more and more irritated and it's just a matter of time before the patient explodes.

In the escalation of the patients' behaviour, the informant had experienced that something was 'in the air', and felt a tense atmosphere. Although, the threatening behaviour and aggression was directed not only at others but also at the patient him/herself. This also includes the intensifying aspect and destructive actions, which can converge to become attempted suicide.

Temporary coercive measures

The informants' experiences from PICU point out that patients were often admitted to custodial care, which in turn was necessary for successful treatments. On account of medicine, nursing, and social efforts, patients' health rapidly increased and they were able to be discharged or transferred back to another ward quicker. When the sense of confusion was less apparent, the patients' care could be treated in a less restrictive ward environment.

> The patient is admitted to ward 77 [the PICU]. The patient becomes violent and is physically restrained at the

> ward and given an injection [. . .]. When the patient is no longer violent, the patient can be a transferred to another ward or discharged.

The care of psychiatric intensive care units

The care in PICU was found in this study consisting of four main nursing care activities: controlling – establishing boundaries, protecting – warding off, supporting – giving intensive assistance, and structuring the environment.

Controlling – establishing boundaries

Controlling patients' exaggerate behaviours, that is, smoking, consuming, showering, promiscuity, manipulation, and aggression, was used as a primary care activity. From experience of controlling patients, it is here understood as a process; at the starting point the informants formed an idea of how the control should be outlined, followed by a dialogue with the patient in whom he/she was given information about the controlling and its implementation. One informant described how the staff formed a 'tight and small group' around a particular patient who they believed was in need for intensive care. The group created an environment for the patient that was filled with structure and rules. All decisions were made by this particular group, which reduced the opportunity for the patient to manipulate the staff and create conflicts. In the intensive phase of the care, 'predictable' behaviour was understood in a positive manner. Another informant described an alternative way to control a PICU patient who was psychotic and when verbal dialogue was not effective in controlling his aggression:

> Then, more people had come, he became aggressive and made trouble. I thought we wouldn't be able to move forward. Then we took him and led him to his room. Then, he calmed down. After 2 weeks we talked about this, 'it was good that you did that and took me with you' [the informant quotes the patient].

To use physical control with the patient involves a risk of insult, and to reduce the impact of insult the informant stated that it was important to answer patients with dignity and sensitivity. Education, experience, and reflection were mentioned as skills that contributed to the ability to create an alliance and a trustful relationship, maintain patience, and communicate without provoking.

> [. . .] one situation was when a patient who was very aggressive and this guy could explode anytime, if I would talk to him, there would be a provocation, therefore I let my colleague go to him, she is calm herself. She explained the importance of taking the medication and it turned out much better. He listened to her and took the medicine. He felt very threatened by the guys, it's important as a caregiver to see such things.

According to the informant, the patient found the male informant threatening, while his female colleague presented a calmer impression to the patient and helped take control of the situation. This situation required self-awareness of what the specific informant expressed as it was experienced from the patient's perspective as well as knowledge to manage the situation in cooperation with colleagues. Because the female informant was experienced as unthreatening to the patient, they were able to establish a dialogue and control was taken of the situation without using coercive measures.

Protecting – warding off

Protecting – warding off was found as a care activity that aimed to ward off or deter situations and behaviours that have negative effects on a patient's health (i.e. self-damage). The informants described situations in which they have prevented patients from inflicting physical or mental injury on themselves or others:

> However, we get frustrated when an elderly person is admitted who are confused – they do not belong at the PICU. Or when a autistic boy is admitted, standing and hugging his teddy bear. We might have to protect him so the other patients wouldn't hurt him.

Protecting was described by the informants in several varieties; for example, patients that were not characteristics for a PICU were described as 'easy targets' for other patients and had to be protected from other violent and aggressive patients. The informants believed that the environment at the PICU itself offered protection as the unit was easy to observe, had secured furniture and was high-staffed; this merged the aspect of intense into the care activity. The opportunity of having separate rooms for each patient was also expressed by the informants as protecting the personal integrity of the patient and could here be understood as a sanctuary where peace and quiet was possible. Patients' integrity was also protected because they as caregivers were able to ignore own prestige and 'back off' to avoid unnecessary provocation. Further, protection also included warding off actions that could lead to shame and insult. One informant described a situation in which she had protected a 'manic' patient by hindering her from selling her house. After a couple of weeks, the patients expressed gratitude to the informant who had been there and said no.

Supporting – giving intensive assistance

The informants had experienced situations in which supported encounters had a positive effect on the patients' health. The initial supportive activity was described by one informant as 'to be an ear': he listened to the patients' stories, and was present and available for the patients.

> [. . .] acted out very much, yelled and screamed. I took her to a room for conversation several times, but she couldn't stick to the main theme [. . .] and I couldn't help her with anything, but she spew (problems). A couple of weeks went by and I assumed that we should keep talking and finally she opens up. She got soft and then, I had been there all the time [. . .] as time went by, her voice got soft, starting to get results. It ended with her being discharged.

