

# Providing Structure

unraveling and building a psychiatric  
nursing intervention



Amar Voogt



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nursing intervention**

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## **Cover**

*The illustration of the cover and on the first pages of each chapter is an artist representation of two historical phenomena. The first drawing with the hands on both sides of the head was used on the first course in psychiatric nursing of the Brothers of Onze Lieve Vrouwe van Lourdes, the founders of Mental Health Care Hospital St. Willibrord in Heiloo, The Netherlands. The drawing symbolizes prudence with head and heart. The author started his career as a psychiatric nurse in this hospital.*

*The dark blue cover and the cross added to the head symbolizes the 'black cross', which was in fact blue. Nurses were obliged to wear this cross when they graduated according to the nursing law of 1921 (Information was attained through the help of Dr. Cecile Aan de Stegge and her archive of psychiatric nursing, and Peter Koopman).*

Providing Structure, unraveling and building  
a psychiatric nursing intervention

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# Providing Structure

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# Chapter 1

## **General Introduction**



## *On a personal note*

*In the beginning of my career in psychiatric nursing I frequently asked my experienced colleagues what they meant with the term “Providing Structure” (PS). To my surprise, no one was able to give satisfying answers or references to literature. Yet, as PS was frequently mentioned as a nursing intervention in treatment plans, I regarded PS as a common and basic psychiatric nursing intervention, naively assuming it could be applied uniformly and effectively in an inpatient ward in psychiatry.*

*I noticed how psychiatric nurses often referred to PS as a means to restore a day-and-night rhythm and set limits, which to me implied that these might be the implicit goals of PS. However, in the treatment plans, nurses neither described what to do nor the specific goals that had to be achieved. Gradually my impression grew that my experienced colleagues had no shared definition of PS, and thus this intervention remained unclear for me also. The uncertainty this caused, became the motivation to conduct research on PS as a psychiatric nursing intervention in order to help nurses to underpin their work, a task I took on once I had become an experienced psychiatric nurse myself.*

*For most of my clinical career, I have worked on inpatient wards where the (involuntarily) admitted patients were often confused, sometimes showed aggressive behavior, and could be a danger both to their own health and safety and that of others. To me these patients always seemed in need for structure. They for instance wanted to have their medication on time, sought to participate in shared activities both inside and outside the ward, and longed for guidance with their plans, activities, and expectations. Yet many of these patients were too confused to organize their lives. At the same time, most of the patients wanted to become independent again, and live outside the ward to regain their normal life. For this, they needed support.*

## Inpatient nursing care and Providing Structure

On psychiatric inpatient wards, patients suffer from severe and complex psychiatric disorders, and they temporarily stay on the ward with nurses and other caregivers. Though uniformity and consensus on what PS entails seem to be lacking, some authors offer insights into what PS might aim for and could consist of. According to Kerr (1990a, 1990b) patients receive support to overcome ego-deficits and regain self-control. Nurses aim for a safe and secure environment for patients (and themselves) by setting limits (Lowe, 1992).

Patients need the constant presence of a caregiver (i.e. constant care) during admittance to an inpatient psychiatric unit (Yonge, 2002). Yonge distinguishes two main dimensions of providing structure: In the first dimension, a nurse facilitates the patient's activities; and in the second dimension, a nurse provides structure by being there and by communicating with the patient about what to do. Delaney, Rogers Pitula, & Perraud (2000) argue that patients can regain control of their illness and behavior when the clinical environment is structured, safe, and staffed with nurses who are capable of providing supportive understanding. Nursing care on these wards often consists of the application of rules. The inpatient wards are structured with a variety of rules such as closed doors, fixed day programs etc., which may stem from jurisdiction, hospital policies, or from local ward policies (Garritson, 1983; Sharrock & Rickard, 2002; Vatne & Holmes, 2006; Walker, 1994). In a study about nursing ward regimes and involvement in rule construction, Alexander (2006) refers to the patient's need to deal with these rules and learn to accept ward rules. On the other hand, these rules can be used inappropriately by nurses on inpatient wards (Nugteren et al., 2015) because these rules focus on following policies strictly rather than caring for the patients' needs in a patient centered manner. In relation to following rules, Lowe et al. (2003), Mohr et al. (1998), and Morales & Duphorne (1995) emphasize patients' need to maintain their autonomy. According to Nugteren et al. (2015), patients need interaction with nurses, and information from nurses after admittance to a closed psychiatric ward. Such information should be 'crucial' information about their treatment (Delaney, 2006; Vrale & Steen, 2005), such as information about the length of stay (Alexander, 2006). Other patient needs are the need to have access to personal facilities and privacy, and the need to have conversations about treatment with nursing staff (Alexander, 2006). Furthermore, additional patient needs for structure become clear with the use of the Ego Competency Assessment Scale (Kerr, 1990a, 1990b). This scale assesses ego-deficits on the following nine ego-functions: impulse control, mood, judgment, reality testing, self-perception, object relations, thought processes, mastery of activities of daily living, and stimulus barrier. According to Kerr, where deficits exist, psychiatric nurses can help to deliver auxiliary ego functions. These different needs may reflect a need for structure, provided by nurses. The need for interaction

with nurses seems to indicate that it concerns structure provided by nurses through frequent contacts during the day. The information from nurses through conversations with nurses seems to refer to a type of structure that enables patients to know what to do or what is expected from them. When patients are unsure of essential elements for structure such as the length of stay and the level of confinement to the ward, patients may express feelings of fear, anxiety and anger (Alexander, 2006).

O'Brien, (2000), advises nurses to impose consistent limits and nevertheless be flexible to allow for individualized care planning. For this, nurses try to relate to each patient and to recognize their individuality (Björkdahl, Palmstierna, & Hansebo, 2010; Delaney, 2006; Hopkins, Loeb, & Fick, 2009; Kozub & Skidmore, 2001; Mahoney, Palyo, Napier, & Giordano, 2009; Sebastian, Kuntz, & Shocks, 1990; Vatne & Fagermoen, 2007; Yonge, 2002). Vrale (2005) suggests that the association between structure and flexibility in the relationship between patient and nurse is a dynamic one; that structure and flexibility in the relationship may transfer into activities to control the patient or to develop the patient's capabilities. This may explain why in the daily practice of psychiatric nursing, the results of PS can vary dramatically. PS may result in an escalation of the situation when applied by one psychiatric nurse and a restoration of peace when applied by another nurse under largely similar circumstances (Lancee, McCay, and Toner, 1995; Lowe, 1992; Lowe, Wellman, and Taylor, 2003; Kozub & Skidmore, 2001; Sebastian, Kuntz, and Shocks, 1990). Moreover, when patients report feeling safe and protected by an individual nurse, and not forced to do what others want them to do, patients may experience involuntary care and coercion as voluntary care (Johansson & Lundman, 2002; Silver Curran, 2007; Vatne & Fagermoen, 2007; Yonge, 2002). Yet, the way nurses approach patients during rule imposition is important in the prevention of aggression. When rules are imposed in an insensitive and punitive manner patients might refuse to comply and become aggressive (Alexander, 2006).

Because of the frequent use of PS as a nursing intervention, it can be hypothesized that PS is a fundamental intervention in psychiatric nursing, yet without a clear definition and with insufficient evidence base. Frauenfelder et al. (2013) found that many nursing interventions on inpatient wards are covered by the Nursing Interventions Classification's different domains. For example, the NIC-domain of Behavioral Care covers interventions aimed at improvement of psychosocial functioning and lifestyle. This domain distinguishes between different classes of interventions and in one of these, a relation to structure is mentioned. The class 'Coping Assistance' describes interventions for assistance in developing personal strengths, to adapt to functional changes and/or to achieve higher functional levels. However, in this class no referral is made to PS as an inpatient nursing intervention. These examples illustrate how the NIC seems to include elements of PS in various domains and classes. Yet as a result of

this fragmentation, the NIC does not offer clear guidance on PS as a comprehensive and key intervention in psychiatric care (Frauenfelder et al., 2013).

In the literature we found referrals to the need for structure and how nurses may support the patient to fulfill this need, but no definition of PS, or knowledge about the application and use of PS is found to this date. Moreover, the knowledge about PS-strategies and terms seems mainly transferred by other nurses in clinical settings (O'Brien, 2000). Thus, at the onset of the work in this thesis, what PS exactly entailed, still remained unclear.

## Aims and methods

The main objective of this thesis was to describe Providing Structure (PS) as a nursing intervention in mental health care, and to provide for a proper description of PS as an intervention according to the requirements suggested in the MRC framework for the development and evaluation of complex interventions (2008).

Three research questions were formulated to conduct the research process:

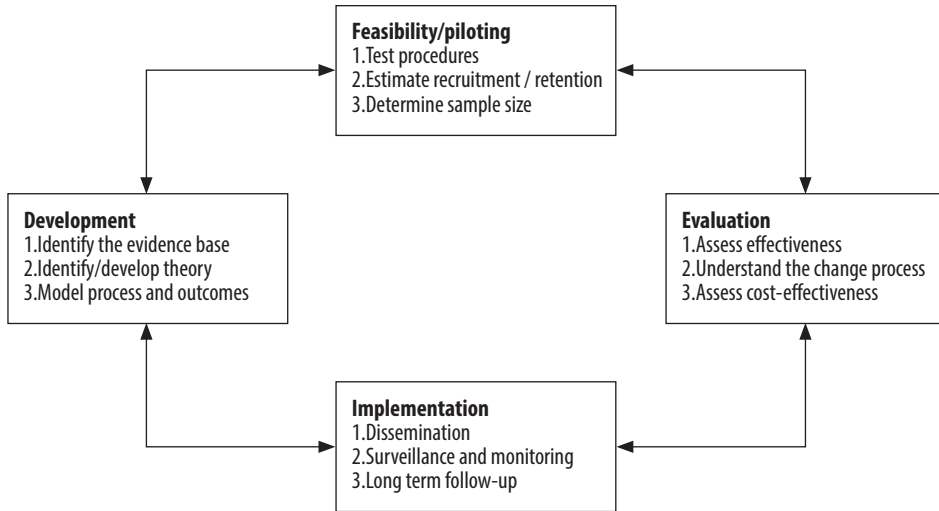
1. What is the definition of PS?
2. Which activities are essential components of 'providing structure' as a nursing intervention in mental healthcare?
3. Which context-variables of PS are important for patients and nurses?

## Developing and Evaluating Complex Interventions

With the "Developing and Evaluating Complex Interventions: New Guidance" of the Medical Research Council (MRC, 2008), we found a framework to unravel and describe PS as a nursing intervention. Judged by the description of complex interventions by the MRC, many nursing interventions may be classified as a complex intervention. MRC defines a complex intervention as *an activity that contains a number of components with the potential for interactions between these components and which — when applied to the intended target population — can produce a range of possible outcomes.*

According to the MRC guidance (2008) for the development and evaluation of complex interventions, the aim is to fill the gap between practice-based knowledge and scientific knowledge. The first phase proposed by the MRC framework is called "development". The development-phase is aimed at both the identification of relevant theory and an evidence base for the complex intervention, and also proposes the modeling of processes and outcomes of a complex intervention. Given the aforementioned lack of clarity on the definition, aims and content of PS, we

**Figure 1. Key Elements of the Development and Evaluation of Complex Interventions (MRC, 2008)**



can conclude that, though used in practice, PS was never properly developed as a complex intervention. In order to clarify this intervention and before research on effects and implementation of PS can be done, we therefore initiated the development of a definition and an operationalization of providing structure as a psychiatric nursing intervention, by performing a literature review and empirical research. A mainly qualitative approach was chosen for this purpose, which partly drew upon the principles of Grounded Theory (Charmaz, 2006; Strauss & Corbin, 1998; Wester, 1995). In the research-process described in this thesis, emphasis is put on the perspectives of both nurses and patients. On the basis of the analyses of the qualitative data obtained and the development of consensus that followed, we aimed to model the process and outcomes of the complex intervention ‘providing structure’.

The other three phases of the MRC - the phase of feasibility and piloting, the evaluation-phase, and the implementation-phase, are to be addressed in future research-studies.

## Outline of the thesis

In order to identify the relevant theoretical and practical components of PS, we conducted a systematic review on the literature related to PS, an observational study, interview studies with patients and psychiatric nurses, and consensus building with experts in psychiatric nursing.

The three research-questions were addressed in 5 studies, which are described in chapters 2 to 6. In chapter 7, the results of the studies are integrated and discussed. In

the sequence of studies we strived to build up a knowledge base for PS and to describe a definition of PS, the activities within PS, and its context-variables. In **Chapter 2** we report on a systematic literature review on PS as a nursing intervention. Here we also searched for the goals of PS when used by nurses, and hoped to discover what was known about the effectiveness of PS. In **Chapter 3** a qualitative study according to the principals of Grounded Theory and with the use of participatory observations of events is reported (Charmaz, 2006; Straus & Corbin, 1998; Wester, 1995). The purpose was to obtain a comprehensive description of behaviors and interactions. On the basis of events (interactions between nurse and patient) we tried to find out what nurses did in the actual practice of providing structure, and what the observed results of providing structure were. The observations delivered a detailed description of the verbal and nonverbal behaviors of nurses and patients during events in which structure was provided. The analyses of the qualitative data resulted in a description of the process and outcomes of providing structure. **Chapter 4** describes the interview study with patients as relevant stakeholders in PS. The interviews immediately followed the observed events described in chapter 3, to gain insight into the patients' perceptions of the behavior of the nurses involved, and the significance of that behavior for the patients. The research questions focused on how patients view and experience PS. A second purpose was to gain insight into the components of PS, the possible interactions between these components, the process of change during events, and — finally — PS as a nursing intervention. In **Chapter 5** the nursing perspective on PS was the central theme, as nurses in this study were regarded as the other important stakeholders. As in chapter 4, the interviews with nurses took the observations of occasions where structure was provided as a starting point. This study resulted in the description of core purposes and prerequisites for PS, and general and specific activities within PS, all from the perspectives of the nurses. In **Chapter 6** experts in the field of psychiatric nursing were consulted using a Delphi-study. The findings of the previous studies were used in the preparation of statements for the three Delphi-rounds in order to gather the collective and shared opinion of the panel of experts, and to be able to reach consensus about the definition, activities and context-variables of PS. In **Chapter 7** the main results from the overall work are summarized and discussed. In this chapter methodological considerations, practical and research implications, and recommendations for psychiatric nurses are described, with a view to further build knowledge on PS, and to add to nurses competencies in PS.

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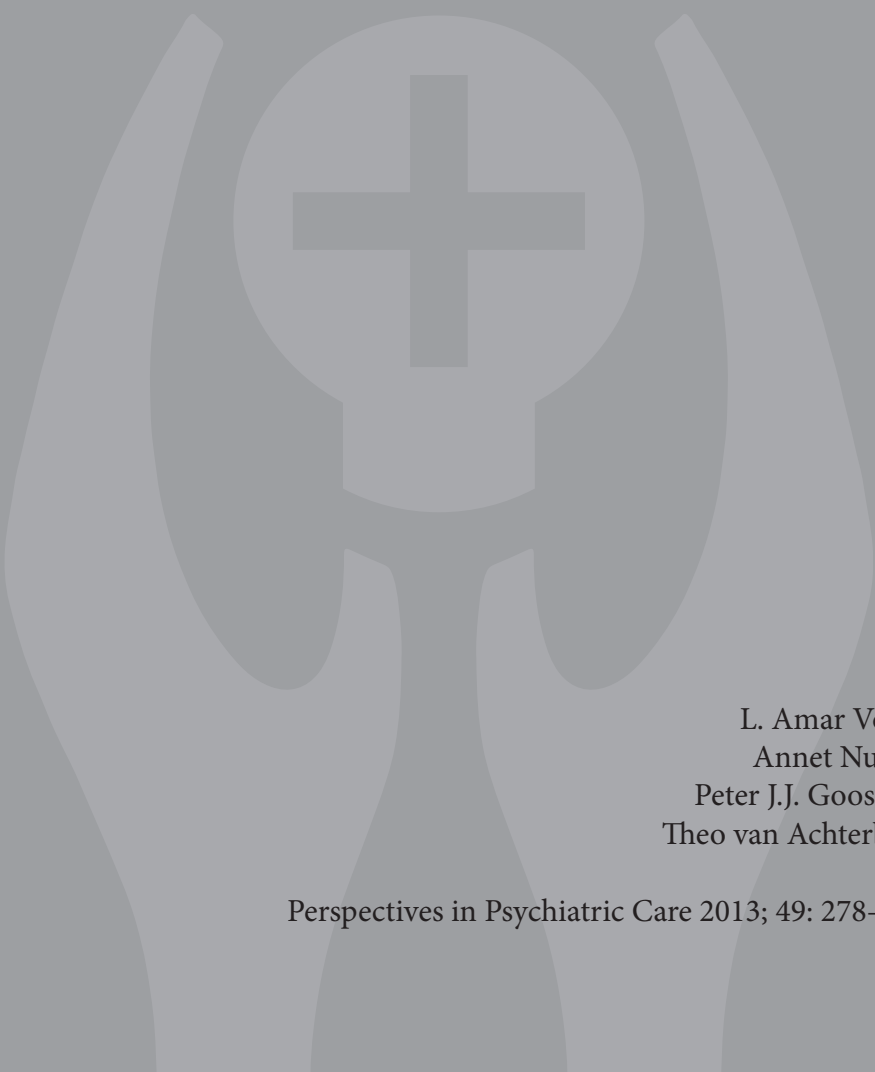


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# Chapter 2

## **“Providing Structure” as a Psychiatric Nursing Intervention: A Review of the Literature**



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Annet Nugter  
Peter J.J. Goossens  
Theo van Achterberg

Perspectives in Psychiatric Care 2013; 49: 278–287

## **PURPOSE**

The focus is on a nursing intervention called “providing structure”(PS). This label does not exist in the Nursing Interventions Classification. The following three questions were asked: (a) How is PS defined? (b) What are the goals of PS? And (c) What is the evidence regarding the effectiveness of PS?

## **DESIGN AND METHOD**

A systematic literature review. Forty articles, predominantly qualitative studies of PS, were selected for review.

## **FINDINGS**

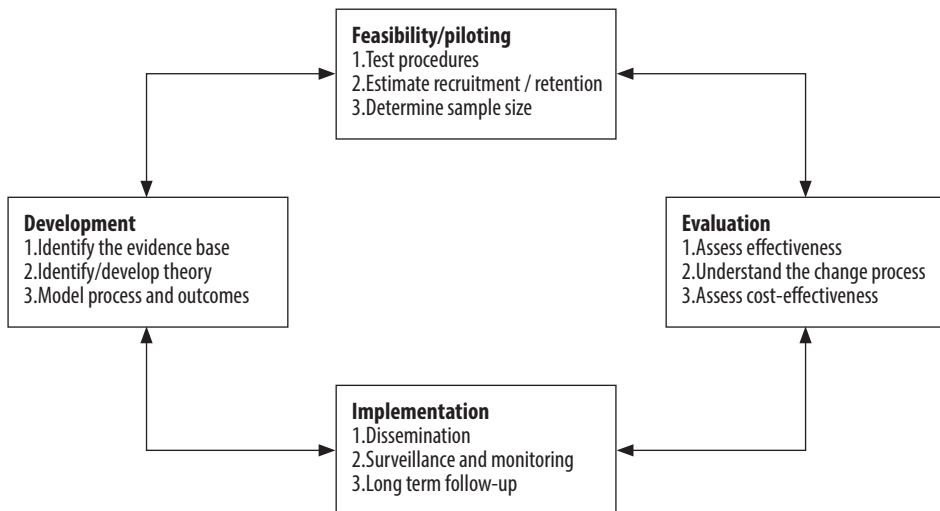
Regarding PS, three elements were mentioned: to impose and maintain rules and limits; to assess the condition of the patient; and to interact with the patient. The goals for PS related to patient security, making expectations explicit, and recovering from illness. Major findings were reviewed, but little was found about the effectiveness of PS.

## Introduction

“Providing structure” (PS) is often referred to by psychiatric nurses as a means to restore a day-and-night rhythm and set limits. PS is also frequently mentioned as a nursing intervention in treatment plans as if it can be applied uniformly and effectively in related situations and settings. However, PS is not classified as an intervention in the Nursing Interventions Classification (NIC) (Bulechek, Butcher, & McCloskey Dochterman, 2008), but related labels were encountered, such as use of structure, restrictiveness, setting limits, and therapeutic milieu. Furthermore, the results of PS can vary dramatically. PS may result in an escalation of the situation when applied by one psychiatric nurse and a restoration of peace when applied by another nurse under largely similar circumstances (Kozub & Skidmore, 2001; Lancee, McCay, & Toner, 1995; Lowe, 1992; Lowe, Wellman, & Taylor, 2003; Sebastian, Kuntz, & Shocks, 1990). According to Anderson and Eppard (1995) and Regan-Kubinsky (1991, 1995), intuitive reasoning plays a major role in the provision of structure by nurses. Little else is known about the application and use of PS. Greater scientific knowledge of PS is needed to supplement what is known about the roles of intuition and personal style in the use of PS as a psychiatric nursing intervention.

According to the requirements of the Medical Research Council (MRC, 2008), the authors must fill the gap between practice-based knowledge and scientific knowledge for the development and evaluation of complex interventions (Figure 1). The

**Figure 1. Key Elements of the Development and Evaluation of Complex Interventions (MRC, 2008)**



first phase that the MRC distinguishes to design a complex intervention is called “development.” The development phase is both aimed at the identification of relevant theory and an evidence base for the complex intervention, and at the modeling of processes and outcomes of this complex intervention. In this review, the main focus is on the development phase. The other three phases of feasibility, evaluation, and implementation will be addressed in future studies. In order to identify the relevant theoretical components for a definition of PS and a possible evidence base, we searched for a systematic review on PS but did not find one.

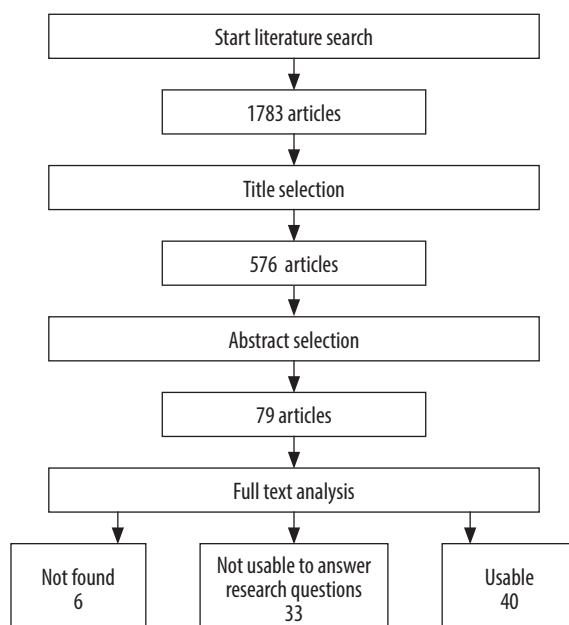
We therefore decided to conduct our own review of the literature with regard to the definition of PS and to assess the available evidence regarding its effectiveness. The following questions were formulated for the review:

- How is the nursing intervention of PS defined in the literature on mental health nursing?
- What are the goals of PS when used by nurses with a patient or patients?, and
- What is known about the effectiveness of PS?

## Method

A literature review was conducted to retrieve studies published between January 1980 and April 2011 using PubMed, EMBASE-Psychiatry, CINAHL, PsycINFO, Medline, and the Cochrane Library (Figure 2). In the NIC, no intervention with the

**Figure 2. Literature Selection**



label PS could be identified. However, some related labels were encountered, namely *use of structure*, *structure*, *restrictiveness*, *limit setting*, and *setting limits* (Bulechek et al., 2008; McCloskey & Bulechek, 1999). “Therapeutic milieu” was added to the list of search terms/phrases because the “use of structure” is explicitly described in the literature on therapeutic milieu (Caplan, 1993; D’Antonio, 2004; Echternacht, 2001; Janzing & Kerstens, 2005; Walker, 1994). All of the foregoing key words and phrases (including PS) were combined with *nursing*, *interventions*, *psychiatry*, and *psychiatric nursing*.

An illustrative list of the key words and phrases used to search the PubMed database is presented in Table 1. Similar searches were constructed for the other databases. Furthermore, the reference lists from the publications initially selected for inclusion in our review were also checked for relevant references.

**Table 1. Key Words and Phrases Used to Search PubMed and Number of Hits**

<b>Keywords and phrases</b>	<b>Hits</b>	<b>1<sup>st</sup> abstract selection</b>	<b>2<sup>nd</sup> full text selection</b>
Structure AND psychiatric nursing	239	39	39
PS AND psychiatric nursing	11	3	0
Restrictiveness AND psychiatric nursing	5	0	0
Setting limits AND psychiatric nursing	7	5	1
Limit setting AND psychiatric nursing	14	9	7
Limit setting OR structure AND psychiatric nursing	250	32	10
Limit setting AND psychiatric nursing AND structure	3	3	1
Limit setting OR PS AND psychiatric nursing	25	12	2
(Setting limits OR limit setting) AND psychiatric nursing	18	11	2
(Providing structure OR setting limits OR limit setting) AND psychiatric nursing	28	13	2
Providing structure AND nursing AND psychiatry	5	1	0
Structure AND interventions AND psychiatric nursing	33	14	3
Therapeutic milieu AND psychiatric nursing	67	17	2
Therapeutic milieu AND psychiatric nursing AND structure	14	7	2
(Therapeutic milieu OR restrictiveness OR Providing structure OR setting limits OR limit setting) AND psychiatric nursing	98	28	5
(Restrictiveness OR Providing structure OR setting limits OR limit setting) AND psychiatric nursing	31	11	1
<b>Total</b>	<b>848</b>	<b>206</b>	<b>77</b>

The titles and abstracts from the hits in our searches were next examined by the first and second authors separately to identify articles for inclusion in the full-text analysis. Publications were included in the review when information judged relevant to the following was found: the definition of PS, the goals of PS, and the effectiveness of PS. The guidelines for systematic reviews (Van Tulder et al., 1997) were used to assess the methodological quality of the selected articles and to separate the scientific articles from the opinion- and experience-based articles. The Van Tulder criteria that we used were (1) description of the research design and method, (2) number of respondents (*N*), (3) description of research aims, and (4) results. The relevant phrases in the articles included in our systematic review were next selected by the first author for further analysis. The selections were examined by the first and second authors independent of each other for relevance and then categorized as pertaining to the definition of PS (question 1), the goals of PS (question 2), or the effects of PS (question 3). The selected articles had to elaborate specifically on the aforementioned three questions, and had to match 3 or 4 from the 4 Van Tulder criteria (see Table 2).

## Results

The systematic search in the PubMed database produced 848 hits. Search strategies for the other databases yielded the following numbers: EMBASE-Psychiatry (14), CINAHL (392), PsycINFO (96), Medline (475), and Cochrane (0).

A total of 1,783 possibly relevant abstracts were found. After title selection and a closer examination of the abstracts by the first author of this review and a second research-assistant independent of each other, 79 admissible articles remained. For 6 of the publications, the full-text articles could not be retrieved from the databases or through libraries. On the Internet we searched for first authors' contact information. Some could not be found and others did not respond. A full-text analysis was then conducted on the remaining 73 articles. In the end, 40 articles—which included both research studies and opinion pieces—were included in our review. In these articles, PS was described either as a nursing intervention or as a combination of interventions. The majority of the research studies were conducted in residential settings, adopted a qualitative approach, and involved case studies, case scenario studies, observations, or interviews (see Table 2). The research articles reporting on these studies contained well-formulated research problems, but the authors did not always specify their study designs or methods. Together with the heterogeneity of how the interventions were conducted, this made comparison of the studies difficult. Two project evaluations and four relevant literature reviews were also included in our selection of articles. Thirteen of the 40 articles were classified as opinion-based articles. These articles were only partly based on the scientific literature regarding PS; the authors mostly reflected on their experiences with the use of PS in these articles (see Table 3).



**Table 2. Overview of QL, QN Research, Project Evaluations, Literature Reviews, and Assessment of Quality With the Use of the Van Tulder Criteria**

Author Study with X of 4 Van Tulder criteria (x/4)	Design, method, N	Aim	Results Introduction (I), Elements of providing Structure <sup>a</sup> , Goals (G) and Effectiveness (E)					
			I	1	2	3	G	E
Allen, 1981 (3/4)	QL, phenomenological study, Participant observation, 11 weeks, N not stated	Investigate the functions of talk in maintaining the social structure						x
Anderson & Eppard, 1995 (4/4)	QL, phenomenological study, Interviews. 24 clinicians: 5 psychiatrists, 5 nurses, 14 counselors	Study the decision-making process in assessing clients	x					
d'Antonio, 2004 (4/4)	QL, historical case study, Daily diaries from patients between 1814–1840	Consider reciprocity between interpersonal relationships and therapeutic environment						x
Björkdahl et al., 2010 (4/4)	QL, exploratory descriptive study, Interviews, 19 nurses	Describe nurses' caring approaches in acute psychiatric wards		x		x	x	x
Caplan, 1993 (4/4)	QN, exploratory descriptive study, Use of scales and questionnaires, 70 (nurses), 37 (pat)	Describe factors of the ward atmosphere and describe structure and compliance with ward routines and behavioral standards	x	x		x		x
Johansson & Lundman, 2002	QL, narrative study, Interviews, 5 patients	Obtain a deeper understanding of the experience of being subjected to involuntary psychiatric care						x
Joseph- Kinzelman et al., 1994	QL, exploratory descriptive study In depth interviews, 15 patients	Understand the clients experience						x
Hopkins et al., 2009 (3/4)	Literature review	Describe what service users expect of inpatient mental health care				x	x	x
Killebrew et al, 1982 (4/4)	QN, evaluation study, A review process with use of questionnaires and a scale, 97 mental health professionals	Outline a methodology for defining and implementing the least restrictive alternative						x
Kozub & Skidmore, 2001 (3/4)	Literature review	Formulate a usable continuum of interventions in response to violent and aggressive behavior	x	x	x	x		x
Lancee et al., 1995 (4/4)	QN, experimental design, role- play scenario's and assessment instruments for level of anger, 97 patients	Test the influence of nurses limit setting styles on anger among psychiatric inpatients	x		x			x
Lowe, 1992 (4/4)	QL, phenomenological study Matrix method multidimensional scaling, semi-structured interviews, observations, field discussions, 33 nurses	Gain insight into nursing strategies in management of challenging behavior	x	x	x		x	x
Lowe et al., 2003 (4/4)	QN, case scenario study case scenario approach, interviews, questionnaires, 70 nurses	Examine the structure of nurses' judgment techniques in situations of conflict	x		x			x
Mohr et al., 1998 (4/4)	QL, exploratory descriptive study Interviews, patient questionnaires and interrogatories, 19 patients	Investigate the experiences and memories of formerly hospitalized children with behavioral problems			x		x	x
Morales & Duphorne, 1995 (4/4)	Project evaluation, 3-month in- service project and review, 1 unit: 25 pat and staff	Decrease the use of restraints and seclusion on an acute unit		x	x			

Author Study with X of 4 Van Tulder criteria (x/4)	Design, method, N	Aim	Results Introduction (I), Elements of providing Structure <sup>a</sup> , Goals (G) and Effectiveness (E)					
			I	1	2	3	G	E
O'Brien, 2000 (4/4)	QL, hermeneutic phenomenological study, Shared conversations about 4 themes with focus groups, 5 nurses and 5 patients	Construct an interpretation of the experience of the nurse-client relationship		x			x	x
O'Brien, 2001 (4/4)	QL, phenomenological study Literature review, interviews, 5 nurses and 5 patients	Construct an interpretation of the experience of nurse-patient relationships in the context of community psychiatric nursing: from the clients perspective		x				x
O'Brien et al., 2001 (3/4)	Literature review	Explore the nature of therapeutic community in relation to the context of destigmatizing mental illness, its structure, and its ability to empower the person		x			x	x
Olsen, 2001 (3/4)	Project evaluation 4 steps procedure: definition of problem, gathering information, synthesis, addressing the problem, N: Not stated	Report findings of investigations into allegations of patient abuse and describe implications for policy and practice			x			x
Ransohoff et al., 1982 (4/4)	QN, evaluation study Simultaneous assessment and comparative evaluation of several value dimensions, 31 mental health professionals	Develop a reliable instrument to measure restrictiveness		x	x			x
Regan- Kubinsky, 1991 (4/4)	QL, grounded theory, In depth interviews (36), 15 nurses	Address judgment processes in psychiatric nursing	x					
Regan- Kubinsky, 1995 (4/4)	QL, grounded theory, In depth interviews (36), 15 nurses	Describe the cognitive tasks involved in making judgments in psychiatric nursing	x					
Sharrock & Rickard, 2002 (4/4)	QL, descriptive evaluative study Expert panels/working parties, N not stated	Develop guidelines for rehabilitation staff on the strategy of limit setting		x		x		x
Vatne & Holmes, 2006 (3/4)	Literature review	Locate the progress of the ideology of limit setting in psychiatry		x		x	x	x
Vatne & Fagermoen, 2007 (4/4)	QL, action research design Participant observation, interviews, written narratives, ward reports of patients, reflection groups, 11 nurses	Explore the characteristics of nurses' limit setting interventions, the rationality in their limit setting approaches, develop nursing interventions for patients with disruptive behavior		x	x	x	x	x
Vrale & Steen, 2005 (4/4)	QL, phenomenological study Individual and focus group interviews, 5 nurses	Describe nursing practice when performing constant observation of suicidal patients					x	x
Yonge, 2002 (4/4)	QL, phenomenological study Literature review and interviews, 8 patients	Describe the patients' perceptions of constant care		x		x	x	x

<sup>a</sup>Element 1 = Impose and maintain rules and limits. Element 2 = Assess condition of patient. Element 3 = Interact as patient and nurse. QL, qualitative; QN, quantitative

## Elements of PS

With regard to our first question about the definition of PS, three elements that seem to be interdependent were frequently mentioned in the reviewed articles:

- To impose and maintain rules and limits
- To assess the condition of the patient
- To interact

*To Impose and Maintain Rules and Limits.* This element of the definition of PS was encountered in eight research articles, one project evaluation, three literature reviews, and six opinion articles. PS could be interpreted as limit setting and the imposing of restrictions, for example, on a closed ward.

On the basis of several studies, two continua for the rules and limits aspect of PS can be distinguished from the following:

- General to specific structure with rules and limits not clearly communicated to or aimed at the individual patient to rules and limits clearly communicated to and aimed at the individual patient
- Least restrictive forms of structure to most restrictive (seclusion, use of restraints)

The first continuum includes the general rules and limits that are part of a patient's stay in a mental healthcare setting (Garritson, 1983; Ransohoff, Zachary, Gaynor, & Hargreaves, 1982; Sebastian et al., 1990; Silver Curran, 2007; Vatne & Fagermoen, 2007; Yonge, 2002). The rules and limits may involve not only such common house rules as keeping the ward clean and dressing yourself, but also rules that apply to involuntary admittance like a closed door policy. Several studies make a further distinction between implicit and explicit rules and limits (Garritson, 1983; Lowe, 1992; Sebastian et al., 1990; Walker, 1994). Both implicit and explicit rules and limits can be seen as part of PS. *Implicit rules and limits* provide a structure that is not directly communicated to the patient and may stem from the implicit norms, regulations, and routines used by hospitals, residential wards, and nurses. Implicit rules and limits form a framework and a daily routine for patients, nurses, hospitals, and wards to function in (Garritson, 1983; Sharrock & Rickard, 2002; Vatne & Holmes, 2006; Walker, 1994). *Explicit rules and limits* are often appealed to in cases of perceived threats to patient safety. A patient may have to be secluded to prevent self-harm, for example (Delaney, Rogers Pitula, & Perraud, 2000; Garritson, 1983; Ransohoff et al., 1982; Sebastian et al., 1990; Vatne & Fagermoen, 2007; Vatne & Holmes, 2006). When a specific patient requires detailed rules and limits these are specifically described in an individualized treatment plan and clearly communicated between nurse and patient (Garritson, 1983; Lowe, 1992; Ransohoff et al., 1982; Sebastian et al., 1990; Walker, 1994).

At the one end of the continuum of least to most restrictive forms of structure (i.e., the second continuum of rules and limits), there are interventions such as verbal interventions and redirection; at the other end are seclusion and the use of restraints (Caplan, 1993; Delaney, 2006; Kozub & Skidmore, 2001; Morales & Duphorne, 1995; O'Brien, 2000; O'Brien, Woods, & Palmer, 2001; Vatne & Fagermoen, 2007). According to Vatne and Fagermoen, limit setting revolves around the nurses' exertion of weak to stronger power in a given nurse-patient situation. In a first contact, the nurse may deliberately choose to use interaction and redirection to highlight rules and limits. This is least restrictive and considered the weakest form of power exertion as it simply offers the patient an alternative way of expressing himself (Delaney, 2006; Kozub & Skidmore, 2001; O'Brien, 2000). Seclusion or the use of restraints is obviously most restrictive and entails the strongest application of power with most explicit rules and limits (Björkdahl, Palmstierna & Hansebo, 2010; Caplan, 1993).

*To Assess the Condition of the Patient.* In seven research articles, two project evaluations, one literature review, and five opinion articles, it is argued that a balanced use of PS can only occur after assessment of the patient's condition.

Researchers in psychiatric nursing have sought to explicitly assess the patient's level of functioning in terms of ego strengths and deficits using the ego competency model (Benfer & Schroder, 1985; Kerr, 1990a, 1990b). In other research, these authors have systematically assessed nine ego functions using the Ego Competency Assessment Scale: impulse control, mood, judgment, reality testing, self-perception, object relations, thought processes, mastery/competence of activities of daily living, and stimulus barrier. According to Kerr (1990a, 1990b), the psychiatric nurse provides auxiliary ego functions where deficits exist, and thereby helps the patient internalize these functions to develop self-control. The nurse can also discover valuable clues to both ego strengths and deficits via such assessment and sufficiently match the PS intervention to the patient's needs.

In order to determine the condition of the patient, other articles refer to the following: responses of the patient to being limited or supported (Delaney et al., 2000; Garritson, 1983; Lancee et al., 1995; Ransohoff et al., 1982); ability of the patient to adequately respond to redirection (Kozub & Skidmore, 2001); and individual need of the patient for autonomy and self-control (Garritson, 1983; Lowe, 1992; Lowe et al., 2003; Mohr, Mahon, & Noone, 1998; Morales & Duphorne, 1995). When these aspects of the condition of the patient are taken into account, the patient does not appear to experience PS as restricting their personal freedom; the patient still feels able to make his own choices (Garritson, 1983; O'Brien, 2001; Olsen, 2001; Vatne & Fagermoen, 2007).

*To Interact.* Although in psychiatric nursing, it would seem to be self-evident that patient and nurse interact and work to build a relationship of trust. In five research articles, three literature reviews, and six opinion articles it is suggested that interaction is an element of PS (Björkdahl et al., 2010; Delaney, 2006; Echternacht, 2001; Hopkins, Loeb, & Fick, 2009; Mahoney, Palyo, Napier, & Giordano, 2009; Sebastian et al., 1990; Silver Curran, 2007; Vatne & Fagermoen, 2007; Yonge, 2002). Kozub and Skidmore (2001) further suggest that interaction is an individualized means of PS. In the context of the nurse–patient interaction, nurses try to relate to each patient by trying to put themselves in the patient’s shoes and recognize their individuality (Björkdahl et al., 2010). When confronted with an aggressive patient, the nurse may intentionally initiate a (non)verbal interaction and thereby try to redirect the patient to a more accepted and safe manner of responding. On the other hand, this interaction can sometimes intensify the aggressive behavior. The nurse explicitly focuses on the patient, and (un)intentionally emphasizes the patient’s problematic behavior. As a result, a major reason for conflict within the patient–nurse relationship occurs (Vatne & Holmes, 2006).

As part of interacting with patients, many authors consider mutual expectations to be critical. A nurse explains to the patient what the nursing care plan entails, which in turn allows patients to put forward their own ideas and expectations with regard to treatment. As a result, the patient and nurse know what to expect during treatment, and the patient is involved in a process of cooperation and formulation of clear treatment goals (Caplan, 1993; Hopkins et al., 2009; Sebastian et al., 1990; Vatne & Fagermoen, 2007; Walker, 1994; Yonge, 2002). The assumption is that a patient feels more self-assured when mutual expectations between patient and nurse are clear and the rules imposed are keeping with expectations. With clear mutual expectations to start from, the patient can interact purposefully to improve his ego functions, develop a more positive self-image, and strengthen his self-esteem. As a result, patients are more capable of meeting treatment goals (Kozub & Skidmore, 2001; Sebastian et al., 1990; Sharrock & Rickard, 2002).

The first question of the review focuses on a definition of PS, and therefore three elements of PS were described above.

The next review question concerns the goals of PS when nurses provide a structure.

## Goals of PS

On the basis of seven research articles, three literature reviews, and three opinion articles (see Tables 2 and 3), the goals of PS identified by the authors could be seen to range from most to least restrictive:

- To attain external security for the patient
- To make mutual expectations within the treatment relationship explicit

- To attain the feeling that the patient better fits into the world and is recovering from illness.

The first goal of attaining external security for the patient by PS was highlighted by nine authors and entails the creation of a climate of trust along with the promotion of an intrapersonal feeling of safety (Lowe, 1992; Mohr et al., 1998; Puskar et al., 1990; Yonge, 2002). Psychiatric nurses realize a physically controlled environment, such as a seclusion room, a closed ward, or hand-in-hand guidance, to allow the patient to express tensions in a safe manner (Benfer & Schroder, 1985; Björkdahl et al., 2010; Vatne & Fagermoen, 2007; Vatne & Holmes, 2006; Vrale & Steen, 2005).

The second goal of PS, namely to make mutual expectations explicit within the treatment relationship, was also highlighted by eight authors (Benfer & Schroder, 1985; Delaney, 2006; Lowe, 1992; O'Brien et al., 2001; Vrale & Steen, 2005). Nurses try to build a trusting relationship with the patient and make the expectations of nurse and patient sufficiently explicit. Barriers between nurses and patients appear to be lowered when nurses try to put themselves in the shoes of the patients (Björkdahl et al., 2010; Hopkins et al., 2009). When the mutual expectations of patient and nurse are made sufficiently explicit within the patient–nurse relationship, the focus in the relationship can be placed on meaningful participation in treatment and personal growth on the part of the patient (Benfer & Schroder, 1985; Delaney, 2006; O'Brien et al., 2001; Yonge, 2002). On the basis of explicit mutual expectations, agreements between nurse and patient can also be made to avoid the occurrence of unacceptable behavior (Lowe, 1992).

Finally, a third objective identified in four articles was for PS to give the patient a feeling of better fitting into the world and recovery from illness (O'Brien, 2000; O'Brien et al., 2001; Vatne & Fagermoen, 2007; Vatne & Holmes, 2006). In particular, community nurses try to help the patient develop from a patient into a person in society and live independently. In addition to PS, the nurse allows the patient to have autonomy and responsibility, which means the patient can shape his own recovery.

## **Effectiveness of the Intervention**

Despite being able to identify critical elements of PS and three main goals for PS, we were not able to find well-articulated studies of the effectiveness of PS as a psychiatric nursing intervention. We assess the possible effectiveness of PS as an intervention in relation to the goals identified above and on the basis of 18 research articles, 1 project evaluation, 4 literature reviews, and 6 opinion articles of relevance.

The first goal of attaining external security for the patient may be realized via a physically controlled milieu (Björkdahl et al., 2010; Garritson, 1983; Joseph-Kinzelman, Taynor, Rubin, Ossa, & Risner, 1994; Killebrew, Harris, & Kruckeberg, 1982; Kozub & Skidmore, 2001; Lowe, 1992; Lowe et al., 2003; Mohr et al., 1998;

**Table 3. Overview of Opinion Articles Based on a Limited Literature Review and on Expert Knowledge**

Author	Aim=result	Introduction (I), Elements of providing structure <sup>a</sup> , Goals (G) and Effectiveness (E)					
		I	1	2	3	G	E
Benfer & Schroder, 1985	Developing an understanding of the tasks and desirable variations of them appropriate to individual patient's strengths and weaknesses			x		x	
Delaney et al., 2000	Describe nursing through the 4 S-model: safety, structure, support and symptom management		x	x			
Delaney, 2006	Formulate 10 milieu interventions for inpatient child/adolescent treatment		x		x	x	x
Echternacht, 2001	Describe the fluid group: concept and clinical application in the therapeutic milieu				x		
Garritson, 1983	Exploration of various interpretations of restrictiveness and the least restrictive alternative. Description of 6 dimensions of restrictiveness e.g. structure and attitude	x	x	x			x
Greig et al., 1985	Replace attendance at day care with activities in the community; initially with support, working towards unsupported participation using a behavioral approach						x
Kerr, 1990a	Describe the ego competency model (ecm)			x			
Kerr, 1990b	Describe the ego competency model (ecm)			x			
Mahoney, 2009	To expand the view of a milieu limited to the unit environment to a broader systems context				x		
Puskar, et al., 1990	Description of the unit					x	
Sebastian et al., 1990	Offer an operational definition of structure and propose a theoretical basis to the client's need for structure	x	x		x		x
Silver Curran, 2007	Identify barriers for restraint reduction, to emphasize the role of education for staff, educational strategies		x		x		x
Walker, 1994	Provide an overview of how the milieu of structure, involvement, containment, support functions, and how validation can be used to create positive treatment environment.		x		x		x

<sup>a</sup>Element 1 = Impose and maintain rules and limits. Element 2 = Assess condition of patient. Element 3 = Interact as patient and nurse. QL, qualitative; QN, quantitative

Olsen, 2001; Ransohoff et al., 1982; Sharrock & Rickard, 2002; Vatne & Fagermoen, 2007; Vatne & Holmes, 2006). The security produced in such a manner appears to enable the patient to express tensions safely under supervision of nurses. Patients also appear to regain self-control as a result of the physically controlled milieu (Allen, 1981; Lowe et al., 2003; Sharrock & Rickard, 2002; Vatne & Holmes, 2006). The effects of PS appear to increase when patients report feeling safe and protected by an individual nurse, and not forced to do what others want them to do. As a consequence, involuntary care and coercion can even be experienced by a patient as voluntary care at times (Johansson & Lundman, 2002; Silver Curran, 2007; Vatne & Fagermoen, 2007; Yonge, 2002). According to Björkdahl et al. (2010), Delaney (2006), Hopkins et al. (2009), Johansson and Lundman (2002), Lancee et al. (1995), and Vrale and Steen (2005), PS may be more effective when the psychiatric nurse is perceived to respect the patient's autonomy, be sensitive to signs of fear and anxiety, respond to signs of fear and anxiety, and clearly adapt his actions to the needs of the patient. When this is not the case, PS can lead to protest, resistance, anger, feeling of impotence, fear, and incomprehension of treatment policy (Johansson & Lundman, 2002; Lancee et al., 1995; Mohr et al., 1998; Olsen, 2001; Silver Curran, 2007; Vatne & Fagermoen, 2007; Vatne & Holmes, 2006; Walker, 1994).