Phrases as 'caring in the long run' and 'giving time' were expressed by informants; the support encompasses being there for the patient, as expressed by an informant: 'To be a caregiver for PICU patients is to care for the patients in their worst phase, waiting for them to get off the ground . . .'. Gradually, by 'giving time' one informant described how the patient opened up and the informant was then able to give support in a more interactive manner than just 'being an ear'. Support also comprised the informants' ability to be serious about listening to the patients' stories despite the fact that they did not understand the entire content.

> The patient was admitted and was physically restrained [. . .] my main task was to receive him at the ward [the PICU] with calm and kindness. Sit by the patient and talk calmingly [sic] and explain things until the patient became calm and could be set free.

Another informant exemplifies how she made her self accessible for conversation by standing with a dishcloth in the kitchen door and letting the patient come to her, instead of pushing the patient to contact.

The meaning of support and giving intensive assistance is also highlighted by the informants' descriptions of critical situations in which they persevered to 'stand by' the patients without rejecting them despite threats and aggressions. In such situations, the support and intensive assistance was also closely linked to courage, which was mentioned by the informants. In some situations, the informants displayed some of their own personality, showed compassion, had a humble attitude, used humour and were able to laugh with the patients. These skills resulted in better relationships, increased understanding and a decreased risk of violent action. Supporting was also considered from another view; stories have been told about patients' bodily needs, for example, reminding about showering and eating. The ability to identify and distinguish all these different needs and to approach patients in a non-threatening manner was described by one informant as her qualities 'will, stamina, and courage'.

Structuring the environment

The informants described their experiences from PICUs and the need for a level of organization with capacity of caring for people who tend to threaten, be aggressive and violent, or in some other way express unacceptable behaviours. One central hallmark of the PICU was described as a structured physical environment, high staff–patient ratio, and limited space. The informants expressed the structured environment was necessary to be able to supervise the ward in their care. This was explained in a positive way as it enabled the informants to keep control.

> The patient needs to be on our ward right now because he tends to act out on other wards with verbal threats. [. . .] The patient knows ward 77 [the PICU]; there is more staff, less space, more men, a sterile environment and strict structure, not so many impressions, and we confront conflicts and don't get soft because of threats.

In the structured environment, the informants express the small space at the PICU in a positive manner because of their opportunity to observe, being present and physical close to the patients. Environmental factors did not only keep the informants in control, it also gave advantages for the patients as it minimized visual impressions and infused peace and quiet, which in terms gave patients the opportunity to rest.

DISCUSSION

In this study, CIT was used to describe core characteristics and the care from one PICU in Sweden by collecting written and verbal data from caregivers' experiences in situations involving care for patients admitted to the PICU. According to Butterfield *et al*. (2005), theoretically validity in a CIT study could also be achieved by comparing the categories with earlier research. Because of the lack of earlier research from Swedish PICUs, the comparison was made against earlier international research from PICUs as well as studies focused on acute psychiatric care. The results do not clarify the differentiation between acute psychiatric care and psychiatric intensive care. Because this was a qualitative study, the results cannot be generalized to other PICUs in Sweden. However, the results can be used to formulate more specific questions that could be used in a broader survey study or in-depth interviews that could result in higher

numbers of critical incidents. Not all of the credibility checks that are suggested by Butterfield *et al*. (2005) were preformed in this study, although such checks were not stated by Flanagan (1954). Instead, the authors of this study reached agreement in the identification of incidents, ensured that data were analysed systematically and maintained consistency in categorizing the data (Silverman 2002). After analysing the data, credibility to the results was also gained by a verbal presentation of the categories to the informants in the study. The main author elucidated each category and the informants were able to ask questions and came to an agreement with the categories and interpretations.

In addition, demographic data of the PICU population regarding sex, age, length of stay, and frequency of violence incidents would have been interesting facts in describing the Swedish PICUs. Best (1996) highlighted the lack of a distinct definition and argued for the usage of acute psychiatric care methods in the psychiatric intensive care, but accentuated the potential risk for violence and safety precautions as an additional issues within the PICU care. In this study, the caregivers have given several examples from situations where aggression and violent behaviour were an issue when caring for patients admitted at the PICU.

This study focused on Swedish PICUs which have not previously been investigated. The concept of PICU is more well-recognized internationally and has been legitimized by public organizations: the Department of Health in Great Britain has formalized national minimum standards for PICUs and the Department of Human Services in South Australia has published similar guidelines regarding admission, care and discharging to PICUs. Differentiation between acute and intensive psychiatric care has no clear definitions according to the Swedish National Board of Health. Further, the concept of 'intensive' psychiatric care is discussed with differential meaning in the literature. Gentle (1996) referred 'intensive' as the close relationship to the patients while Cohen and Khan (1990) addressed the concept lack of activities and minimum impressions for the patients. Both these aspects of 'intensive' were contented in the data for this study.