The second goal, namely of making mutual expectations explicit within the treatment relationship, actually appears to be a prerequisite for PS (Caplan, 1993; Sebastian et al., 1990). The positive effects that patients experience as a result of PS and making expectations clear are preservation of control over impulsive behavior (D'Antonio, 2004; Sebastian et al., 1990; Vrale & Steen, 2005), increased ability for group interaction (Hopkins et al., 2009; O'Brien et al., 2001), and increased interest in helping, and support of other patients and nurses (Caplan, 1993). However, when inadequate communication occurs, expectations may be unclear and mutual misunderstandings may arise as a result (Johansson & Lundman, 2002; Olsen, 2001; Walker, 1994). In these cases, PS appears to be ineffective; patients can become insecure about the course of treatment and develop feelings of loneliness (Johansson & Lundman, 2002). Furthermore, patients might feel deceived and dissatisfied and show resistance to PS (D'Antonio, 2004; Olsen, 2001; Vatne & Fagermoen, 2007).

The third goal of PS is achieved when the patient feels that he fits better into the world and is recovering from illness. In order to realize this goal, close contact between the nurse and patient is needed along with verbal exchanges with the nurse who conveys empathy. Such contact allows the patient to test his thoughts about reality, and to ultimately feel understood (D'Antonio, 2004; Kozub & Skidmore, 2001; O'Brien, 2001). As a result of PS, patients feel they can now manage fear and impulsivity, can develop a positive self-image, and can preserve their human dignity (Kozub & Skidmore, 2001). The patient then seems ready to resume his "normal" life after a period of illness, to build his physical condition, and to develop relationships in his own



surroundings. The patient feels supported and is now able to function independently both inside and outside the hospital (Greig, Miller, Rollo, & McGillvray, 1985). The patient develops from a patient in the community to a person in the community (O'Brien, 2000; O'Brien et al., 2001).

## Discussion and Conclusion

Although PS is often used in practice, a solid literature review of its nature and potential effectiveness could not be found. In the NIC (Bulechek et al., 2008), PS could not be found as an intervention. Therefore, related key words were included for this literature review. The articles we identified for our review were based on qualitative and quantitative research studies in residential settings, literature reviews, and opinion papers. The Van Tulder criteria were used to assess the quality of the aforementioned studies, reviews, and opinion papers. Despite the fact that the scientific evidence on PS remains poor, the review provides insights in three key elements of PS, along with three key goals and the presumed effectiveness of PS with regard to these three goals. We have formulated the following provisional definition for PS:

*The aim of PS is to create a workable, well-organized situation between nurse and patient in which both can work purposefully and effectively towards the strengthening of ego-functions, towards the attainment of external security for the patient, towards explicit mutual expectations within the treatment relationship, towards participation in different life areas and recovery on the part of the patient. In order to do this, the nurse uses interaction, assesses the patient's condition, and imposes and maintains rules and limits in a balanced manner.*

In this provisional definition, there are clear interrelations among the interaction between patient and nurse, the assessment of the patient's condition, and the imposing and maintenance of rules and limits. Just how these three elements interrelate should be examined in future research. Of particular interest is how nurses assess the condition of the patient and determine the amount of structure needed.

For actual nursing practice, a balanced use of the different elements of PS appears to be necessary. There seems to be a complex interdependence between strategies for PS (Lowe, 1992; O'Brien, 2000), and psychiatric nurses are not always able to indicate exactly what or why they did when they applied PS.

It is difficult to decide if we have discerned all of the goals related to PS and just how nurses use the three key elements of PS to attain the goals we identified. Both positive and negative effects of PS were found, which may relate to aspects of the definition of PS. Negative effects appear to occur when the actions for PS are not carefully

considered. As a consequence, the goals of PS are unclear for both the patient and the nurse, which makes PS difficult to carry out effectively. The most effective means for implementing PS should be investigated in future research. At this moment, the practice-based knowledge and experiences of nurses in combination with their personal styles seem to determine the application of PS. In light of the MRC (2008) guidance and findings of this literature review, we may conclude that PS should be considered a complex intervention.

## Implications for Nursing Practice

PS is not well established as a psychiatric nursing intervention, and PS is not mentioned as an intervention label in the NIC. Although we found similarities in the description of nursing activities as part of related labels or key words, we cannot conclude that PS should be a new NIC label on the basis of this review. It still remains unclear what nurses mean when they provide structure, which may consist of the aforementioned elements. The expectation is that a definition of PS and the description of the underlying mechanism of PS will influence the programmatic structure, such as maintenance of limits and rules, on wards and nursing activities related to PS. The ultimate goal of future research should therefore be to develop an evidence-based nursing strategy specifically aimed at improving the provision of structure as an intervention within mental healthcare settings.

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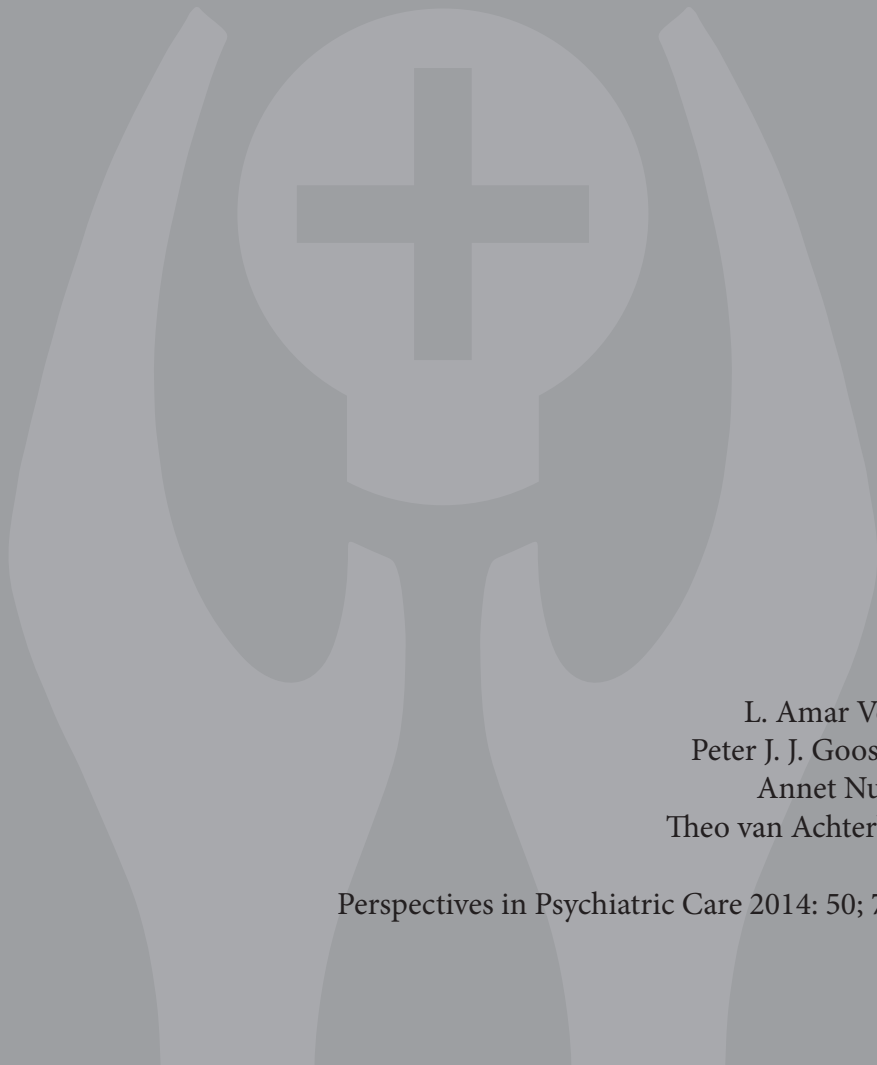
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# Chapter 3

## **An Observational Study of Providing Structure as a Psychiatric Nursing Intervention**



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## **PURPOSE**

To observe the actions of psychiatric nurses when providing structure and identify results in order to better understand providing structure as a complex nursing intervention.

## **DESIGN AND METHOD**

Participant observation data were collected on a dual diagnosis ward and a crisis intervention ward in a mental healthcare organization. A total of 52 events were selected that involved providing structure.

## **FINDINGS**

Three phases in the processing of providing structure were identified: the start of the interaction, the interaction phase, and the end of the interaction. For each phase in the intervention, both critical nurse and patient responses were coded.

## **PRACTICAL IMPLICATIONS**

The results of this observational study contribute to a formalization of the nursing intervention “providing structure” in the Nursing Interventions Classification.



## Introduction

Psychiatric nurses often write “provide structure” in their nursing plans, but without further description of nursing actions or achieved goals. The Nursing Interventions Classification (NIC) (Bulechek, Butcher, & McCloskey Dochterman, 2008) also does not mention an intervention called “provide structure” or “providing structure.” It is thus questionable whether nurses know exactly what to do to provide structure for psychiatric patients.

A recent review of the research literature using NIC keywords closely related to the concept of “providing structure” (e.g., use of structure, structure, restrictiveness, limit setting, setting limits, therapeutic milieu) revealed 40 research or opinion articles that were based on predominantly qualitative research. The methodological quality of these studies was assessed using the criteria of Van Tulder, Assendelft, Koes, Bouter, and the Editorial Board of the Cochrane Collaboration Back Review Group (1997) and, despite sufficient methodological quality, it proved difficult to compare the data on providing structure. Research designs and means for providing structure differed widely across the studies reviewed.

Based on the literature review and closer inspection of the included studies, three elements of providing structure could be discerned, namely to impose and maintain rules and limits, to assess the condition of the patient, and to interact with the patient (Voogt, Nugter, Goossens, & Van Achterberg, 2013).

With regard to the imposing and maintenance of rules and limits, two continua could be distinguished:

- (a) the continuum from general to specific structure (Garritson, 1983; Ransohoff, Zachary, Gaynor, & Hargreaves, 1982; Sebastian, Kuntz, & Shocks, 1990; Silver Curran, 2007; Vatne & Fagermoen, 2007; Yonge, 2002), and
- (b) the continuum from least to most restrictive forms of structure (Caplan, 1993; Delaney, 2006; Kozub & Skidmore, 2001; Morales & Duphorne, 1995; O'Brien, Woods, & Palmer, 2001; O'Brien, 2000; Vatne & Fagermoen, 2007).

In relation to the assessment of the patient's condition, four aspects were mentioned. These were the assessment of ego functions (Benfer & Schroder, 1985; Kerr, 1990a, 1990b), responses of the patient to being limited or supported (Delaney, Rogers Pitula, & Perraud, 2000; Garritson, 1983; Lancee, McCay, & Toner, 1995; Ransohoff et al., 1982), ability of the patient to adequately respond to redirection (Kozub & Skidmore, 2001), and the individual need of the patient for autonomy and self-control (Garritson, 1983; Lowe, 1992; Lowe, Wellman, & Taylor, 2003; Mohr, Mahon, & Noone, 1998; Morales & Duphorne, 1995).

Through the interaction nurses tried to relate to each patient, and nurses tried to put themselves in the patient's shoes to recognize the patient's individuality (Björkdahl, Palmstierna, & Hansebo, 2010). Nurses also tried to exchange mutual expectations about what to expect during treatment. This led to involvement of the patient in a

process of cooperation with nurses and it led to the formulation of clear treatment goals (Caplan, 1993; Hopkins, Loeb, & Fick, 2009; Sebastian et al., 1990; Vatne & Fagermoen, 2007; Walker, 1994; Yonge, 2002). The three elements of providing structure appeared to be interrelated.

On the basis of literature review, three goals and several effects of providing structure could be identified, which ranged from most to least restrictive: to attain external security for the patient, to make mutual expectations within the treatment relationship explicit, and to attain the feeling that the patient better fits into the world and is recovering from illness (Voogt et al., 2013).

The attainment of external security entailed the creation of a climate of trust, an intrapersonal feeling of safety at the same time (Lowe, 1992; Mohr et al., 1998; Puskar et al., 1990; Yonge, 2002), and a physically controlled environment to allow the patient to express tensions in a safe manner (Benfer & Schroder, 1985; Björkdahl et al., 2010; Vatne & Fagermoen, 2007; Vatne & Holmes, 2006; Vrale & Steen, 2005). Providing structure seemed most effective when psychiatric nurses respected the patient's autonomy, were sensitive and responsive to signs of fear and anxiety, and adapted their actions to the needs of the patient. If not, providing structure led to resistance, anger, fear, and incomprehension of treatment policy (Johansson & Lundman, 2002; Lancee et al., 1995; Mohr et al., 1998; Olsen, 2001; Silver Curran, 2007; Vatne & Fagermoen, 2007; Vatne & Holmes, 2006; Walker, 1994).

When mutual expectations were made explicit, barriers between nurses and patients lowered. This occurred as nurses tried to put themselves in the shoes of the patient (Björkdahl et al., 2010; Hopkins et al., 2009). In addition, the occurrence of unacceptable behavior could be avoided (Lowe, 1992).

When inadequate communication between nurse and patient existed, expectations became unclear, mutual misunderstandings arose (Johansson & Lundman, 2002; Olsen, 2001; Walker, 1994), patients became insecure about the course of treatment, developed feelings of loneliness (Johansson & Lundman, 2002), and patients felt deceived, dissatisfied, and showed resistance to providing structure (D'Antonio, 2004; Olsen, 2001; Vatne & Fagermoen, 2007).

The final goal of achieving a better fit in the world meant that the nurse helped the patient to develop from a patient into a person in society, to live independently, and to allow the patient to have autonomy and responsibility, in order to enable the patient to shape his own recovery (O'Brien et al., 2001; O'Brien, 2000; Vatne & Fagermoen, 2007; Vatne & Holmes, 2006). Effects in relation to this final goal were that the patient felt supported, was able to function independently both inside and outside the hospital (Greig, Miller, Rollo, & McGillvray, 1985), and that he/she developed from a patient in the community to a person in the community (O'Brien et al., 2001; O'Brien, 2000).

Despite being able to identify critical elements of providing structure and three main

goals for providing structure, no studies were found on the effectiveness of providing structure as a psychiatric nursing intervention.

The literature review led to the following provisional definition of providing structure as a psychiatric nursing intervention:

*The aim of providing structure is to create a workable, well-organized situation between nurse and patient in which both can work purposefully and effectively towards the strengthening of ego-functions, towards the attainment of external security for the patient, towards explicit mutual expectations within the treatment relationship, towards participation in different life areas and recovery on the part of the patient. In order to do this, the nurse uses interaction, assesses the patient's condition, and imposes and maintains rules and limits in a balanced manner (Voogt et al., 2013).*

Although in this provisional definition clear interrelations between the interaction between patient and nurse, the assessment of the patient's condition, and the imposing and maintenance of rules and limits existed, it remained unknown how these three elements interrelated, how nurses assessed the condition of the patient, and how nurses determined the amount of structure needed. For actual nursing practice, a balanced use of the different elements of providing structure appeared to be necessary. It was also difficult to decide if all of the goals related to providing structure were discerned and how nurses used the three key elements of providing structure to attain the aforementioned goals.

However, providing structure can also be construed as a *complex intervention* due to the number of components (i.e., nursing activities) that it involves. According to the Medical Research Council (MRC, 2008), many nursing interventions can be classified as a complex intervention, which they define as an activity that contains a number of components with the potential for interactions between them and which—when applied to the intended target population—can produce a range of possible outcomes and thus variable outcomes. For example: Providing structure applied in one situation can result in a calmed patient (or group of patients) but, applied in a different situation, it can result in an escalation of the situation (Kozub & Skidmore, 2001; Lancee et al., 1995; Lowe, 1992; Lowe et al., 2003; Sebastian et al., 1990). The complexity of an intervention can thus be defined in terms of the number of components and possible interactions between these components, and the degree of flexibility and tailoring possible for the intervention.

With that preceding in mind, an observational study of actual nursing practice was undertaken with an eye to developing a useful framework and an evidence base for the complex nursing intervention of providing structure, which would help nurses to underpin their interventions to provide structure. At this moment, the practice-

based knowledge and experiences of nurses in combination with their personal styles seem to determine the application of providing structure.

The aim of this observation was 2-fold. First, we wanted to determine what nurses do when providing structure in actual practice and thus describe the content of various “providing structure” interventions in detail. Second, we wanted to identify the impact (i.e., results) of different forms of providing structure. The following research questions were thus formulated.

- What do nurses do when providing structure in actual practice?
- What are the observed results of providing structure?

## Method

Based on the principles of grounded theory (Charmaz, 2006; Strauss & Corbin, 1998; Wester, 1995), a qualitative research design was adopted. Grounded theory aims to discover the perceptions and significance of people’s behaviors, to reconstruct the ways in which people make sense of behavior, and to identify how people’s interpretations of behavior influence their interactions. Grounded theory also aims to ground theory in empirical data, and thus the name.

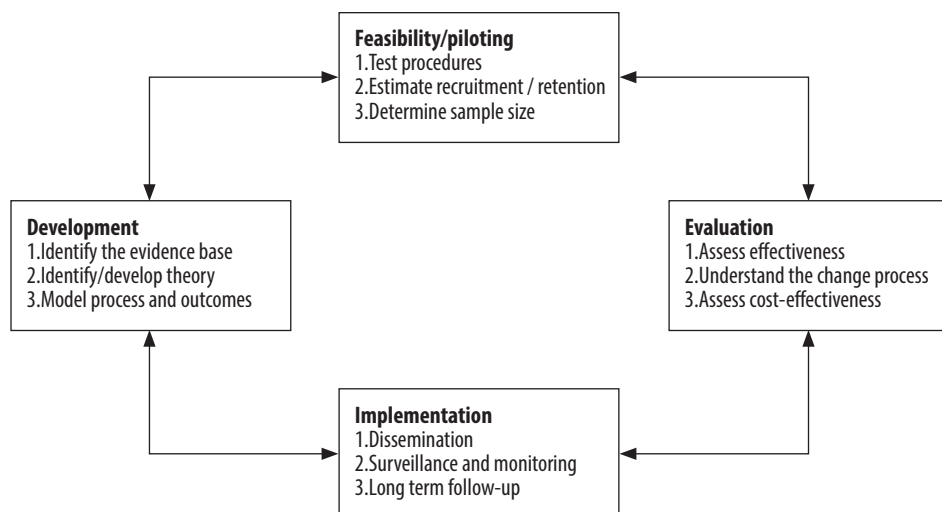
To obtain a comprehensive description of behavior and interactions, we undertook participant observation. These observations resulted in an extensive set of field notes on the verbal and nonverbal behavior of nurses and patients during events in which structure was provided.

For the study of complex interventions, the MRC (2008) recommends a combined process of development, testing/piloting, evaluation, and implementation with a dynamic interchange between the different phases in the process. Each phase is important and can be quite lengthy in itself (see Figure 1).

The present observational study can be considered part of the development phase for the creation of a complex “providing structure” intervention. First, we identified the evidence base for such an intervention via the aforementioned review and analysis of the literature (Voogt et al., 2013). In the present study, we initiated the development of a framework and theory for providing structure as a psychiatric nursing intervention. A qualitative research design and a participant observation approach were chosen for this purpose. Furthermore, on the basis of the analyses of the qualitative data obtained in such a manner, the process and outcomes of providing structure for psychiatric patients were modeled.

With the use of purposive sampling (Morse & Field, 1996), we selected patients from two intensive care wards at a mental health hospital for observation. The expectation was that events that require providing structure would occur rather frequently on such wards with explicit boundaries. The patients on these wards could be characterized as patients with acute mental illness or a combination of acute mental

**Figure 1: Key elements of the development and evaluation process (MRC, 2008)**



illness and addiction problems, long-term care and chronic treatment needs, and a profound need for structure to meet these needs. Both wards were closed, and there were signed agreements with the patients in their treatment plans. Each ward had two separate units with 24 patients and 15 nurses in each unit.

The observed events had to meet one or more of the following criteria for consideration to be included:

- The nurse had intervened because the patient had to participate more in certain life areas; the intervention was to ensure safety; or the intervention was to create a more habitable environment
- The nurse wanted the patient to do something that the patient initially did not want to do
- The patient wanted something the nurse could not provide immediately

The end of an event was assumed to be reached when the nurse and patient parted and the verbal/nonverbal communication between them ceased. These criteria were developed in expert meetings with experienced psychiatric nurses. It took three meetings until consensus was reached.

Observations were conducted between August 2009 and January 2010. Intensive nurse–patient interactions were expected to occur at wake-up, breakfast, patient meetings (either group or individual), coffee breaks, lunch, evening meal, and bedtime. A total of 52 events met the aforementioned criteria and were included for analyses: 30 on the crisis ward and 22 on the ward for double diagnoses.

## Procedures

The observations were performed by the first author. The observer had to be unobtrusive, so as not to disturb the usual ward routines (Polit, Beck, & Hungler, 2001). In one case, that meant to sit in the corner of the central living room with an eye on the nursing office, and in the other case the observer joined dinner with patients and nurses. The data from the first five observations were used to evaluate the initial observation format. The use of a standard observation format proved impossible because the observed events did not follow the order of the format or a standardized order. The use of a voice recorder to document the interaction also proved impossible because we could not get close enough to the participants without interfering. Thus, in the end, the observer simply made short notes on the nurse–patient interaction and providing structure process during the event. Immediately following the event, these notes were elaborated to record the event in as much detail as possible. After completion of the first 25 observations, the observation protocol was again evaluated to check that the written descriptions of the events met the inclusion criteria. No further adaptations were necessary.

The observer noted the date and time of the event, the number of patients and nurses present, the atmosphere on the ward at the time, the event itself, the initial reaction of the patient or nurse, the follow-up interaction, the verbal and nonverbal communication, how the interaction ended, and the outcomes of the interaction. The names of the patients and nurses were not noted and, in such a manner, the anonymity of the patients and nurses was assured.

Both the patients and the nurses were informed individually and in group meetings about the aims of the study, the methods, the use of the data, and the possibility of withdrawing from observation or the study any time. This information was also provided in a written document. Consents of patients and nurses were recorded in the minutes of group meetings. Prior to the start of each period of observation on a unit, the observer asked the nurses if the patients were stable enough to be observed and if there were any patients who did not want to be observed. When this proved to be the case, those patients were indeed excluded from observation. The medical ethics committee of the mental healthcare hospital approved the study and provided written consent.

## Data Analysis

To develop a categorization scheme for the observed interactions and activities, we undertook open, selective, and axial coding (Charmaz, 2006; Strauss & Corbin, 1998; Wester, 1995). We used constant comparison to check the emerging codes and categories, to examine tentative ideas regarding the data, and to refine the categories. After a detailed open coding of the events, a preliminary coding tree of categories

and activities was developed with brief descriptions of the codes on memos by the researcher. Next, the initial coding tree was discussed with a research group, both individually and at a group meeting for which cases were selected at random to discuss. Among the initial activity codes were “Ask something from the patient” and “Confront the patient.” As a result of the constant comparison of the event data with the coding memos and the use of axial coding, the researcher decided the two codes of activities to become part of a new category code “Stop patient’s current behavior” because both activities were aimed to stop the patient’s behavior. Furthermore, the former code “Ask something from the patient” transformed in “Request the patient to do something.” “To request to do something” specifies expected behavior better than “to ask something from the patient.” “Confront the patient” transformed in “Confront after action took place” because this emphasized the importance of reflection on activities the patient had performed.

With the use of selective coding, this resulted in the category code “Stop patient’s current behavior” together with the activity code “Request” being a less restrictive manner of stopping patient’s behavior than together with the activity code “Confront” as a more restrictive way to respond.

Finally, a logbook was created to keep track of all discussions of the cases in the research group, the decisions made during the analysis of the data, and the changes made to the coding tree.

Data analysis was supported by the software tool for textual analysis, MaxQDA (Kuckartz, 2007). Data analysis stopped when no additional data, theoretical insights, or properties of the core categories were discovered (Charmaz, 2006).

## Findings

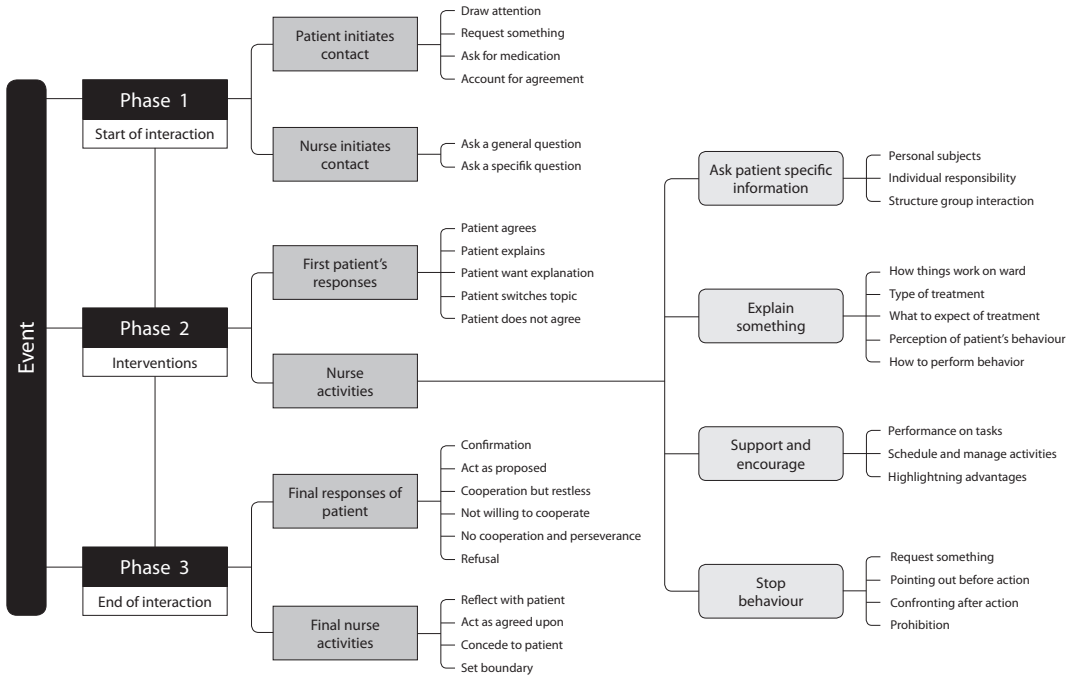
With regard to the first research question, the data analysis led to the identification of an intervention process “providing structure,” which can be tentatively described as what nurses do to provide structure in actual practice. The following phases could be identified on the basis of our observations (see Figure 2).

- Start of the interaction
- Intervention phase
- End of the interaction

### *Start of the Interaction*

A providing structure event was assumed to start when either the patient or the nurse initiated contact in a situation that met the criteria outlined in the Method section (i.e., the nurse intervened to get the patient more involved, ensure safety, create a more habitable environment; the nurse wanted the patient to do something that the patient

**Figure 2: Activities of Providing Structure**



initially did not want to do; the patient wanted something that the nurse could not provide immediately). The atmosphere in the units could be generally characterized as relaxed during the events.

*Initial Contact Initiated by the Patient.* We identified four ways in which patients could initiate an interaction:

- Draw attention by behaving conspicuously
- Request something or indicate a desire to talk
- Ask for medication or ask something about medication
- Call a nurse to account for an agreement

In some of the events, the conspicuous behavior displayed by the patient created tension among the other patients. Examples of this were agitated talking, yelling, or walking away from the nurse without listening. The nurse would sometimes stop patient's behavior under such circumstances and otherwise ignore the conspicuous behavior of the patient (see figure 2; activities). In all other patient-initiated events, the patient talked calmly and slowly to the nurse. The patients rarely mentioned their



expectations but, when they did, they used short sentences such as “I do not want you [the nurse] to act like this,” or patients reminded a nurse of something previously agreed upon, for example, that the nurse would give his medication an hour ago.

*Initial Contact Initiated by the Nurse.* We identified two ways in which the nurses could initiate an interaction:

- Ask a patient or patients a general question or address a general remark to a patient or patients
- Ask a patient a specific question

When the nurse posed a general question, it was usually relevant for a number of patients. For example, the nurse might inquire about the activities planned for the day while sitting at the breakfast table. When a nurse posed a specific question, her attention was usually focused on a certain patient. For example, the nurse might remind a patient of an agreement to take medication. Patients seldom refused to cooperate when the nurse initiated the contact; this only happened when the patient wanted to do something other than what the nurse asked or did not want to talk about what the nurse proposed.

The nurses only mentioned their expectations in 8 of the 52 events that were coded. An example is as follows: “You have been warned to not take drugs on the ward, and you know what the consequences of your doing this can be for your stay. So what I expect of you is that you not use drugs on the ward anymore. If you do use drugs, you will first be sent to your room. You may then be discharged depending on staff evaluation.”

In this example, the nurse clearly connected the present behavior of the patient to the consequences of the behavior for the patient’s treatment and used explicit sentences to do this.

### ***Intervention Phase***

After the start of an interaction, we next identified the first response of the patient to a nurse’s attempt to make contact and the first response of the nurse to a patient’s attempt to make contact.

*First Responses of the Patient.* The first responses of the patients to an initiation by a nurse could be classified along a continuum from most to least cooperative as depicted in Table 1.

When a patient answered with a firm “Yes,” it was clear that the patient was agreeing or consenting to the nurse’s proposal. In other cases, the patient explicitly said he would cooperate with the nurse or do what the nurse proposed. The patient might

**Table 1. Continuum of First Responses of Patients From Most to Least Cooperative**

Patient agrees to something or consents to a proposal	Patient explains something	Patient wants explanation or asks a follow up question	Patient switches topic	Patient does not agree to something and perseveres with undesirable behavior	Patient refuses explicitly
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also simply walk with the nurse, which also indicated agreement. Cooperation was further evident when the patient explained the reasons for his behavior. The reasons could involve a personal boundary; the verbal explicit wish to perform the activity; or the patient's feelings, needs, or judgments.

Lack of understanding was observed when the patient asked for an explanation, posed a follow-up question, or the patient switched subject. Then the patient seemed to indicate, also nonverbally, a hesitation to act as proposed by the nurse, and the patient appeared to be inhibited by a personal barrier. Some amount of cooperation nevertheless remained, however, because the patient stayed in contact with the nurse. Possibly, as a result of this conflict between verbal and nonverbal behaviors, the nurse often appeared to be caught by surprise.

A fierce explicit and verbal reaction of the patient often indicated that the patient did not agree to what the nurse proposed in which no cooperation between patient and nurse existed.

*First Responses of the Nurse (i.e., Nursing Activities).* The first responses of the nurses to a patient's attempt to make contact could be classified into four categories of nursing activities:

- Ask the patient for more specific information
- Explain something to the patient
- Support and encourage the patient to follow treatment as planned
- Stop a patient's current behavior

The first category of nursing activities in response to a patient-initiated interaction entailed *asking for more specific information*. The nurse could ask about specific *personal subjects* that mostly concerned medication, and the patient's day and night rhythm. For example, when a patient had red eyes and complained about fatigue during breakfast, the nurse could ask him if he can handle his planned activities for the day in relation to his fatigue. The nurse with her reaction, in this instance, appeared to help structure the patient's day.

Questions could also be directed at *individual responsibilities for group activities*. For example, nurses could ask when a patient would do the grocery shopping that day, or

what will happen if the grocery shopping is not done before noon.

Finally, the nurses could ask questions that appeared to *structure the group interaction*, but in fact referred to an individual patient. At a ward meeting, for example, the effects of borrowing money from each other and lending money might be asked about.

The second category of nursing activities concerns *explanation of something to the patient*. Among other things, the nurse may *explain the treatment process*. Similarly, the nonverbal behavior of the nurses (e.g., give confirmation by nodding, look the patient in the eye) may indicate they are trying to understand the patient's behavior and/or trying to comfort the patient.

The explanations provided by the nurses could thus range from general hospital-related issues to very patient-specific issues, as outlined in Table 2.

The most *general explanations* concerned how things work on a ward in cases of involuntary admission, including closed-door policies and house rules. Less general explanations concern the type of treatment, phases in treatment, and speed of treatment planning. More *individualized explanations* concerned what to expect of treatment (i.e., medication and therapies), the goals of treatment, and the criteria for discharge.

Even more specific were explanations of how the individual patient's behavior may be perceived and affect the behavior of other patients. Finally, the most *specific explanations* concerned just how the individual patient can perform new and desired behaviors and activities. During these - often repeated - explanations, the nurses spoke clearly and calmly, which provided support and comfort and was thus convincing.

The third category of nursing activities concerned the *support and encouragement of the patient to follow treatment as planned*. Three subtypes of this activity could be distinguished: support with the performance of agreed-upon tasks, the scheduling and management of activities, and support with the highlighting of the advantages for the patient to perform as suggested.

The first subtype of support and encouragement of the patient to follow treatment as planned involved *help with the performance of agreed-upon tasks*. This concerned the clarification of what the goals of task performance might be, and specification of what the expected outcomes of task performance might be. In doing this, the nurse did not question the intentions of the patient or the utility of performing the task at hand. The patient was complimented upon completion of the task. Moreover, when

**Table 2. Explanations Provided by Nurses From General to Specific Issues for the Patient**

1. Explanation of	2. Explanation of	3. Explanation of	4. Explanation of	5. Explanation of
how things work on a ward in cases of involuntary admission	type of treatment, phases of treatment, speed of treatment planning	what to expect with regard to treatment, goals of treatment, medication, therapies, discharge criteria	how behavior of patients can be perceived and affect the behavior of other patients	how individual patient can perform new / desired behaviors and activities

the nurse or a patient was not satisfied with the outcome, the nurse reflected on task performance and focused on the task as opposed to the patient when doing this. The nurse might therefore repeat the explanation of the task, provide more details on task performance, or reformulate the task. The nurse might also demonstrate task performance and thus act as a role model.

The second subtype of support and encouragement of the patient to follow treatment as planned involved help with *the scheduling and management of activities*. The support of the nurse might consist of formulating a time structure together with the patient to remind the patient of task performance and emphasize the importance of fulfilling tasks. The nurse might inform the patient with regard to the expected duration for an activity, the time remaining to perform a task, or when the nurse will come and help finish the activity.

The third subtype of support and encouragement provided to help the patient follow treatment as planned involved *highlighting of the advantages for the patient to perform as suggested*. In order to help the patient follow treatment as planned, the nurse could reflect on how the patient was doing relative to earlier or relative to other situations. The nurse might recall and emphasize the positive effects that occurred when performed as suggested, and emphasize positive effects expected to occur, for example, to regain the ability to solve a problem with another patient, or to become more independent in organizing groceries.

The fourth and final category of nursing activities occurring in response to a patient initiative was *stopping the patient's current behavior*. Four subtypes of stopping behavior were observed: requesting something, pointing out consequences of an action prior to the occurrence of the action, confronting the patient with the consequences of an action after occurrence of the action, and prohibition. The four subtypes of activities formed a continuum from least to most restrictive with regard to the boundaries imposed on the patient's behavior. In most cases, the stopping behavior concerned prior agreements such as undue taking liberties on the ward, failing to do something that was previously agreed upon, and reminders of house rules. The various nursing activities also often concerned the making of agreements to perform a specific task within a set time period.

The least restrictive and thus first subtype of stopping behavior is a simple *request*. The nurse requests that the patient perform a task that may have previously been agreed upon. A specific style of questioning was used for this purpose. The style could be characterized as friendly, positive, and assertive attitude of the nurse. The nurse sometimes had to remind the patient of an agreement that had been made between them and, in doing this, delivered the directive message as an inviting question or neutral question: "Could you come with me, please?"

The second subtype of stopping behavior is *pointing out the consequences of an action on the part of the patient prior to the occurrence of the action*. This is obviously aimed

at the prevention of certain consequences. For example, a nurse was observed to tell a patient that he was not allowed to enter the nurses' office and mentioned that he [the nurse] would get angry if the patient did this. The patient immediately stopped and did not proceed to enter the nurses' office. The nurse continued talking to the patient and mentioned an alternative behavior such as "You could turn around now," and the situation normalized. This specific activity borders on the following more restrictive subtype of stopping behavior, namely confronting the patient with his behavior.

The third subtype of stopping behavior is *to confront the patient with the consequences of his or her action after its occurrence*. Reference is often made to a mutually agreed-upon task that was nevertheless not performed. More specifically, the task can be a task that the patient should have known about or performed, a responsibility with respect to staff and/or other group members, or the consequence of not performing things as agreed upon. The confrontation subtype of stopping behavior is focused directly on the patient's behavior and quite detailed. Such confrontation can lead to situations that are more tense than other situations requiring stopping behavior.

The most restrictive and thus fourth subtype of stopping behavior is *prohibition*. This occurs when there is no room left for negotiation. Prohibition is typically a last resort and only turned to after several warnings have been issued but the patient's intolerable behavior persists: yelling or the damaging of goods on the ward. A critical boundary has been reached. The nurse voices disapproval of the patient's behavior, and the patient has to obey the nurse.

### ***End of the Interaction***

The findings with regard to how the interactions between the nurse and the patient end provide an answer to our second research question, namely: What are the observed results of providing structure? Similar to the interaction phase for providing structure, we examined the final responses of the patients and nurses' activities separately.

*Final Patient Responses.* The final responses of the patients could be classified along a continuum from most cooperative to least cooperative. Their final responses were observed to range from a *clear statement of agreement* to a *refusal* (see Table 3).

Patients were observed to acknowledge their behaviors, confirm their intentions to cooperate, or agree with a mutual solution using such clear statements as "okay" or "thank you." Occasionally, the patients provided more information on what they intended to do and/or what the other patients needed to do in light of the division of tasks on the ward. In the interactions observed in this study, the patients generally acted as proposed by the nurse. The patient could also verbally or nonverbally show cooperation but, at the same time, restlessness or irritation. Such a final response was nevertheless still considered cooperation because the patient acted as mutually agreed upon. For example, when a patient was walking around restlessly on the ward

**Table 3: Continuum From Most to Least Cooperative Final Responses of Patients in Providing Structure Interactions**

Patient verbally confirms cooperation	Patient acts as nurse proposes or asks him to do	Patient cooperates, but remains restless or shows irritation	Patient seems not willing to cooperate, but stays in contact without an explicit and clear mutual satisfying result.	The patient does not cooperate, shows he does not want to stay in contact with the nurse or returns and shows the same undesirable behavior as before and provokes the nurse	Patient refuses
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and a nurse later turned him around and guided him to his room, the patient did not resist, although some irritation appeared the moment the patient was being touched. Further along the continuum is the patient initially verbally disagreeing with the nurse's proposal or walking away from the nurse but then reconsidering the nurse's proposal or request, returning to the nurse, and thus maintaining contact. This can be seen as a form of cooperation for which a mutually satisfying final result has yet to be made explicit. No cooperation was apparent when the patient walked away from the situation, indicated that he or she did not want to stay in contact with the nurse, and did not return soon thereafter. Alternatively, the patient might return but continue showing the same undesirable behavior as before, which then formed a provocation for the nurse. No cooperation was also obviously visible when the patient simply refused to act as the nurse proposed or previously agreed upon with the patient.

*Final Nursing Activities.* The final nursing activities during a providing structure intervention could be divided into the following four categories:

- Reflect with the patient on what has happened between them
- Act according to what has been agreed upon
- Concede to the patient while staying in contact but without mutual agreement
- Set a clear boundary in order to stop the patient's persistent behavior

In the first two ways of responding, cooperation between nurse and patient was obviously present and the atmosphere could be regarded as friendly. Both patient and nurse were relaxed and smiles appeared. Furthermore, equality between the nurse and the patient appeared to be present, both physically and psychologically. The nurse, for example, stood beside the patient; the nurse and the patient showed attention and interest in each other.

In the last two ways of responding, there was tension and a threat of escalation of the

situation. In one situation, the nurse might concede to the patient's behavior and not demand anything more from the patient. For example, in the case that the patient had to clean the hallway on the ward, the nurse reminded him to do this on time, but the patient started to get more excited. At this stage, the nurse looked at the patient, did not remind the patient again, and went on doing other things. In another situation, the nurse just puts a firm stop at the patient's behavior, for example, when the patient was requested three times to leave the nursing office if he consisted swearing at one nurse, but refused to stop. Two nurses held the patient each on one side and guided him to his room.

This refers to the aforementioned category in the intervention phase: "Stop a patient's behavior; prohibition." At the end of these events, the reason for the nurse's (and the patient's) behavior could not always be discerned. The responses of the nurses in these two categories often occurred without explanation of why the nurse decided to concede to the patient or how the boundary for putting a stop to the patient's behavior was determined.

## Discussion and Conclusions

The aim of this study was to describe, via participant observation, the complex nursing intervention of providing structure. In our search of the research literature, we found that the intervention label "providing structure" does not exist in the Nursing Interventions Classification (Bulechek et al., 2008) although psychiatric nurses in the Netherlands often use such an intervention (i.e., provide structure).

According to the guidelines of the MRC (2008), providing structure can be considered a complex intervention. Both an examination of the literature and observation should thus be part of the development phase for the study of this complex nursing intervention (MRC, 2008). In doing this, we asked the following two research questions:

- What do nurses do when providing structure in actual practice?
- What are the observed results of providing structure?

The answers to these research questions contribute to constructing a framework and theory for "providing structure."

With regard to the first research question, three phases could be distinguished which cover the beginning and end of an event, and also cover the range of activities of nurses during an event that required providing structure:

- The start of the interaction
- The intervention phase
- The end of the interaction



A nurse or a patient initiated an interaction typically when they wanted something from the other party. The subsequent response of the patient or nurse then formed the start of the intervention phase. The first response of the patient to a nurse was often a turning point in the event, which could either escalate or remain peaceful. The initial responses of the patients could be categorized along a continuum from most to least cooperative. The first responses of the nurses to a patient initiative could be divided into four categories: ask the patient for more specific information, explain something to the patient, support and encourage the patient to follow treatment as planned, or stop a patient's current behavior.

With regard to the second research question concerning the end of an interaction and the observed results of providing structure, the last response of the patient could again be classified along a continuum from most to least cooperative. The last responses of the nurses could be divided into four categories: reflect with the patient on what has just happened, act according to what has been agreed upon, concede to the patient while staying in contact but without mutual agreement, or set a clear boundary in order to stop the patient's persistent behavior. Although the reason for the nurse to concede to the patient could not be discerned through observations, we assume that this was done to prevent further escalation.

The frequent call for providing structure in nursing plans suggests that providing structure is largely experience based rather than evidence based, and that providing structure thus depends upon the knowledge and experience of the nurses and nursing teams. The MRC (2008) has acknowledged these findings and therefore considers close examination of the experiences of nurses to be part of the development and evaluation phases for the establishment of complex interventions. In the introduction, it was mentioned that the outcomes of providing structure could vary dramatically. Some preliminary explanations for this variability can be derived from the continuum of possible patient's reactions, as described in Table 3.

Our observations showed the first response of the patient to a nurse initiative to stand out as a turning point in the interaction between nurse and patient. At this point in an interaction, the event can easily escalate or remain relatively stable. In only 8 of 52 events, nurses mention their expectations to patients which may itself influence a successful application of providing structure. This refers to the exchange of expectations we found in the literature review, that, for example, when inadequate communication between nurse and patient existed, expectations became unclear and misunderstandings arose (Johansson & Lundman, 2002; Olsen, 2001; Walker, 1994), which led to resistance (D'Antonio, 2004; Olsen, 2001; Vatne & Fagermoen, 2007).

It is also possible that following assessment of the patient's first response, the intuitive reasoning of the nurse, the personality of the nurse, and the experience of the nurse and the nursing team come to bear on the situation and shape the reactions of both



patient and nurse during the subsequent interaction.

In our review of the literature, we discovered that the NIC (Bulechek et al., 2008) did not use the intervention label “providing structure” despite the frequent use of this term by psychiatric nurses. In this literature review, we further identified three elements of providing structure: to impose and maintain rules and limits, to assess the patient’s condition, and to use interaction as patient and nurse.

In this observational study, we could discern the three elements of providing structure as distinguished in the literature review. During our observations, we recognized the continuum of general to specific agreements mentioned in the literature, in the continuum of explaining general to specific issues (see Table 2). But, it was impossible, with the use of observations, to understand just how the nurse assessed the condition of the patient, for example, in relation to the assessment of ego functions (Benfer & Schroder, 1985; Kerr, 1990a, 1990b), or the assessment of the patient’s need for autonomy and self-control (Garritson, 1983; Lowe, 1992; Lowe et al., 2003; Mohr et al., 1998; Morales & Duphorne, 1995). On the basis of the observations, we assume the existence of a continuing assessment of the condition of the patient. The ability of the patient to adequately respond to redirection (Kozub & Skidmore, 2001) and the responses of the patient to being limited or supported (Delaney et al., 2000; Garritson, 1983; Lancee et al., 1995; Ransohoff et al., 1982) may be first assessed by using Table 1, and during following contacts by using Tables 2 and 3, which all contain a range of responses and nursing activities.