Intensive as limited structures and closeness in care

PICUs could be considered as a specific level of care with short length of stays and rapid improvement. In the PICU, there are possibilities for the patient to be intensively cared for in a safe manner because of the specific environment and closeness to a caregiver. It may be as the informants in this study believed, that other units are unable to care for 'PICU patients' especially because of large spaces, limited structured environment and a lack of skilled staff.

In this study, several informants draw attention to the structured environment and its benefits in caring for PICU patients. The environment and safety procedures prohibited drugs in the PICU and the small unit, as it was easy to observe, the possibility to be physically close to the patients made it easier to deter patients' unwanted behaviours, that is, drinking too much water or patients' bothering each other. Similar apprehensions are supported by Vaaler *et al*.'s (2006) study where patients in the restricted PICU environment had significant lower rate of violent incidents than those patients who were admitted to an acute psychiatric ward with less restricted areas.

In internationally research from PICUs, patients who were admitted at PICUs constituted a risk for oneself or others (Citrome *et al*. 1994; Dawson *et al*. 2005; Pereira *et al*. 2005) and should be considered as high-risk patients (Wynaden *et al*. 2001) with risk of elopement (Rachlin 1973). Allan *et al*. (1988) described PICU patients as acutely disturbed patients who showed serious manageable problems.

Beer *et al*. (1997) illustrated that extra care wards, special care and locked wards often are terms used to describe units similar to maximum secure units by White (2005), medium secure units by Isherwood *et al*. (2006), acute psychiatric wards by Bowers *et al*. (2006), regional secure units by Watson (1998), and psychiatric emergency units by Sar *et al*. (2007). As these units are treating patients with similar problems and diagnosis as the PICUs, the treatment often focused on management strategies such as seclusion and restraint as it is described in earlier research from PICUs. This raises the idea that PICU care can be set out in other units than specifically PICUs and aligns psychiatric intensive care into a level of care.

We argue that the limited structures compose one aspect of the term 'intensive' in PICU; in addition, we also assert closeness as a significant part of the intensive aspect of PICUs. To our understanding, the closeness is central in the care activities. 'Control' as an intervention in clinical psychiatric nursing has frequently been discussed in previous literature (Cohen & Khan 1990; Harris & Morrison 1995; Vaaler *et al*. 2006; Vatne & Fagermoen 2007; Wynaden *et al*. 2001). Earlier research described separately ways of controlling patients' violent and deviant behaviours, and focus has mostly been put on medical-based decisions, such as pharmacology interventions (Hyde & Harrower-Wilson 1996), use of seclusion

(Tunde-Ayinmode & Little 2004; Wynaden *et al*. 2001), and physical restraints (Lee *et al*. 2003). All these interventions were also described by the caregivers in this study. In addition, the concept of care activities in the PICU is further described here with more depth from situations involving caregivers' encounter with violence and other behaviours considered undesirable in patients admitted to the PICU. Controlling patients without using coercion strategies is described in this study and constitutes a more human and caring alternative to traditional management strategies in PICUs as described in previous research. In this study, control was further described in terms of achieving an alliance by a caring relationship with the patients to get control of a situation. The caregivers' ability to create a dialogue in a non-threatening way with the patients is here interpreted as fundamental in controlling patient without provoking. Harris and Morrison (1995) also highlight the risk of staff's provocation when controlling patients and address the importance of communicating a caring attitude and encounter patients with an 'interactional' style. The risk of staff's provocation was also assigned by Omérov *et al*. (2004) who addressed the importance of interpreting how patients perceive the staff's behaviour in order to prevent violent incidents. In this study, one situation was described when a male caregiver apprehended himself as provoking the patient, by 'just being a male'. To avoid further escalation of the situation, he asks his female coworker who expressed a non-threatening attitude to the patient to take over. However, this seems to contradict Rachlin (1973) who addresses the lack of male staff as a problem in running PICUs.

The second care activity was protecting – warding off. When the caregivers are present, observing the PICU and being close to the patients, we interpret this as an intensive protection. By being close to the patients and able to observe, Delaney and Johnson (2006) interpret this as a way of keeping a unit safe. We interpret that because of the high ratio of staff at the PICU in our study, the intensive observation revealed safety and enabled protection for the patients. Cutcliffe and Barker (2002) argued that the term 'observation' should be changed into a more caring aspect by calling it 'engagement-hope inspiration'. This is similar to the third care activity: supporting – giving intensive assistance. The caregivers' closeness to the patients also implicates a feeling of support from the caregivers who kept standing by the patients despite threats and violent behaviours.

In summary, this study has described the core characteristics and the nursing care activities provided for patients admitted to a PICU in Sweden from a caregiver's perspective. This study do not differentiate acute psychiatric care from psychiatric intensive care, although it puts focus on describing the intensive aspect of psychiatric care which has not been done in a Swedish perspective before. Therefore, we want to enlighten PICU as a level of care composed by limited structures and closeness in care.

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