On the basis of our previous review of the literature and the present observational study, we conclude that a number of frequently mentioned and related concepts, keywords, and activities could be distinguished as part of providing structure as a psychiatric nursing intervention. The literature review yielded three elements, two continua, three goals, and a description of effects related to these goals. The observational study delivered a process of providing structure, where each phase of the three steps process activities of nurses and responses of patients are distinguished. On the basis of two studies, we might suggest that “providing structure” be introduced as a new intervention label within the NIC (Bulechek et al., 2008). To supplement this proposal, the nursing responses and activities described on the basis of our observations should be included as part of “providing structure” in the NIC.

We also conclude, on the basis of the present observations, that we can now elaborate upon the process of providing structure as a complex nursing intervention and identify a useful theoretical framework, model the process of providing structure, and evaluate the attained outcomes. In such a manner, we can better understand just why patients and nurses respond in a particular manner and make the decisions that they do during an interaction that calls for providing structure. And we can then try to gain further insight into their expectations with regard to their actions in future research.

## Limitations

The first limitation on the present study was the position of the observer and the incomparability of the events we observed. The position of the observer on the two wards had to be unobtrusive in order not to disturb usual ward routines; this required a certain distance from events and may have led to the incomplete description of some events. Therefore, we made adjustment to record the nurse–patient interaction. This is described in the Method section.

The second limitation on the basis of this observational study is that the data were collected in one country and are therefore culturally specific.

## Implications for Nursing Practice

The present observations and classifications of the interactions between patients and nurses during events requiring the provision of structure give us a provisional framework for reflection and feedback on the performance of nursing activities. Psychiatric nurses and nursing teams should be encouraged to reflect upon exactly what they do when providing structure for a patient and the results that this yields. Such reflection can provide insight into why providing structure may sometimes—but not always—result in an escalation of events. Moreover, the results of this observational study will contribute to a formalization of the nursing intervention in the NIC.

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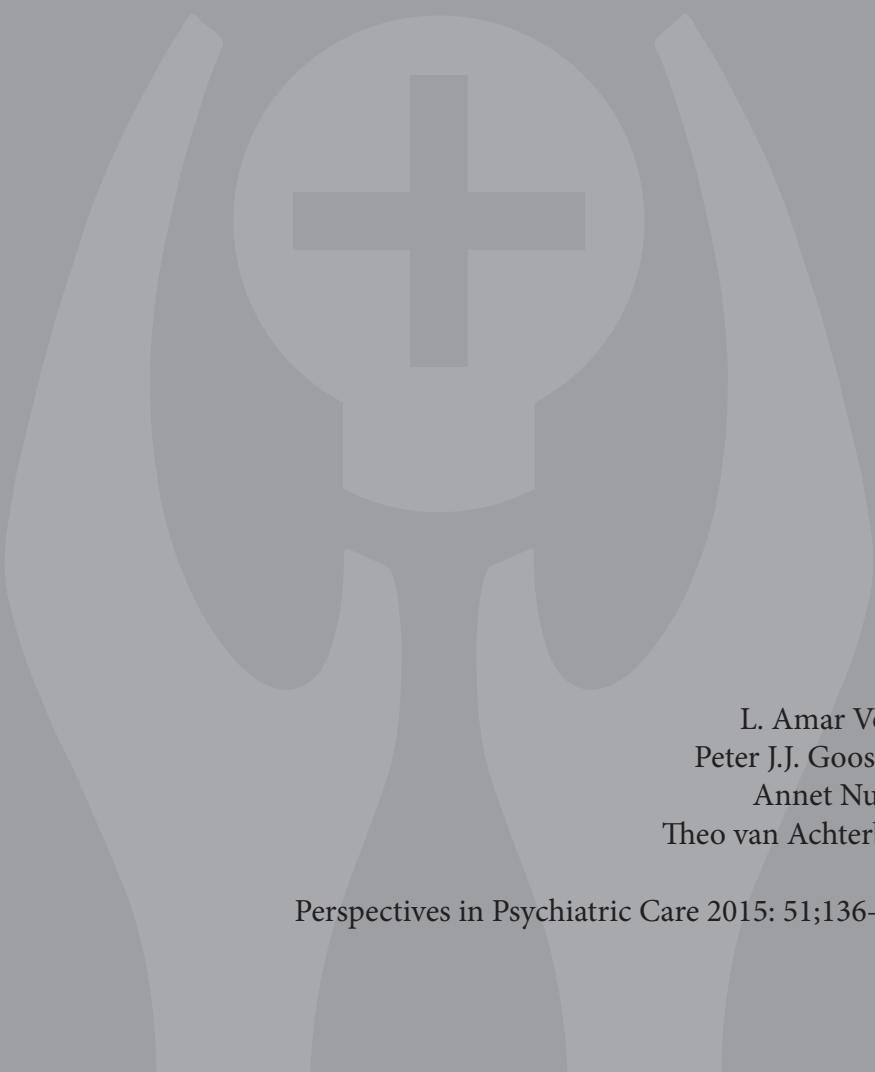
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# Chapter 4

## **The Patient's Perspective on "Providing Structure" in Psychiatric Inpatient Care: An Interview Study**



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## **PURPOSE**

To gain insight into the patients' experiences on providing structure (PS) as a nursing intervention during psychiatric inpatient care.

## **DESIGN AND METHOD**

Interviews were conducted with patients ( $n = 17$ ) from two inpatient wards within a mental healthcare organization. For data analysis, a qualitative coding process was followed.

## **FINDINGS**

The patients' expectations for PS were described. One expectation seemed to reflect key concern: the need to maintain autonomy.

## **PRACTICAL IMPLICATIONS**

The study reveals the patients' views about PS. When the importance of PS is mentioned, nurses can refer to our description of PS. We were able to further stipulate the required activities of PS and provide for an adapted definition of PS.



## Introduction

Patients who need constant presence of a caregiver (i.e., constant care) during admittance to an inpatient psychiatric unit have identified “providing structure” (PS) as an important nursing behavior (Yonge, 2002). Yonge distinguished two main dimensions of PS: In the first dimension, the nurse facilitates patient activities; and in the second dimension, the nurse provides structure by being there and by communicating with the patient about what the nurse is doing. Delaney, Rogers Pitula, and Perraud (2000) have similarly argued that patients can regain control of their illness and behavior when the clinical environment is structured, safe, and staffed with nurses who are capable of providing supportive understanding. Nevertheless, the response of patients to PS can vary (Kozub & Skidmore, 2001; Lancee, McCay, & Toner, 1995; Lowe, 1992; Lowe, Wellman, & Taylor, 2003; Sebastian, Kuntz, & Shocks, 1990). According to Alexander (2006), patients were often confused about the reasons for restriction and could feel dehumanized. Despite a literature review (Voogt, Nugter, Goossens, & van Achterberg, 2013) and an observational study (Voogt, Goossens, Nugter, & van Achterberg, 2014), more scientific knowledge of PS is needed for the effective application of PS.

Psychiatric nurses working on inpatient units often refer to PS in their care plans and also appear to agree on what PS entails and how they should act with respect to this (Voogt et al., 2013, 2014). However, in the two studies by Voogt et al., it is argued that PS can be understood as a *complex* intervention because of the number of components, the possible interactions between these components, and the degree of tailoring to the patient and environment, but also flexibility that the intervention requires (and allows). Important for the design and use of such complex interventions is thus a sufficient understanding of the process of change on the basis of existing evidence, theoretical insights, and interviews with patients (Medical Research Council [MRC], 2008).

PS has not yet been incorporated into the Nursing Intervention Classification (NIC) (Bulechek, Butcher, & McCloskey Dochterman, 2008). For this reason, a recent review of the literature on the use of PS as a nursing intervention was conducted using a combination of keywords closely related to the concept of PS (i.e., use of structure, structure, restrictiveness, limit setting, setting limits, and therapeutic milieu). The review revealed three key aspects of PS as a nursing intervention: imposition and maintenance of rules and limits; assessment of the condition of the patient; and interaction with the patient (Voogt et al., 2013). These elements were therefore incorporated into the following definition of PS.

*The aim of PS is to create a workable, well-organized situation between nurse and patient in which both can work purposefully and effectively towards the strengthening of ego-functions, towards the attainment of external security*

*for the patient, towards explicit mutual expectations within the treatment relationship, towards participation in different life areas and recovery on the part of the patient. In order to do this, the nurse uses interaction, assesses the patient's condition, and imposes and maintains rules and limits in a balanced manner (Voogt et al., 2013).*

In a subsequent study by Voogt et al. (2014), the actions of psychiatric nurses when PS were identified via the observation of events ( $N = 52$ ) and the interactions between nurse and patient on two inpatient units across a period 6 months.

It was found that when the nurse or patient wanted something from the other party during an event, the *initial* response of the other party was critical: Things could either escalate or remain peaceful thereafter. Initial responding was thus a turning point in most of the observed events. Patients could respond along a continuum of agreement to disagreement. And throughout the observed event, nurses were observed to ask the patient for specific questions; offer explanations and other forms of support; and either encourage the patient further or work to stop the patient's behavior. When the nurse ended an event, they usually took time to reflect with the patient on the following: what had happened during the event; whether both patient and nurse had acted in keeping with what was agreed upon or not; whether the nurse had conceded to the patient or not; or whether the nurse had stopped the patient's disruptive behavior or not. When the patient ended the event, the patient's response could range from agreement to act as proposed, to refusal to act as proposed. Because this second study focused on the perspective of the nurse when PS, no further conclusions could be drawn about the patient's behavior or the reasons for the patient's behavior during such events. Information on the patient's viewpoint is nevertheless essential for the further development of PS as a nursing intervention, gaining greater insight into the activities that this requires, and understanding the conditions under which PS can be expected to be more or less effective.

In light of the review results and observational results summarized in the preceding, an interview study was next undertaken with psychiatric inpatients to gain insight into their experiences with PS. Our question was quite simply: How do patients view and experience PS? But in answering this question, we also aimed to gain greater insight into the components of PS, the possible interactions between these components, the process of change during events involving a nurse, and—finally—PS as a nursing intervention.

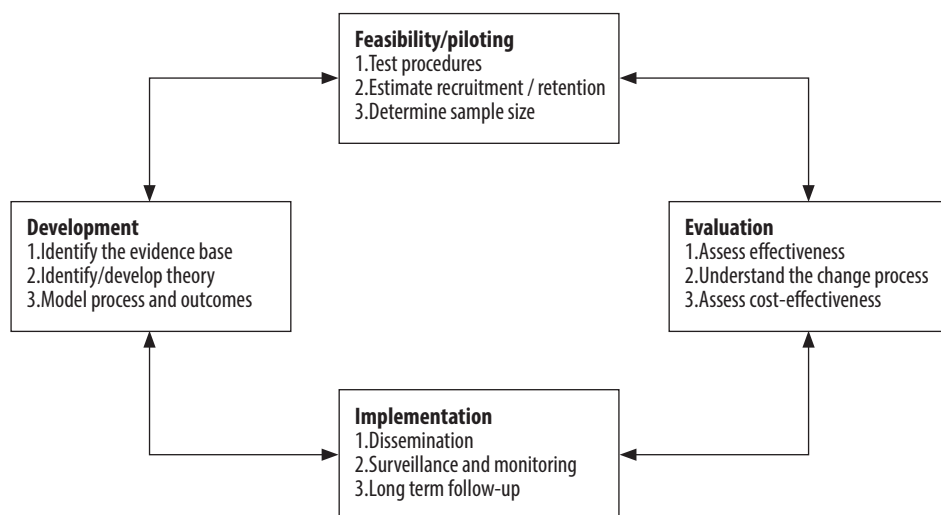
## Method

### *Study Design and Approach*

A qualitative research design that drew upon the principles of grounded theory was used (Strauss & Corbin, 1998; Wester, 1995). Grounded theory aims to discover perceptions of behavior and the significance of people's behavior to reconstruct the ways in which people make sense of behavior, and to thereby identify how people's interpretations of behavior influence their interactions. Participant observation of events (see below for definition) was used to obtain a comprehensive overview of the behavior and interactions of both nurses and patients. Immediately following an event, an interview was conducted with the patient to discover their perceptions of the behavior of the individuals involved and the significance of that behavior for the patient.

For the study of complex interventions, the MRC (2008) recommends a cyclic process of development, testing/piloting, evaluation, and implementation (see Figure 1). The MRC also recommends holding interviews with various stakeholders in the intervention process and, in the present study, the patients were the stakeholders of interest. The present study can thus be considered part of the development phase for the creation of an explanatory model of PS as a psychiatric nursing intervention.

**Figure 1: Key elements of the development and evaluation process (MRC, 2008)**



## ***Patients and Events***

With the use of purposive sampling (Morse & Field, 1996), patients (11 males, 6 females) and events were selected from two intensive care wards at a mental health hospital in the Netherlands. The expectation was that events that required PS would occur rather frequently on such wards. Both of the wards were closed wards composed of two separate units with 24 patients and 15 nurses per unit. The patients on these wards were patients with acute or severe mental illness (e.g., acute psychosis, bipolar disorder, obsessive compulsive disorder, and comorbid addiction problems); they were also unable to provide for their safety within different life areas and therefore needed not only long-term care, but also admission to a closed ward for intensive treatment.

The observed events had to meet one or more of the following criteria for inclusion in the present study. (a) The nurse intervened because (1) the patient had to participate more, (2) the safety of the patient was of concern, or (3) amore habitable environment needed to be created. (b) The nurse wanted the patient to do something that the patient initially did not want to do. (c) The patient wanted something that the nurse could not provide immediately. The end of the event was assumed to be reached when (1) the nurse and patient parted and (2) the verbal/nonverbal communication between them ceased. These criteria were developed in three expert meetings held with experienced psychiatric nurses who reached consensus on the criteria.

A total of 18 events were observed and immediately after, interviews were planned between January 2010 and July 2010 (see Table 1). One patient withdrew from the interview, which resulted in a total of 17 interviews for further analysis.

## **Procedures**

The first author conducted all of the observations and interviews. The observer had to have some understanding of the nature of the relationships between the nurses and patients on these wards to assess the occurrence of event criteria but also have sufficient independence to observe.

A protocol was designed to guide the observations and conduct the interviews uniformly. The observer wrote down event information parallel to the observation or shortly after the end of the event. The observer then interviewed the patient. He first asked the patient for the interview as quickly after the completion of the event as possible. He then checked if the patient remembered the actual event, if the patient considered the event one in which structure was provided, and if the patient was willing and able to reflect upon the event. The patient was then asked to explain how the structure was provided and what he or she considered essential for the provision of the necessary structure. The semi-structured interviews were audio-recorded and transcribed literally for further analysis.

**Table 1. Description of Start of Events**

<b>Number situation</b>	<b>Description of start of the event</b>
1	Both P (patient) and nurse (N) are sitting at table in living room. P brings personal documents and wants to structure them with help of N in order to know what bill to pay first. N says that they have to talk about day structure. P is confused and does not agree.
2	P asks N for help, but N is very busy and therefore asks P to wait and be patient for a moment.
3	P is annoyed with how a telecom company has handled his complaint. This is during breakfast with other patients present, so N tries to structure P's thought process and preserve good group atmosphere at the same time.
4	P has had to eat in separate room. P asks for sugar, which is kept behind a locked door. P does not like having to ask for these things. He wants to be able to get them himself, but he is dependent on others for this now.
5	Two situations with the same topic: First situation is at the breakfast table when P and N discuss day program, performance of household tasks, how P slept, taking of notes at group meeting), start of day, close of the day, etc. The second situation is a meeting with patients immediately after breakfast. One patient interacts vividly in both situations and brings forward his ideas about providing structure and his day-program.
6	P is negative about having to exercise (i.e., do sports) but is stimulated to do so by N. P has to go to sports when it does not fit him, he says.
7	At breakfast, P and N talk about day-night rhythm. P had a bad night and got emotional at breakfast?). N asks P to talk to each other after breakfast.
8	Two patients are exercising together in the living room. They accidentally touch each other and their exercising is thus getting dangerous. N enters room and tells them to stop immediately. They stop, and each patient goes their own way.
9	P withdrew from interview following event; therefore not described here.
10	Two Ps are discussing what providing structure is with N. In doing this, they mention personal examples of having to take medication and being secluded.
11	The nurse promised P to go shopping outside the ward together after breakfast. Other activities came up, and N cannot go anymore. P was really looking forward to getting out and therefore very disappointed.
12	P is annoyed with other patients and says that other patients are talking too much during breakfast. N tries to guide conversation in a peaceful manner, but P remains annoyed by everything.
13	P is waiting for lab employee who is scheduled to come at 8 am to arrive. It is already past 8 and the employee has not arrived yet. P paces restlessly around the ward, complains, goes to smoking room, and talks to nurses. It is not clear what P wants from nurses, however. N confronts P with how P is dealing with situation.
14	During breakfast, N discusses tasks and activities for the weekend. The topic is how to adhere to rules and structure during the day and not watch TV during therapy hours. P objects to TV rule and mentions not wanting to be corrected in a childish manner.
15	During breakfast, N discusses tasks and activities for the weekend. N asks someone to take notes at group meeting. No one volunteers and N does not pursue further. P claims that taking notes is the responsibility of one other group member. N looks at Ps) each member of the group individual. After a while, P says that he cannot take notes because he has concentration problems, etc. N offers to help with elaboration of notes and P then agrees to take notes.
16	P tells the nurse about the goal of her admission. She has an agreement for admission once a month to prevent relapse. When on the ward, she rests and things generally go well. Both nurses and doctors have agreed on this type of structure and how structure is applied.
17	At breakfast, P1 has already started to eat while the rest is praying. P2 remarks on this before the nurse arrives. N does not interfere but nonverbally shows some disapproval of P1 doing this. Patients think that they can solve problems/ disagreements themselves. N thus talks about individual activities and rules for breakfast table. P2 mentions that rules differ too much between nurses.
18	At the breakfast table, day program is discussed without any irritations. Everyone seems cooperative. P who is known to usually oppose rules has changed attitudes and become more cooperative. How come the day program seems to be accepted by P?

The internal scientific board approved the study, and the anonymity of the patients was assured. Patients were informed individually and in group meetings about the study aims, methods, use of the data, and the possibility of withdrawing from the observations and interviews at any point. A brief summary of the study was also given to potential participants and informed written consent obtained from all who agreed to participate. Before the start of each observation on a unit, the observer asked the nurses if the target patient was stable enough for observation, agreed to be observed, and agreed to be interviewed. If not, the patient was excluded from the interview study.

## Data Analysis

Open, selective, axial coding (Charmaz, 2006; Strauss & Corbin, 1998; Wester, 1995) was undertaken to develop a categorization scheme for the interactions and activities mentioned by the patients. Via constant comparison, emerging codes and categories of activities were checked, tentative ideas for the interpretation of the data developed, and the categories of activities refined. The same process of inductive analysis was thus used in the interview study as in the observation study of Voogt et al. (2014). And on the basis of the analyses of these qualitative data, the process and outcomes of PS for psychiatric patients could be modeled (MRC, 2008). That is, the relevant concepts and relations between these concepts for PS viewed from the perspective of the patient could be determined on the basis of the present data and our research question then answered.

To check that the interpretation of the interview data had sufficient reliability, three of the 17 interviews were analyzed and coded by two judges independently (i.e., the first author and a psychiatric nurse specialist). Their codings and interpretation of specific sentences and words were discussed until these could be agreed upon. The first judge/author then continued with the analysis of the data. After completion of the analysis of the next 10 interviews, another meeting was held to check on the reliability of the interpretations provided for coding purposes. After 17 interviews, no additional information emerged from the data, and data saturation seemed to be reached. No new events were included.

After the detailed coding of the interviews, a tree of category codings developed with brief descriptions of the codes and memos with regard to each code. Different versions of the tree were discussed with the research group, both individually and in meetings, with specific interviews and codings randomly selected for consideration. An agreed-upon coding tree provided the basis for the draft version of this article.

During the article revision process and in discussions with the research group, overlaps in the description of the codes were discovered and the coding tree was pruned as a result. The discussion of the interviews and codings in the research group, the decisions made during the analysis of the data, and the changes made to

the coding tree were all recorded in a logbook.

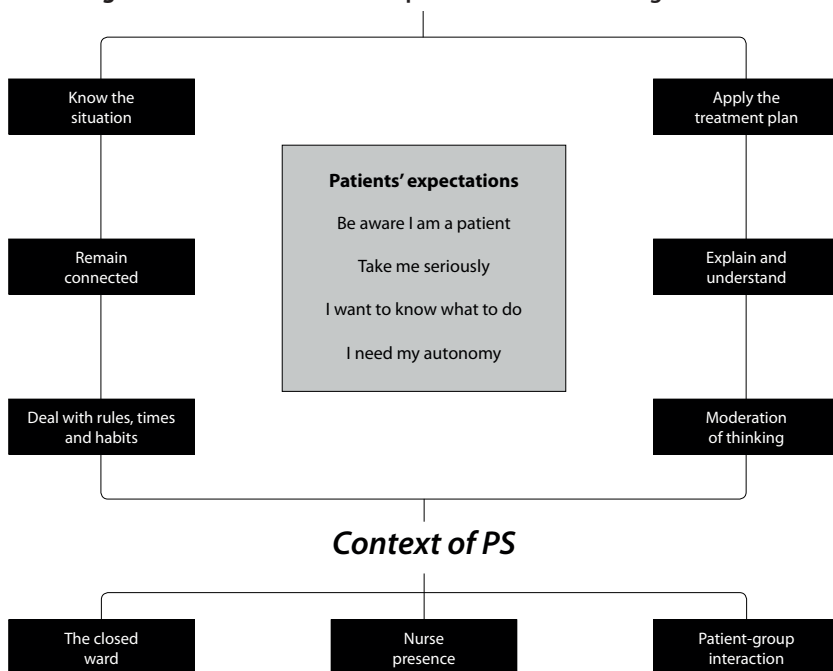
The textual analysis software tool, MaxQDA (Kuckartz, 2007), was used to facilitate the analysis of the data. Analysis stopped when no additional theoretical insights or unique properties for the core categories in the coding tree were discovered (Charmaz, 2006).

## Findings

The 18 events observed in this study were found to start as: an interaction between a patient and a nurse in the living room, an interaction between a nurse and a group of patients at breakfast, or an interaction between patients and nurses during a formal group meeting to discuss ward rules and housekeeping. During a formal group meeting, for example, the chair of the meeting (i.e., nurse) had discussed something with a specific patient and continued the discussion during the meeting or continued the discussion after the meeting. In Table 1, the start for each of the 18 events is briefly summarized.

In Figure 2 and in the following text, the expectations of the patients, the premises identified for PS, the nursing activities described by the patients, and relevant quotations from the patients are then presented. The quotation number corresponds to the event number supplied in Table 1.

**Figure 2. Patients' views and experiences with Providing Structure**



## Patients' Views and Experiences With PS

When asked about their experiences with PS as a nursing intervention, the patients mentioned the following activities:

- Know the patient's situation
- Remain connected with the patient
- Deal with rules, times, and habits on the ward
- Apply treatment plan
- Explain and understand
- Moderation of thinking

### *Know the Patient's Situation*

With regard to PS, the patients explicitly mentioned the importance of nurses being informed about different aspects of the patient's situation, which could include: the patient's feelings, state of mind, problems, ways of usually dealing with his or her problems, and how the patient may interpret the behavior of others.

First, this nurse was obviously well aware of my situation before he came to me. He knew my feelings, and he knew the state of mind in which I was. That, I think, is necessary to be able to care for me. The nurse applies this knowledge in a subtle way. The nurse only has to briefly mention where the boundaries are or what the treatment planning is . . . enough to bring things into memory. (5)

The nurse has to know how a hand around my shoulder can be interpreted .. .. In the past, I have had too many hands around my neck which were painful. (11)

### *Remain Connected With the Patient*

The patients reported feeling connected when the nurse approached them individually, allowed to bend the rules at times, and allowed them to cross a boundary in specific situations. The individual approach meant that the nurse focused on the patient's specific needs. According to a number of patients:

. . . it is important to focus on the structure or rules I am used to having at home. (16)

The nurse gives him [another psychotic patient] personal attention, does not let him down. And therefore we can have peace and quiet at the breakfast table. (5)



Conversely:

When the nurse is psychologically absent or neglects me, I notice this immediately because the nurse tends to react differently than expected to a question then. I refuse to talk to the nurse anymore then. (1)

Connection is reported to remain even in situations where rules cannot be bent. In one such case, the patient describes things as follows:

Ward rules have to be followed, if at all possible. But together with the nurse it still is possible to maneuver between sticking to a ward rule, the state of mind I am in, and my ability to adhere to the rules. (17)

### ***Deal With Rules, Times, and Habits on the Ward***

According to the inpatients in our study, PS is all about the nurses deal with the combination of ward rules, times, and habits. In the words of one patient:

When speaking of a living rule, structure is something large but small at the same time, such as: the habit or rule that patients and a nurse end the meal together. . . . It can be difficult to create a set of rules for yourself and attend to these rules as I was used to rules being imposed on me. (17)

Another patient mentioned only recognizing the significance of rules, schedules, and habits after having left school, becoming unemployed, and now being admitted to a psychiatric ward:

. . . then I recognized the importance of rules . . . searched for the structure I once had. It meant that I had to deal with the ward rules. Without rules, I become crazy. Now, together with the nurses, I discovered the importance of rules and have learned to accept and appreciate them. (18)

Patients further mentioned not only the possibility of opposing rules and then being warned about crossing a boundary by the nurses, but also that the nurses themselves must differentiate between rules, their relative importance, and their applicability: The one rule is not the other. The way in which nurses provide structure and enforce rules can therefore differ from one situation to the next and from one patient to the next:

One rule can count more than the other, or count more for one patient than for the other. (5)

Patients specifically identified schedules and habits as important for PS—adherence to appointed times and the day-and-night rhythm. Nurses may subtly help patients do this. And patients expect nurses to help them do this as well:

Nurses need to mobilize everyone in the morning to get them to the group meeting on time, . . . and see that the meeting ends as agreed upon . . . so we can be on time for the next appointment. If not, I get really pissed off. (13)

Patients explicitly mentioned the day program as important for providing a day-and-night rhythm:

I want to have the same day scheme as I have at home and know what I can expect. A fixed day program of work, and fixed therapy hours with my case manager. (15)

Patients who were frequently readmitted to the unit also noted changes over time in the imposition of ward rules, times, and habits accompanied by greater reliance on the patient with regard to this. Patients mentioned having to account for both their own structure and group structure now, with individual responsibility for the imposition and adjustment of rules for special occasions or to meet individual needs. According to the patients:

They used to put you in a fixed group program. Nowadays, they [the nurses] start an observation first to assess what structure you need and what activities you can perform. . . a personal program. . . .And, I also learned to consciously choose an activity to relax. (16)

In the early days you had to do more, but you did less. Now, you have to do less and you are allowed to do more yourself. (16)

Nurses try to create an atmosphere of cooperation in which you want to work together. They do not sit on top of the rules because this simply causes individual and group resistance. (5)

### *Apply the Treatment Plan*

During the observed events, discussions between the nurse and patient often turned to the treatment plan, with a focus on learning during ward admittance. Nurses and patients discussed and sometimes adjusted the agreements contained in the treatment plan. Patients emphasized their need to adhere to the established treatment plan, even when it contains agreements and boundaries that are not very appealing (e.g.,

attend to the sports, therapy, or to remain abstinent from alcohol).

The treatment plan is the work of the specialists . . . I leave it to them to decide what it should contain and I cooperate. . . . I am here for a reason. I do what is best for me and adhere to the treatment plan as long as they say that it is needed. (8)

If I quit treatment now, I will have proved that I am unable to provide a safe and stable living environment for my family. I do not want to risk that. (14)

I need a clear treatment rule, even if I don't like it. I want to take responsibility and not always find excuses . . . I have agreed not to do stupid things. That is now part of my treatment plan. (3)

### ***Explain and Understand***

For a variety of the observed events, the patients referred to the nursing task of explaining the need for the patient to perform a particular activity or adhere to a particular agreement. In addition, the patients frequently mentioned the need for nurses to understand the *reasons* for this need on the part of patients. The nurse plays an important role in the explanation of activities:

It helped when a nurse explained how things worked for reaching goals, why certain rules existed and that you could even make up a rule yourself. The nurses were close by and you felt that you could always go to them for support. (15)

During one of the observed events, the nurse clearly explained to the patient why he could not help him immediately. The reaction of the patient was then as follows: The nurse had to finish something for another patient first, before he was able to help me. That explanation was decent. (2)

Another patient only understood her obligatory absence from the dinner table after the nurse carefully explained the reasons for this to the patient.

The nurse explained that my behavior can be disturbing for other patients. I can be too busy for the other patients and myself. Therefore, I understood why I was sent to my room. . . . My thoughts did not interfere with the group anymore. I could recharge my battery. Nurses told me I need that type of structure [fixed resting times and activities] and I know their reasons: I may lose myself without this. (11)

Another patient noted that he was only able to function on the ward once he finally understood what his liberty agreements were and what the consequences of exceeding these were. Patients further mentioned becoming wiser during their admission and as a result of understanding how treatment works. One specific ward rule nevertheless elicited mixed emotions among patients: the closed-door policy. Numerous patients mentioned that they did not like having to ask permission to leave the ward and the obligatory conversation that this typically entails. According to a different patient, however, this conversation was welcome.

I feel safe when a nurse initiates a little chat about what I intend to do, and when I think I will be back. (4)

All visitors and the so-called “friends” (e.g., from former criminal networks) similarly had to ask permission to visit someone on the ward. And when the patient understands the purpose of the policy (i.e., this type of structure), they grow accustomed to it and are able to live with it.

This closed-door policy is intended to protect me from my former friends. (17)

In most cases after an event, the patients were able to understand the explanations provided by the nurses (e.g., staff needs to keep an eye on a patient, nurse needs to take control in a given situation).

They need to send me to my room sometimes, to get me to rest . . . I was glad the nurse intervened because the situation got out of control. (10)

### *Moderation of Thinking*

In a number of the interviews, the patients regarded moderation of thinking to be part of PS.

I have a tendency to complicate things too much. It becomes too big for me to comprehend, and the nurse helps me with that. She brings me back to reality, what happens now at this moment, on this ward. I must not talk too much about the past. (5)

One patient described this as the nurse serving as a moderator of your individual thinking but also the thinking and conversations of others—for example, at the dinner table. This entails paying attention to the start and finish of meals, choosing and discussing a particular theme for discussion in a given period of time, and taking

take time to reflect upon the behavior of each other. In these situations, the nurse structures the patient's thoughts, helps delineate problems, and search for solutions.

Nurses made me think about themes, focus on a specific topic I mentioned or ignore just that topic, which created rest in the conversation and my thought processes. (16)

In the words of two other patients:

Moderation of thinking helps us organize and deal with the rules and to discover what you like to do. (3)

## Patients' Expectations for PS

During the interviews, the patients also described their expectations for PS as a nursing intervention. The following themes were found to occur while doing this.

- Nurses need to be aware that I am a patient
- Nurses need to take me seriously
- I want to know what to do
- I need to maintain autonomy

### *Nurses Need to be Aware That I Am a Patient*

One patient describes the need for recognizing the patient as a patient, even when PS, in the following manner.

... the nurse ... needs to be aware that I am a patient and ... need to be treated as a psychiatric patient. ... I cannot allow them to interfere with my voices too much. (3)

Patients on these wards often mention that nurses seem to apply too much pressure when the patient is feeling particularly vulnerable. The nurses seem to ignore the patient's thoughts and feelings at times.

### *Nurses Need to Take Me Seriously*

Having nurses take them seriously meant to the patients that they, themselves, are allowed to take responsibility for ward routines and ward processes.

Because we were made responsible for ward routines and ward rules, I felt useful for others and part of the group. (7)

This feeling was said by another patient to be strengthened when a nurse pointed out that rules are to be broken and that a group of patients may adjust the rules when this is to the advantage of all.

### ***I Want to Know What to Do***

The need to know what to do while on the ward is a particular expectation of patients for PS as a nursing intervention, they need to know what is allowed and what is not allowed, and patients need space to negotiate rules (as indicated in other statements). Wanting to know what to do is reflected in the following statements.

I know what I have to do on this ward and how to behave. This allows me to function easily on the ward. (14)

When I broke a rule, I was reprimanded. That was okay. . . . (18)

### ***I Need to Maintain Autonomy***

Finally, the need to maintain their own autonomy was also mentioned by many patients as an expectation for the provision of structure as a nursing intervention.

I am not used to being dependent, to being asked to do things which I would rather not do, to losing my freedom of choice. . . . (4)

We discuss the rules [. . .] but finally . . . they leave the choice up to me and that feels like self-determination. (5)

They finally gave me back my freedom and that is the type of structure I desired. (16)

### **Aspects of the Context of PS Considered Important by Patients**

Further, when asked what they considered essential for PS as a nursing intervention, the patients mentioned the following aspects of the context as particularly important.

- The closed ward itself
- Presence of the nurse
- Patient–group interaction

### ***The Closed Ward***

The patients in this study were predominantly admitted to the psychiatric unit on an

involuntary basis and thus had to deal with a closed-ward environment. When they referred to PS, they typically mentioned the following:

Rules and limits form more of a protective structure than an army structure . . . and the rules and limits give me a sense of calm and relief. (13)

. . . protection against falling into errors or danger . . . a feeling of being safe while being confined. (17)

Conversely, some of the involuntarily admitted patients mentioned being opposed to any limits. The patient below, for example, explicitly and immediately pointed out his resistance to the rule being imposed.

. . . a source of conflict. . . . I opposed the nurse about my solitary confinement. (10)

### *Presence of the Nurse*

For many of the patients, the presence of the nurse included many other little things as well:

Sharing a cup of coffee, the offer of support, or the touch of a hand (4).

When you need a nurse, you know that she is just on the ward. (7)

The nurses were all prepared to talk in privacy about my thoughts and things I had to do. (7)

. . . they stand beside you. . . . (10)

The patients also mention it becoming easier to perform a task and feeling more safe with the presence and availability of a nurse.

. . . I [patient] dared to take notes at a patient-group meeting when the nurse proposed sitting next to me during the meeting and helping me after the meeting. (5)

This prevented me from doing stupid things. (16)

Sometimes the presence of more colleagues was needed to apply an intervention, and appreciated by the patient.

. . . the overwhelming presence of manpower . . . prevented me from crossing a boundary. (10)

Once again, however, disagreements about the presence of a nurse can also surface with regard to an intervention, with clear distrust as a possible result:

I refused to take my medication and was injected . . . without any warning . . . held by nurses who I trusted. (11)

### ***Patient–Group Interaction***

Patients mentioned the group interaction as a critical part of the context in which PS takes place. The patient can raise both personal and group issues in the group—in so far as it has been agreed to discuss or not discuss personal issues in the group:

The group provided a shelter for the individual to hide and leave others to speak or to practice in a comfortable manner how to distinguish yourself from other group members. Also the group contributed to the enhancement of individual motivation and support for each other. (18)

In a trusting group, with patients in a more or less comparable situation, patients are willing to do more on the ward and for others. (8)

As might be expected in patient groups with a variety of psychiatric and substance abuse problems, however, promoting positive group interactions often proved difficult. The patients say that it is difficult to build a climate of trust and safety within the group.

These different patients with their own histories of mental diseases and behavior. . . What were the reasons for a patient's admittance . . . we do not know each other, and what to expect from each other. . . I sometimes feel fear of another patient and do not know how to communicate with the patient. (5)

## **Conclusions and Discussion**

The research question in this interview study was: How do patients view and experience PS? The perspectives of patients on PS were therefore explored via semi-structured interviews ( $n = 17$ ). On the basis of the information gathered in these interviews, we were able to describe how patients view and experience PS, what their expectations of PS are, and the role that context is perceived to play in PS (see Figure



2). Our description of PS thus contributes to the development of this intervention in terms of the Guideline of the MRC (2008), by involving stakeholders (i.e., patients) in this study.

Our description of the patient's perspective on PS provides more detailed information than related NIC interventions such as: "limit setting," "the use of structure," "restrictiveness," or "the therapeutic milieu" (Bulechek et al., 2008). These descriptions were used as keywords for the previous literature review of Voogt et al. (2013). The NIC does not, however, include PS as an independent nursing intervention.

When asked how patients view and experience PS, patients mentioned the following components: The nurse knows the patient's situation; remains connected with the patient; helps and teaches the patient to handle ward rules, times, and habits; applies the treatment plan; explains and thus helps the patient understand things; and helps in the moderation of thinking.

When asked about their expectations for PS as a nursing intervention, the patients only provided short descriptions. The patient expected the nurse to recognize that he or she was a patient who wants to be taken seriously, wants to know what to do, and wants to maintain autonomy. These expectations can thus be taken as a starting point for PS and a possible guideline for the acceptance of PS. The need for patients to know what to do and how to behave, for example, can be met by not only rules and regulations, but also providing hints for the minimum structure a patient needs on how to do and how to behave. Alexander and Bowers (2004) mentioned that the absence of clear communication, rule clarity, and consistency in their literature review was linked to patient aggression.

When admitted to a closed ward, patients highlighted the following aspects of the context as key aspects: the closed ward itself, the presence of the nurse, and the patient-group interaction. As a consequence of typically involuntary admission, for example, patients have to deal with the context of the closed ward—namely not being able to freely come and go. This aspect of the ward context is an indisputable part of PS. A number of the patients also reported feeling particularly safe and secure as a result of the structure the ward provided. They did not lose their day-and night rhythm, for example, or were protected from their former network of so-called friends.

When we compare the results of the present interview study with the elements and goals of a review of the research literature (Voogt et al., 2013), considerable overlap was detected. For example, the element "Impose and maintain rules with verbal interventions and redirection as least restrictive form of PS and seclusion or use of restraints as most restrictive" (Caplan, 1993; Delaney, 2006; Kozub & Skidmore, 2001; Morales & Duphorne, 1995; O'Brien, 2000; O'Brien, Woods, & Palmer, 2001; Vatne & Fagermoen, 2007) resembles "Learn to deal with ward rules, times, and habits" in the present study of patient perspectives on PS. Furthermore, when a nurse

provides structure, the results of the present interview study emphasize adherence to the following components (for example): know the situations of patients before trying to connect with them, take them seriously, and help them maintain autonomy. In the review study of Voogt et al. (2013), a similar component was formulated for PS: “To assess the patient’s condition and need for autonomy and self-control (Garritson, 1983; Lowe, 1992; Lowe et al., 2003; Mohr, Mahon, & Noone, 1998; Morales & Duphorne, 1995).

Further comparison of the results of the present interview study with the results of the previous observational study (Voogt et al., 2014) emphasizes the importance of nursing activities for patients. The observational study showed that the contact between patient and nurse could be initiated by either party and results in “an explanation of something” by the nurse. The nursing activity of “explain something” in the observational study resembles the nursing activities mentioned by patients in the interview study: “To explain and make me understand” and “The moderation of thinking.” While we were not able to analyze the role of the patient group in the observational study as in the interview study, similar text fragments in the two studies emphasized this role. For example, in the observational study, a part of PS is the nursing activity “to ask a question”: Amidst a group of patients, the nurse asks a question which appears to positively structure the group interaction but in fact provides structure to an individual patient. In the present interview study, patients explicitly mentioned the patient–group interaction as a context aspect for PS, a “shelter” for the individual who is feeling particularly vulnerable. The patient–group interaction can also lead to feelings of discomfort and feeling threatened due in part to the unpredictability of others.

On the basis of the outcome of this interview study, we have adapted the definition of PS put forth on the basis of the literature study to read as follows:

*The aim of PS is to create a relationship of trust and cooperation between nurse and patient in which the patient is taken seriously, is able to organize his life himself, and is able to maintain autonomy while both patient and nurse are also aware of the patient’s vulnerability. In this relationship, the focus is on clear expectations regarding the treatment and the patient’s behavior during ward admission. As part of PS, the nurse should: know the patient’s situation; connect with the patient; assess the degree of vulnerability; teach and help the patient to deal with ward rules, times, and habits; teach the patient how to adhere to treatment; explain things and make sure the patient understands; and help the moderation of the patient’s thinking. The nurse is constantly aware of three context variables to effectively provide structure: the influence of being on a the closed ward, the presence of the nurse, and the patient-group interaction.*

In the former two studies conducted by Voogt et al. (2013, 2014), PS was considered a complex intervention (MRC, 2008). This was due to the number of components (i.e., nursing activities) that the process of PS involves. The results of the interview study with patients also show PS to be a complex intervention. This is again because of the number and variety of components involved (i.e., nursing activities and patient expectations for PS, but also the large number of possible interactions between the components).

With the information provided here on the patient's perspective of PS, we were able to expand and fine-tune our description of the use of PS as a nursing intervention and emphasize the components of particular relevance for patients in doing this. Our information is based on patients in need of constant care (Yonge, 2002) and an environment in which the patient is expected regain control over the illness (Delaney et al., 2000). The interviews with these patients provided valuable clues to how to understand one component of PS in relation to another and especially the importance of recognizing the patient's need to maintain some autonomy. Research with a larger number of patients and a more varied group of patients should nevertheless be done in the future.

## **Limitation**

One limitation on the present study is that the interviews were conducted on the closed wards of a psychiatric unit. The use of PS in other contexts may certainly involve other components (i.e., different relations between components and additional components).

## **Implications for Practice**

The clinical importance of this study is that it shows patients to have clear expectations about the use of PS as a nursing intervention. Patients want to be taken seriously and want to maintain autonomy even though they have been admitted to the closed ward of a psychiatric unit, are very vulnerable, and thus require considerable structure. Our results also highlight the complexity of PS as a nursing intervention. When, in a multidisciplinary meeting, the importance of PS for a patient is mentioned, nurses must know which activities and goals are needed and thus meant. Nurses can call upon our description of PS to do this and also our description of the patient's needs when doing this. And in such a manner, the effectiveness of PS as a nursing intervention can be enhanced.

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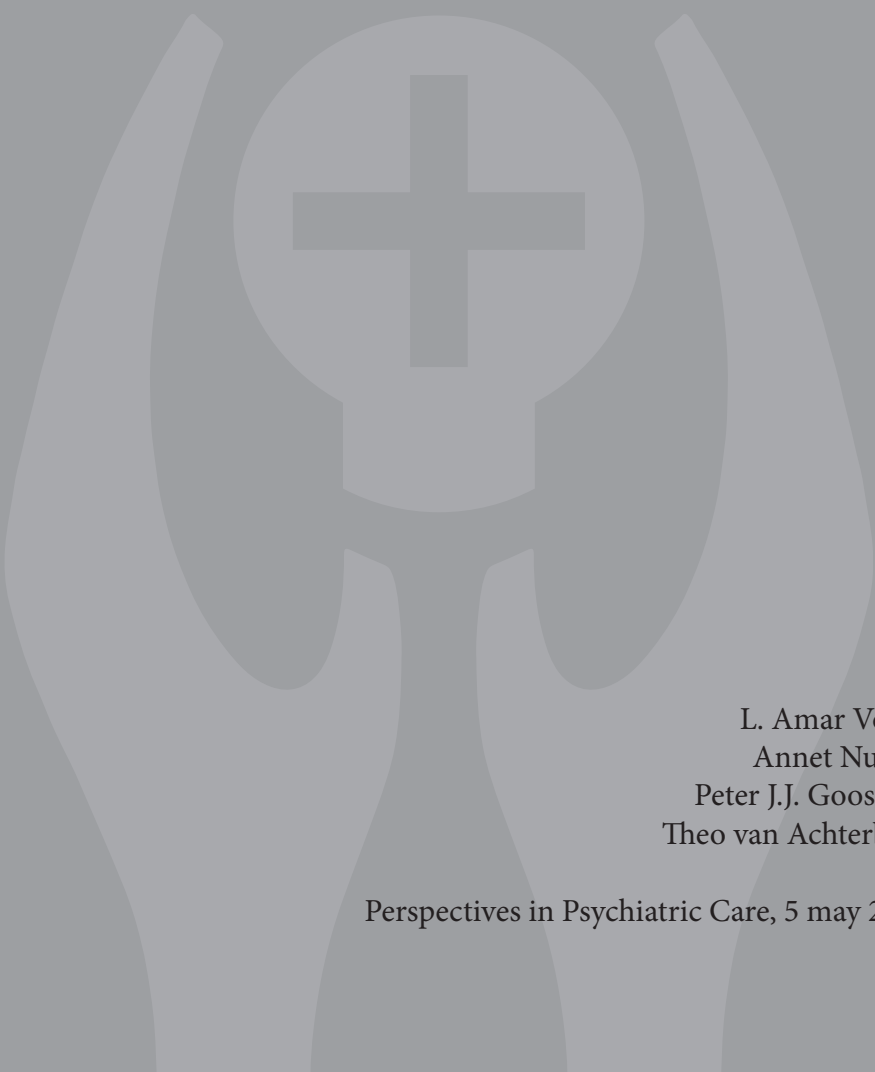
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# Chapter 5

## **An Interview Study on “Providing Structure” as an Intervention in Psychiatric Inpatient Care: The Nursing Perspective**



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## **PURPOSE**

To gain insight into nurses' perceptions and use of providing structure (PS) as an intervention during psychiatric inpatient care.

## **DESIGN AND METHOD**

Interviews were conducted with nurses ( $n=18$ ) from two inpatient wards in psychiatry immediately following the occurrence of a PS event. This was done immediately following the occurrence of a PS event. Transcripts were analyzed using a qualitative coding process.

## **FINDINGS**

Four general and 14 specific PS activities were described associated with the nursing intervention PS.

## **PRACTICAL IMPLICATIONS**

Nurses can now refer to specific activities of PS. An elaborated definition of PS is provided to facilitate a better understanding and using of PS as a psychiatric nursing intervention.



## Introduction

Psychiatric nurses in clinical settings often refer to “providing structure” (PS) for patients as part of care plans (O’Brien, 2000). There seems to be agreement, moreover, between psychiatric nurses as to what PS entails and how it can be done (Voogt, Goossens, Nugter, & van Achterberg, 2014a; Voogt, Nugter, Goossens, & van Achterberg, 2013). Nurses often refer to the setting of limits and the imposition of structure when they mention PS—strategies and terms mainly transferred via their use by other nurses in clinical settings (O’Brien, 2000).

According to Lowe (1992), the strategies of setting limits and the use of structure are interdependent. This means that nurses generally work to ensure a safe and secure environment for patients (and themselves) by setting limits while simultaneously use norms, rules, and activities to provide structure. Nurses are further advised to impose consistent limits but nevertheless be flexible to allow for individualized care planning (O’Brien, 2000).

Vrale and Steen (2005) suggested that the association between structure and flexibility in the relationship between patient and nurse is a dynamic one. That structure and flexibility in the relationship may transfer into activities to control the patient or to develop the patient’s capabilities.

PS constitutes a complex intervention as defined by the Medical Research Council (2008). The complexity of the intervention depends on the number of components included in the intervention, the interactions between the components on the intervention, and the extent of tailoring and flexibility incorporated into the intervention. The first step in the development of such a complex intervention is theoretical insight into the underpinnings and purpose of the intervention (i.e., PS). And three earlier studies conducted by our research group and briefly summarize below have added to the theory necessary to understand PS.

In a review of the relevant psychiatric nursing literature, three elements of PS were identified as critical: the imposition and maintenance of rules and limits; assessment of the condition of the patient; and interaction with the patient (Voogt et al., 2013).

In a subsequent observational study (Voogt et al., 2014a) of the actual practices of nurses for PS, the following key activities occurred: request of more specific information from the patient for purposes of clarification (e.g., more about a personal matter or an individual responsibility); explanation of a ward matter or treatment expectations to the patient; to support and encourage the performance of a task or scheduling of activities; and to stop behavior by requesting to stop or by prohibiting continuation of the behavior.

In an interview study with psychiatric inpatients (Voogt, Goossens, Nugter, & van Achterberg, 2014b), further insight was gained into the expectations of *patients* with regard to PS as a nursing intervention and the types of activities and actions that they expect to be a part of PS. Patients expected nurses to recognize their need to

be taken seriously, their need to know what to do while on a ward, and their need to maintain autonomy. Patients expected the following activities to be a part of PS: staff getting to know the patient's situation; staff staying connected with the patient; staff learning patients to deal with ward rules, times, and habits; staff explaining how to apply agreements within the treatment plan; and staff moderating the patient's thinking process. Patients also pointed to the roles of three context variables in PS: the nature of the closed ward; the presence of a nurse; and the characteristics of the patient-group interaction. The closed ward could either be a source of protection or a source of conflict. The presence of a nurse on the ward could elicit either a feeling of safety or a feeling of not being able to escape. The patient group could similarly provide a feeling of being sheltered and made at ease or a feeling of distrust and not knowing what to expect in light of the unpredictable behavior of patients.

Taken together, the three aforementioned studies provided valuable insight into the critical elements and activities needed for PS. The results of these studies also helped us formulate a definition of PS in terms of the available literature, observations of actual nursing practice, and interviews with patients. But still, the nurse perspective is missing of what nurses regard PS to be and what activities it entails.

Given our knowledge of PS and what we still needed to find out, we decided to conduct a fourth study to capture the professional perspective of the nurses themselves on the use of PS as a nursing intervention. Our research question was formulated as: How does the nurse describe, use, and explain PS following the observed event?

## Methods

### *Study Design*

The present interview study was a qualitative grounded theory study (Charmaz, 2006; Strauss & Corbin, 1998; Wester, 1995). Grounded theory aims to discover the perceptions and significance of people's behavior, to reconstruct the ways in which people make sense of behavior, and to identify how people's interpretations of behavior influence their interactions. Participant observation was first undertaken in situations/events calling for PS (see definition of these events below). An interview was then conducted with the relevant nurse to gain insight into the nurse's perceptions of the situation and PS behavior. The interviews were initiated and completed immediately following the occurrence of the event.

### *Nurses, Patients, and Events*

The events that we aimed to observe for PS had to meet one or more of the following inclusion criteria:

- the nurse intervened to get the patient to participate more in certain life areas, to ensure safety, or to create a more habitable environment
- the nurse wanted the patient to do something that the patient initially did not want to do, and
- the patient wanted something that the nurse could not provide immediately

The end of each event was assumed to have been reached when the nurse and patient parted and any verbal/nonverbal communication between them ceased. These criteria were developed in three expert meetings and reflect the consensus achieved between experienced psychiatric nurses involved in these meetings.

A total of 18 events and 18 nurses were selected via convenience sampling undertaken on two intensive care wards at the same mental health care hospital. The event observations and interviews were then conducted between January 2010 and July 2010. The expectation was that events requiring PS would occur rather frequently on these closed wards with 24 patients and 15 nurses on each ward. The patients on the wards had acute or severe mental illnesses (e.g., mood disorders, acute psychoses, obsessive compulsive behaviors) frequently accompanied by comorbid addiction problems. The patients were generally incapable of seeing to their own safety in a variety of life areas such as relationships or work. The nurses were all experienced psychiatric nurses with 5 or more years of experience in different fields of psychiatry and with a variety of psychiatric patients on these wards.

## Procedure

The observations and interviews were performed by the first author who had to have some insight into the relationships between the nurses and patients on the wards but also be independent enough to objectively observe things. In light of our definition of a PS event, the most preferred occasions for observation were mainly waking, breakfast, coffee breaks, lunch, evening meal, and bedtime (Voogt et al., 2014a, 2014b).

A protocol was created to obtain some uniformity of observation and consistency of interview conduct. The observer took notes either during or immediately following the conclusion of a particular event. He then asked the nurse if she could be interviewed with regard to the event. Beforehand, nurses were informed about this procedure and had agreed to be interviewed immediately following an event whenever possible. When interviewing the nurse, it was first checked that they remembered the event and also considered it one in which PS was used as an intervention. The nurse was then asked to Explain the PS intervention and to identify the essential parts of PS. The semi-structured interviews were recorded and a verbal transcript was made of each interview for further analysis.

Given that the focus of the present study was on the content of the events, the names/

identities of the nurses are not relevant and therefore not reported. The nurses were informed individually and in group meetings about the purpose and procedures of the study. This information included the aims of the study, the methods, and the use of the data. The nurses were also told that they could withdraw from the study at any time. No nurse withdrew from the study.

Prior to the start of each observation, the nurses were asked if the patients were stable enough to be observed and still agreed to be observed. If not, events in which these patients were involved were excluded from observation.

The internal medical ethical scientific board of the mental health care hospital gave its approval for the study.

## Data Analysis

Open, axial, and selective coding of the data (Charmaz, 2006; Strauss & Corbin, 1998; Wester, 1995) was undertaken by multiple parties to develop a categorization scheme for the critical interactions and activities mentioned by the nurses. In a process of inductive analysis and constant comparison of the coding results, emerging codes and categories were checked and refined.

To ensure a reliable interpretation of the data, 3 of the 18 interviews were analyzed and coded by two researchers independent of each other. The two researchers compared their results and discussed their interpretations of particular sentences and words until a manner of interpreting the interview transcripts could be agreed upon. The first author then analyzed an additional 10 interviews. In a meeting of the two researchers responsible for the coding of the first three interviews, the reliability of the coding/interpretation of the subsequent interviews was checked. When the additional five interviews were completed and coded for a total of 18 interviews, no additional information emerged (i.e., codes and coding categories). It was therefore decided that data saturation had been reached and no new events were observed and included for coding and analysis purposes.

The preliminary coding trees emerging from the analyses of the interviews were discussed with the members of a research group—both individually and in meetings—with events selected randomly for discussion. A more definitive coding tree gradually developed and formed the basis for the initial writing of this manuscript. Overlap in the descriptions of some codes was discovered during this writing process and during the ongoing discussions with the research group, which resulted in more concise descriptions of codes in the coding tree.

The discussion of the cases in the research group, the decisions made during the analysis of the data, and the changes made to the coding tree were all recorded in a logbook.

For the analysis of the coded interview data, use was made of the MaxQDA software for textual analysis (Kuckartz, 2007). Data analysis stopped when no additional

theoretical insights or further features of the coded categories emerged from the analyses (Charmaz, 2006).

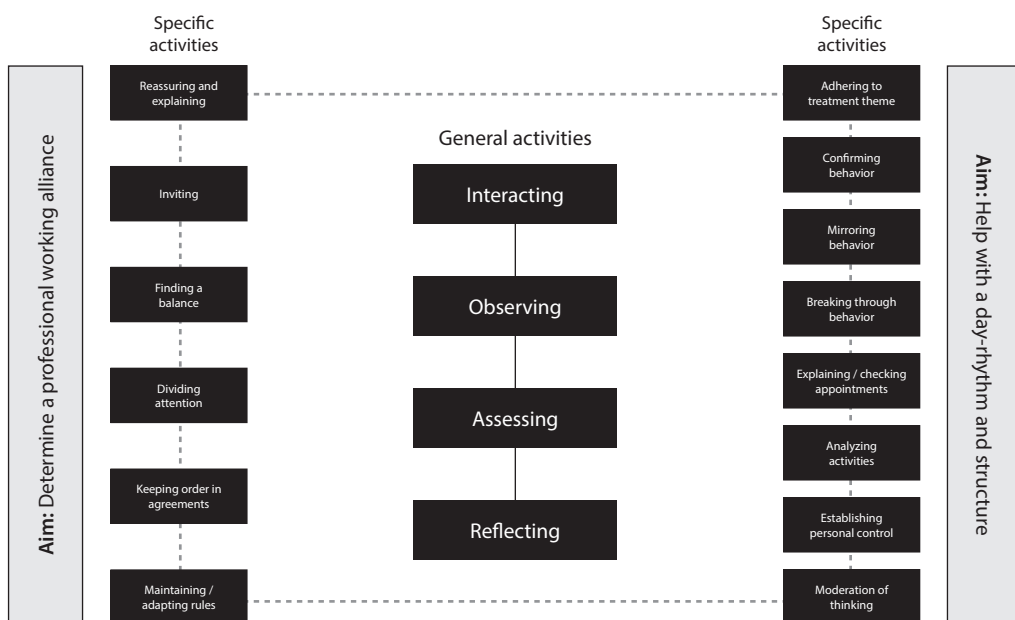
## Findings

The 18 PS events observed in this study could start in different ways. For instance, via a patient requesting his medication at the doorway to the nursing office, via a discussion of grocery shopping between nurses and patients at a formal group meeting, or via a situation in which the nurse refuses to open a locked door for a patient who seems to want to leave the ward.

The analyses of the interviews with the nurses led to the identification of 4 general activities associated with PS and 14 specific activities performed as part of PS (see Figure 1).

Furthermore, three core purposes for PS could be identified, and five prerequisites for doing this.

**Figure 1. Activities Associated with Providing Structure**



## Three Core Purposes Identified for PS

Nurses often refer to the general purpose of “providing structure.” One of the core purposes thereby is “to firmly adhere to established structures, rules, regulations, and agreements.” This aspect of PS is perceived by the nurses to provide a basic sense of safety for the patient, a sense of acceptance, and a starting point for additional positive developments.

A second purpose of PS mentioned by the nurses is “to achieve rest, routine, and hygiene.” Nurses therefore identify important moments in the day and thereby give the patient an overview of the day, make the day predictable, and provide for some calm.

The third purpose of PS identified by the nurses is to promote personal control for the patient. The provision of structure is thought to give patients control over emotions, help them accept established rules, and also encourage them to accept help. The nurses also mention that PS can promote personal control by helping patient and nurse identify common values and cooperate to find solutions for problems together.

## Prerequisites Identified for PS

While the patients in our study were already involuntarily admitted to the closed ward of a mental health care institution, the nurses reported immediately providing structure (PS) to further ensure the safety of the patient. In order to be able to do this, they mentioned five prerequisites. The first is that the *nurse be visible*. According to nurses, patients often become suspicious when nurses can be seen to be talking about them behind the closed door of a nursing office. Nurses should do their work in the living room of the ward to ensure maximum visibility. This also makes the nurses more approachable.

The second prerequisite is that the *nurse stands with the patient* (metaphorically speaking). Psychiatric nurses generally strive to create an atmosphere in which the patient feels welcome and protected by the nurses caring for them. They do this with an attitude which they characterize as down to earth, light, and open. Nurses make themselves available for questions, involve themselves with patients, and solve problems together with patients.

The third prerequisite for being able to PS is *being well informed with regard to the patient's character and personal situation*. This information enables nurses to compare and assess the patient's present situation, determine if this is in line with what has been previously reported, and in such a manner adapt things to the patient and connect with the patient.

The fourth prerequisite for PS is *allowing the patient to talk about personal experiences, emotions, and frustrations*. Nurses report that the existence of this possibility adds to the creation of a working alliance between the nurse and patient.

The fifth prerequisite mentioned by the nurses for PS is *use of humor*. According to the nurses, the use of humor can relieve the tension of—among other things—being admitted involuntarily. Humor also allows the nurse and patient to share an experience and thus create the so-called common ground for relating to each other.

## Four General Nursing Activities Associated with PS

The four general activities that nurses apply but not necessarily in this order are as follows: interact, observe, assess, and reflect.

In order to understand patients, nurses must purposefully *interact* with them and establish a connection with them. Nurses must *observe* if and how their behavior leads to a particular reaction on the part of a patient. At the start of a shift, moreover, nurses *assess* the individual patient and group atmosphere. In doing this, they check if the patients' reactions are in line with those mentioned in nursing reports. They also determine if the atmosphere in the group or on the part of a patient can be characterized as one of tension or trust. Psychiatric nurses can “feel” the tension that occurs when the mood of a patient easily switches. Tensions can also manifest themselves as the patient pacing back and forth or talking with a different tone of voice. Psychiatric nurses “feel” (i.e., observe and assess) trust when patients appear to be in control of themselves and when their verbal and nonverbal (i.e., gestures, posture) behaviors reflect this. Nurses may ask for the planning of daily activities, assess the patient's state of mind, and note the patient's motivation to adhere to the planned day structure. Nurses may also talk with patients about what they need to successfully start and finish the activities planned for the day. At the end of the day, the nurses and patients *reflect* together on the activities performed that day.

## Six Specific Nursing Activities Used to Connect with the Patient

Establishing a connection with the patient and thus a professional working alliance with the patient is reported to enlarge the probability of the patient accepting proposed or imposed structure. Nurses report that both the nurse and the patient negotiate the boundaries on this alliance/cooperation. Within the boundaries of shared values and the agreements that have been made with the patient, there should nevertheless be space to maneuver. In addition to this, the nurses emphasize that the patient must feel seen and heard and perceive that their individual story is recognized.

In the establishment of a connection (i.e., professional working alliance) with the patient within the context of PS as a nursing intervention, nurses report the following six specific activities as important: reassure and explain; invite; find a balance; divide attention; keep order in agreements; and maintain or adapt rules.

Nurses can try to *reassure* the patient by showing understanding and talking about the reasons for the involuntary admission. Patients recently admitted to the closed

ward of an institution often experience feelings of circumstances being completely beyond their influence and powerlessness as a result. Talking to the patient about their admission and the reasons for this, however, can help prevent patients from feeling completely lost. Nurses must also *explain* to patients which behaviors are allowed and which behaviors are prohibited along with how they (i.e., the nurses) can help the patient behave accordingly. Nurses may also explain the purpose of the various individual and group rules, treatment goals, and the nursing support that the patient will receive.

When first admitted, patients cannot be expected to immediately start performing all tasks for themselves and they are therefore *invited to talk* about the activities planned for the day and *invited to participate* in various activities. Nurses report asking specific questions for this purpose (i.e., to involve the patients in activities) but also tune into the individual patient's needs to involve him. But also a brief chat may be sufficient to calm the restless patient down, moreover.

The nurses in our study further reported the importance of trying to *find a balance between personal treatment appointments and the general day program* together with the patient. The nurses characterize this process as one of determining the patient's boundaries, what the patient wants, and the patient's ability to stick to treatment agreements. To find a suitable balance between personal treatment appointments and the general day program, the nurses report collecting information on the patient's treatment agreements and the contextual requirements for fulfilling these agreements. Nurses mention that they must consciously *divide their attention* between patients when, for example, two patients both want to speak to the nurse at the same time. The nurse must pay attention to both people but nevertheless address their individual questions. In doing this, the nurses also report sometimes trying to involve the patients in each other's situations.

When the house rules or individual agreements are involved, the nurses try *to keep order via adherence to established rules and agreements*. The nurses provide structure during dinner by adhering to a fixed sequence of steps: When seated at the dinner table, they ask for a moment of silence before starting to eat; everyone expected to remain seated at the dinner table until the last person has finished eating; and everyone is expected to help clean up after dinner.

The nurses also pointed out that a basic set of rules exists on the ward, for example, house rules concerning times to watch television together and that they may decide *to maintain or adapt these rules*, depending on a patient's current state of mind, the atmosphere in the group, or the planning of activities. The nurses also mentioned the importance—and necessity at times—of drawing the attention of patients to set rules, deciding to modify the rules, and enforcing the rules.



## Eight Specific Nursing Activities Used to Help Re-Establish Day Rhythm and Structure

According to psychiatric nurses, the disorganization of the patient's structure and disruption of their day rhythm often pose a major threat to their safety and well-being, which is then often the reason for their involuntary admittance. As part of PS, nurses try to help patients regain their day-night rhythm and provide for structure. The nurses mention eight specific nursing activities as critical for doing this: adhere to the treatment theme; confirm behavior; mirror behavior; break through behavior; explain and check appointments; analyze activities; establish personal control; and moderate the thinking.

*Adherence to the treatment theme* obviously guides the treatment process and is therefore critical. Nurses define the central treatment theme as the treatment goal put forth by the patient him/herself or formulated on the basis of observations of the patient's behavior. The central treatment theme preferably consists of mutual agreements established with the patient to be adhered to during the course of treatment. The nurses state that they must be well-informed of the content of the individual patient's treatment plan for PS. They must also have some overall knowledge of all of the patients' treatment plans and daily activities in order to be able to properly structure the day. The nurses then guide and support the patient's performance of activities and may have to remind the patient of their treatment goals at times.

During the process of guiding and supporting the patient's performance of activities, the nurses not only assess the patient's ability to adhere to the central treatment theme but also the patients' ability to develop their self-management competencies. When patients stick to agreements, nurses report frequently to *confirm* this and the positive attitude shown toward the activity by the patient. In one case in which the patient demonstrated his ability to express constructive criticism, for example, the nurse complimented this and acknowledged that the patient was doing well at practicing this skill as required by part of his treatment. In addition to explicit verbal confirmation, nurses reported using more subtle means to confirm a patient's behavior, such as a slight touch, listening intently to the patient, giving the patient full attention and warmth.

Nurses can also *mirror patient behavior and place boundaries on patient behavior*. When a patient shouts at the nurse, the nurse can mirror by replying: "You shout at me to get things done immediately. I find it shameless to be spoken to like this, keep your comments decent please."

In some cases, the nurses report trying to *break through behavior* to allow the patient to get a grip on things. One way of doing this is to distract the patient from their thoughts by going out for a walk together. Another way is to make an unexpected remark. In the case of a patient who only tells of disasters, the nurse reported asking

him to “tell us about something that you have enjoyed.” The nurse reported a startled reaction on the part of the patient, who indeed then switched to telling about positive experiences.

Nurses repeatedly *explain agreements and check the patient’s understanding* of them. Such explanation and checking provides insight into the patient’s patterns of thinking, feeling, and behaving. It also provides clues to bring these matters under better control.

Nurses also report that it is necessary to recognize that an activity is usually composed of smaller sub-activities that all required attention from the nurse and independent support. Performance of the general activity independent of such attention and support for the individual sub-activities could prove too complex for the patient and confront them with inabilities. Both the nurse and the patient therefore *analyze a complex activity* into smaller, more accessible sub-activities and make agreements with the patient on what criteria must be met for achievement. For example, doing the groceries for the group can be broken down into taking inventory of the groceries: checking the stocks, making a list, arranging for enough money, and so forth. The nurses report discussing each sub-activity with the patient in detail and defining (together with the patient) what is needed to successfully accomplish the sub-activity. In helping to *establish personal control*, patient responsibility is a core theme. Nurses do not take responsibility for the patient at first. They expect patients to gradually organize and perform activities themselves, and they assess the ability of patients to take personal control and not cross boundaries along the way. When patients are capable of handling and adhering to rules, they are reported by the nurses to feel safer. The nurses therefore do not dictate how activities should be performed on the ward but prefer, instead, to discuss the house and other rules with the patients, amend these when the patients suggest legitimate changes, and hold the patients responsible for adherence to the rules in the end.

The last activity mentioned by nurses as part of PS is the *moderation of patient thinking*. Nurses describe how they help patients order their thoughts, help them keep in the present, and help them avoid drowning in details. Nurses use different techniques to do this, including giving patients space to chat, cutting off disruptive conversations, and confirming agreements that have been clearly met. As part of the moderation of patient thinking, nurses also reported asking very practical questions in order to draw the patient and their thoughts back to the present situation. The nurses also assume that the patients use nurses to check on their perceptions of reality or contact with reality at times.

## Conclusions and Discussion

In this interview study, the perspective of nurses on the use of PS as an intervention on the closed wards of a mental health care organization was explored in order to

gain more insight into how PS is perceived and applied in actual practice. On the basis of the information gathered in a total of 18 interviews that were needed to reach data saturation, we were able to identify 3 core purposes for PS, 5 prerequisites for its use, and both 4 general and 14 specific activities associated with the use of PS as a psychiatric nursing intervention. The three core purposes of PS described by the nurses are as follows: to provide for a basic sense of safety; to achieve rest, routine, and hygiene; and to promote personal control on the part of the patient.

The prerequisites for PS all revolve around being able to make contact with the patient and maintaining contact with the patient. The prerequisites are being visible to the patient; standing with the patient (metaphorically speaking); knowledge of the patient's character and personal situation; encouraging and allowing the patient to talk about his personal experiences, emotions, and frustrations; and use of humor. These prerequisites seem to be applicable to other interventions, but nurses mentioned these explicitly with regard to PS. In a prior interview study but then with psychiatric nursing patients (Voogt et al., 2014b), the patients *also* mentioned the importance of nurses being knowledgeable of their personal situations and the importance of nurses staying connected with them. In addition, the patients mentioned that the presence of the nurse made them feel safe.

Contrary to the patients, the nurses did not explicitly refer to the closed door aspect of the nursing situation or the nursing office as a prerequisite. The nurses did, however, mention the effect of keeping the door of the nursing office closed: A closed door clearly gives rise to suspicion on the part of patients and should thus be avoided. An open door, in contrast, made the nurses clearly approachable and is thus recommended.

Two main groups of PS nursing activities could be distinguished and seen to relate to the purposes establishing a professional working alliance with the patient, on the one hand, and establishing a day rhythm and structure with the patient, on the other hand (see Figure 1).

- The four general activities of interact, observe, assess, and reflect.
- The fourteen specific activities of reassure and explain; invite; find a balance; divide attention; keep order in agreements; maintain or adapt rules; adhere to the central treatment theme; confirm patient's behavior; mirror and put boundaries on behavior; break through persistent behavior; explain and check appointments; analyze a complex activity; help to establish personal control; and to moderate the thinking.

Three of the four general activities mentioned by the nurses in the present study were also clearly apparent in the research literature (Voogt et al., 2013): the importance to *observe* and to *assess* the patient's condition, and the importance to *interact*.

Observation and assessment of the patient's condition by the psychiatric nurse mainly concerned responses to being limited or supported, responses to redirection, and the patient's ability to maintain autonomy and self-control. Interaction with the patient is needed to individualize the PS intervention and work toward a relationship of trust. Through interaction, nurses try to relate to each patient and try to recognize their individuality (Björkdahl, Palmstierna, & Hansebo, 2010; Delaney, 2006; Hopkins, Loeb, & Fick, 2009; Mahoney, Palyo, Napier, & Giordano, 2009; Vatne & Fagermoen, 2007; Yonge, 2002). In our prior study with psychiatric nursing patients, they did not explicitly mention "interaction with the nurse," but they did mention the importance of nurses "staying connected" with the patient (Voogt et al., 2014b).

In the present interview study, nurses considered to *reflect* a general activity. In the observation study we conducted (Voogt et al., 2014a), reflection was a specific activity used at the end of an event to assess specific task performance together with the patient.

Both nurses and patients mentioned the activities of *explaining/checking appointments* and *moderation of thinking* in the relevant interview studies. In the observational study (Voogt et al., 2014a), activities entailing *support and encouragement* were also discerned with their descriptions resembling the more detailed descriptions provided by the nurses with regard to *invite, find a balance, adhere to the treatment theme*, and *confirm* in the present interview study.

The specific activities of maintain and adapt rules and adhere to the treatment theme in the present study show similarities with the explicit rules and limits for an individual patient (Sharrock & Rickard, 2002; Vatne & Holmes, 2006; Walker, 1994) in the literature review. Nurses refer to the process of dealing with rules and drawing the patient's attention to rules specifically described for him as part of his treatment plan. The patients in our previous interview study similarly stressed the importance to *adhere to the treatment theme*, even when it contains agreements and boundaries that are not very appealing to them (Voogt et al., 2014b).

In the nurses' descriptions of working to establish (or re-establish) a day rhythm and structure with a patient, they mentioned the problem of conflicting interests. On the one hand, the patient's willingness and capacity to participate in a day program must be respected. On the other hand, some persuasion is sometimes needed to get patients to participate in activities. A *balance* must thus be constantly sought as mentioned in not only the previous studies but also in the present interview study. For many patients, involvement in the decisions on the structure their day will predispose them to participate in the agreed-upon activities as it also gives them some *personal control*. For other patients, more persuasion may be needed to not only get the patient to follow their agreed-upon day program but also prevent them from losing control over emotions and possibly becoming completely uncooperative.

During interviews with the nurses in the present study, they did not mention a number of considerations discerned in our review of the relevant literature: a continuum

from general to specific structure with rules and limits not clearly communicated to the individual patient (Voogt et al., 2013). The specific activities to *maintain or adapt rules* and to *find a balance* can be seen to pertain to maintaining a structure, but as the nurses in the present interview study explained, they pertain to the maintenance of a specific structure for the patient, not in terms of a general structure or a structure for the nurses to hold onto themselves.

The main difference between the results of the present interview study and the results of our literature review and other two studies is that the nurses were more explicit about the specific activities that they perform as part of PS: *reassure and explain for the patient, divide attention across patients, maintain or adapt rules, and help establish (or re-establish) personal control*. Although these activities were found in the literature on PS, were discerned in our observational study, and also mentioned by patients, the nurses we interviewed were much more explicit about the need to support the autonomy of the individual patient despite them being on a closed ward and despite their psychiatric illness.

Drawing on the outcomes of the present interview study, we can now formulate the following definition of PS.

*For nurses in mental health care, PS means to establish a working alliance with the patient, help with day rhythm and structure, and find a balance between adherence to rules, regulations, and agreements-on the one hand-and regaining personal control for the patient-on the other hand. To do this, nurses must interact with the patient, observe patient reactions, assess patient's state of mind, and reflect upon patient behavior.*

In keeping with the definition of a complex intervention by the Medical Research Council (2008), PS can be considered a complex intervention that thus contains a number of components (i.e., nursing activities). The results of the present interview study confirm the complexity of PS as a nursing intervention.

## Study Strengths and Limitations

On the basis of our observations of actual PS practice (i.e., PS events) and the conduct of immediate interviews with the nurses involved in these events, we were able to gain insight into the use of PS as a psychiatric nursing intervention. The nurses were indeed able to reflect instantly upon the events calling for a PS intervention.

As a result of this grounded theory study, we were able to identify a number of key activities, gain insight into the aims of using PS as a psychiatric nursing intervention, and better understand what nurses consider important prerequisites for the use of PS as an intervention. The breadth and depth of insight into the nursing perspective on PS is thus a major strength of this study.

A limitation on the present study is that the interviews were conducted with only nurses working on two closed wards of a single mental health care hospital. The use of PS by other nurses working in other psychiatric contexts may certainly involve other components. Generalization to other PS contexts should thus be done with care. Another limitation is that the researcher could be biased through the previous other studies on PS. The danger of researcher bias was constantly present and was recognized at the start of the research process. In order to prevent this type of bias, three peers monitored the research process.

On the basis of the subjective experiences of the nurses, conclusion cannot yet be drawn about the most successful ways of using PS.

## Implications for Practice

The importance of this study is that it provides insight into how nurses can use their presence to make *contact* with patients in psychiatric care and how they can work to provide structure. The study also shows the *complexity* of fulfilling the goals of PS when used as a psychiatric nursing intervention. At the same time, it is now possible to list a number of factors that need to be taken into consideration, such as the purposes, the prerequisites, and the activities.

The results of the present study further place us in a position to supply more explicit descriptions of the activities required for PS as a nursing intervention than currently found in the Nursing Interventions Classification (Bulechek et al., 2010). The NIC does not presently include PS as an *independent* nursing intervention.

With these results in mind, nurses can now report more transparently on the use of PS, collaborate more explicitly on the use of PS, and hopefully enhance the effectiveness of using PS as a psychiatric nursing intervention.

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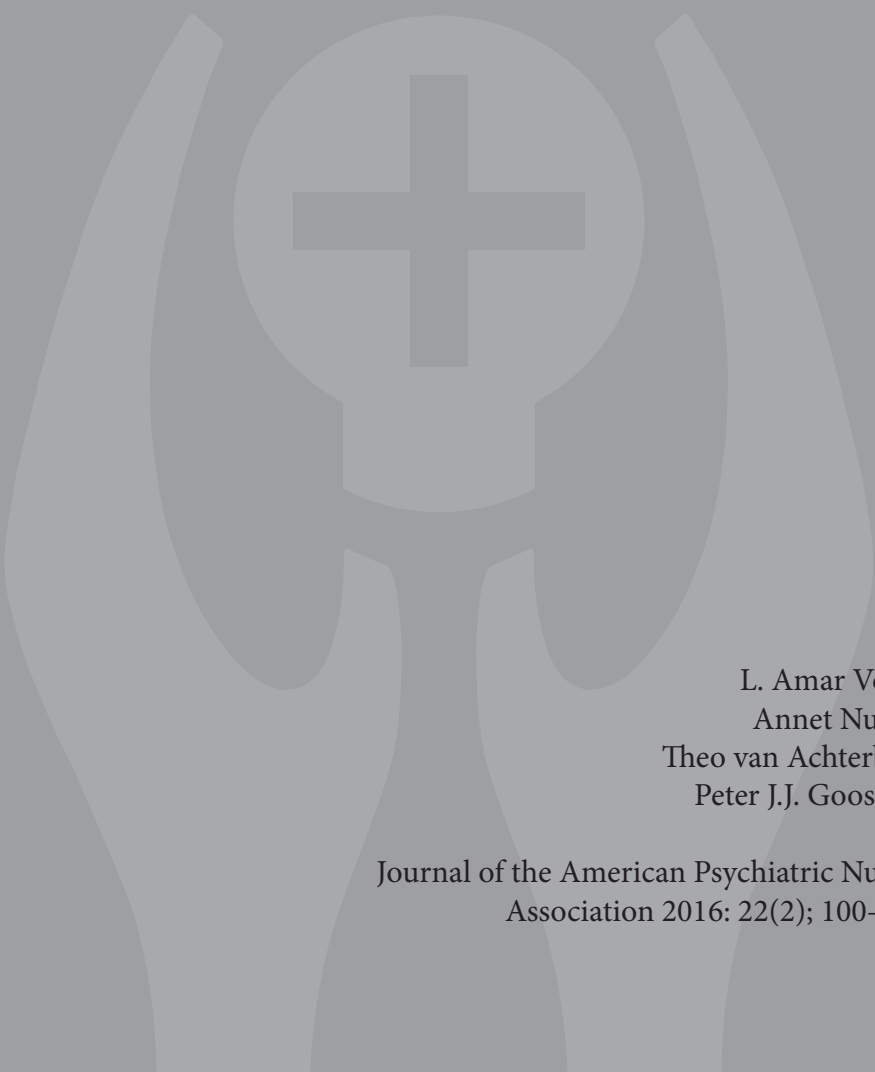






# Chapter 6

## **Development of the Psychiatric Nursing Intervention Providing Structure: An International Delphi Study**



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## **BACKGROUND**

Psychiatric nurses commonly refer to 'providing structure' (PS) as a key intervention. But, no consensus exists about what PS entails. PS can be understood as a complex intervention. In four previous studies a definition, activities and context-variables were described which were presented to experts in a Delphi-study.

## **OBJECTIVE(S)**

To reach consensus about the definition of PS, its activities and context-variables.

## **DESIGN**

In a qualitative study a Delphi-study is used to gather the opinions of experts. The Delphi-study consisted of three rounds with statements to score in each round.

## **RESULTS**

Experts reached consensus about a definition of PS, its activities and context-variables. Eleven statements related to the definition were accepted. Fourteen statements of in total seventeen statements related to the specific activities reached sufficient agreement, and four statements related to context-variables were accepted.

## **CONCLUSIONS**

A definition could be given of PS with 4 general PS-activities, 15 specific activities, and 3 context-variables. Psychiatric nurses can use the information about PS to reflect on the use of PS-activities within their own working environment, and these insides can help nurses to develop their professional growth.

In mental healthcare, nurses commonly refer to "providing structure" (PS) as a key intervention in the care for patients. Yet little is reported on what exactly defines PS or what activities constitute PS as a mental healthcare intervention. In the literature review conducted by Voogt, Nugter, Goossens, & van Achterberg (2013), three elements were found to characterize PS namely: the imposition and maintenance of rules and limits, assessment of the condition of the patient, and interaction with the patient. Of particular relevance for the imposition and maintenance of rules and limits was the distinction of implicit versus explicit rules and limits (Garritson, 1983; Lowe, 1992; Sebastian, Kuntz, & Shocks, 1990; Walker, 1994). Implicit rules and limits provide a structure that is not clearly communicated to the patient, such as implicit norms or regulations, which form a framework and daily routine for patients, nurses and the hospital to function in. Explicit rules and limits are mostly clearly communicated to the patient and explicitly described in an individual treatment plan. Of particular relevance for assessment of the patient's condition were the following: response of the patient to not only being limited but also receiving support (Delaney et al., 2000; Garritson, 1983; Lancee, McCay, & Toner, 1995; Ransohoff et al., 1982); the ability of the patient to adequately respond to redirection (Kozub & Skidmore, 2001); and the individual patient's need for autonomy and self-control (Garritson, 1983; Lowe, 1992; Lowe, Wellman, & Taylor, 2003; Mohr, Mahon, & Noone, 1998; Morales & Duphorne, 1995). Finally, of particular relevance for the interaction between the nurse and patient were the following: recognition of the patient's individuality (Björkdahl, Palmstierna, & Hansebo, 2010), exchange of mutual expectations with regard to treatment; and involvement of the patient in the process of cooperation (Caplan, 1993; Hopkins, Loeb, and Fick, 2009; Sebastian et al., 1990; Vatne & Fagermoen, 2007; Walker, 1994; Yonge, 2002).

Despite growing insight into the goals and important aspects of PS, no studies that we know of on the effectiveness of PS as a psychiatric nursing intervention were available at the time of the Voogt et al. review. For this reason, a series of studies was undertaken and subsequently drawn upon to prepare statements regarding PS as a mental healthcare nursing intervention for use in the present Delphi study. An initial observational study was conducted on two inpatient wards of a mental health care hospital (Voogt, Goossens, Nugter, & van Achterberg, 2014a). And two interview studies were conducted: one with patients from a mental health care hospital (Voogt, Goossens, Nugter, & van Achterberg, 2014b) and one with psychiatric nurses working with these patients on the same wards (Voogt, Nugter, Goossens, & van Achterberg, 2015).

The observational study (Voogt et al., 2014a) revealed a process of PS with various activities at the start of the interaction between nurse and patient, in an intervention phase, and at the end of the interaction between them.

The patient-interview study (Voogt et al., 2014b) resulted in an overview of 6 PS-

activities: know the situation, remain connected, deal with rules, times and habits, apply the treatment plan, explain and understand, and moderation of thinking. Patients also described four expectations towards nurses: The nurse must be aware that they are vulnerable as patients; nurses need to take patients seriously; patients want to know what to do; and finally, patients expect that nurses know the patients' need for autonomy.

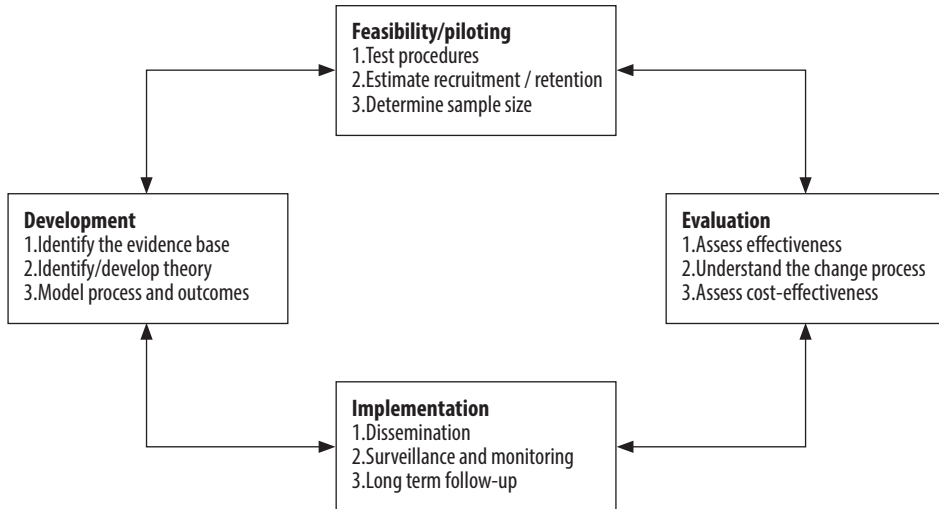
The results of the interview study with nurses (Voogt et al., 2015) showed two main groups of activities to be of particular relevance for PS: 4 general activities and 14 specific activities. The general activities were: interacting, observing, monitoring, and reflecting. The specific activities were: reassuring and explaining; inviting; finding a balance; dividing attention; keeping order in agreements; maintaining or adapting rules, adhering to the treatment theme; confirming behavior; mirroring behavior; breaking through behavior; explaining and checking appointments; analyzing activities; establishing personal control; and moderation of thinking. Most of the general and specific activities were also cited as important in previous studies. Only 'dividing attention,' 'confirming behavior,' and 'analyzing activities' were not encountered in the literature of relevance for PS (Voogt et al., 2013). In the interview study with patients, there was no mention of 'to observe' or 'to monitor' as general activities and no mention of 'to invite' or 'to analyze' as specific activities (Voogt et al., 2014b).

Three contextual variables were identified as important for PS as a nursing intervention in the same interview study with patients, namely: being on a closed ward with its rules and regulations, the presence of a nurse, and the patient-group interaction. Similarly, in the interview study with the nurses, five prerequisites for being able to provide structure were identified: the nurse being visible to the patients; the nurse standing — metaphorically speaking — beside the patient; the nurse being well-informed about the patient's character and personal situation; the patient being allowed to talk about personal experiences, emotions, and frustrations; and the use of humor by nurses. Based on the four studies, the following draft definition of PS was derived:

*Providing Structure (PS) means establishing a working alliance with the patient, helping with day rhythm and internal structure, and finding a balance between adherence to rules, regulations, and agreements — on the one hand — and regaining personal control — on the other hand. For PS, nurses must interact with the patient, observe a patient's reaction, monitor a patient's state of mind, and reflect upon patient behavior.*

Although consensus about PS does not exist yet, PS can be understood as a complex intervention given the number of components, possible interactions between the

**Figure 1. Key Elements of the Development and Evaluation of Complex Interventions (MRC, 2008)**



different components, and variety of outcome possibilities depending on the target population and specific situation.

According to the requirements of the UK Medical Research Council (MRC, 2008), a Delphi study can be part of the first development phase for the design of a complex intervention (see Figure 1).

The development phase is aimed at the identification and modelling of the definition, activities, and contextual variables of relevance for a complex intervention. In the present study, we aimed to gain a more sufficient understanding of PS by calling upon expert knowledge, and use of the guidelines for the development of new interventions in the Nursing Intervention Classification (Bulechek, Butcher, & McCloskey Dochterman, 2010).

The following research questions were formulated for the present study.

- Can the members of a Delphi panel reach consensus on a definition of PS?
- What activities do the experts consider essential for PS as a mental healthcare nursing intervention?
- What contextual variables do the experts consider important for PS?

## Research method

### *Study design*

We conducted a web-based Delphi study to enable participants (i.e., the experts)

to easily respond from diverse geographical locations. A Delphi study can be characterized as a series of surveys interspersed with controlled feedback (Gill, Leslie, Grech, and Latour(2013). This Delphi study consisted of three rounds, as recommended by Boelkedid, Abdoel, Loustau, Sibony, and Alberti (2011). Experts respond independently to statements, and in each following round experts may individually reflect on revised statements on the basis of summarized scores and comments. The premise underlying the Delphi method is that the collective opinion of a panel of experts is more valid than the individual opinion (Landsheer et al., 2003). Clear guidelines to conduct a Delphi study remain illusive, however (Keeney et al., 2010).

### *Selection of the panel of experts*

To assess the content of the PS intervention, definition, activities, and contextual variables within a psychiatric nursing environment, we approached a panel of nationally and internationally recognized experts from the field of psychiatric nursing (n=28). All 28 (100%) agreed to participate in the Delphi study. In the scientific literature, no agreement exists on the ideal panel size. Gill et al. (2013) suggest 25 experts, which we increased to 28 to allow for 10% nonresponse. Our experts were either:

- practicing as a psychiatric nurse, a nurse practitioner, or clinical nurse specialist and had experience with both inpatient psychiatric care and the use of PS; or
- practicing teachers or researchers prepared to reflect upon psychiatric nursing from an educational or scientific perspective; or
- otherwise known for their expertise within the field of psychiatric nursing due to their intensive cooperation with psychiatric nurses and patients but without actual personal practice experience.

### *The Delphi survey*

Based on previous studies (Voogt et al., 2013, 2014a, 2014b, 2015), a draft definition of PS was formulated along with 4 general activities, 9 specific activities, and 4 contextual variables for use in the Delphi procedure.

The first Delphi round involved the presentation of statements regarding the definition of PS. The panel members could independently comment on each statement. These comments were then used to reformulate the initial statements.

In the second Delphi round, the statements which were not accepted (but also not immediately rejected) and therefore reformulated were presented to each individual panel member for re-evaluation and new statements regarding specific activities and contextual variables related to PS also presented to the experts for independent evaluation.

In the third Delphi round, reformulated statements were again presented to the experts. No new statements were presented during this round (see Table 1).

In all rounds, the panel members were asked to judge the presented statements along a 7-point scale: entirely agree (1), mostly agree (2), somewhat agree (3), neither agree nor disagree (neutral) (4), somewhat disagree (5), mostly disagree (6), or entirely disagree (7).

### *Procedure*

To assess the clarity and feasibility of the Delphi rounds 1 and 2, each round was piloted with a smaller research panel prior to its conduct (Cowman et al., 2012). The composition of the pilot panel was different than that of the Delphi panel. And in the pilot studies, four experts were invited to complete the Delphi survey and provide any feedback and comments on the statements, process, instructions, and ease of completing the survey.

For each round of the Delphi procedures, the individual panel members were sent an email with a short introduction to the study and a web link to the Delphi survey. The researcher was able to check whether an expert had responded or not. And reminders were sent when necessary. The panel members could only respond once as the web link closed after completion of the survey.

The panel members were asked to conclude the survey within two weeks. At the end of week two, those members who had not responded were sent a reminder. For those who had trouble completing the survey within the allocated time frame due to workload, vacation, or illness (for example), the response period was extended for

**Table 1: Delphi procedure for evaluation of Providing Structure as a mental healthcare nursing intervention**

<b>Generation of statements</b>
Recruitment of experts for the panel (n=28)
<b>Delphi round 1</b> Panel 28 experts Aim: To reach consensus about a definition of PS, and what defines PS (11 statements)
<b>Delphi round 2</b> Panel 26 experts Aim: To reach consensus about the reformulated statements from D1 and the adapted definition of PS (2), about the activities within the scope of 'providing structure' (17), and about the context-variables of PS (4)
<b>Delphi Round 3</b> Panel 25 experts Aim: To reach consensus about the reformulated statements (13)

another two weeks. Those respondents who had not responded at the end of each additional week were again sent a reminder.

The same procedure was followed for the Delphi rounds 2 and 3 except that at the start of each round, the panel members received feedback on the previous round in addition to the statements. The feedback provided for rounds 2 and 3 of the Delphi procedure included the aggregated scores of the experts for the statements from the previous round and an overview of the comments provided by the experts.

A response rate of 70% for each of the Delphi rounds was judged to be acceptable and thereby maintain rigor (Keeney et al., 2010).

### ***Data analysis***

The panel responses for each statement were summarized and visualized in a stack bar chart for presentation to the panel members. Their comments provided alternative explanations for a statement or suggestions for changes to the wording of a statement. Two researchers reformulated statements on the basis of the analysis and discussion about the scores and comments. The scores of the members of the panel on the statements were processed using SurveyMonkey (2011). The cut-off scores for acceptance or rejection of a statement and thereby determination of the Content Validity Index (Wynd et al., 2003; Polit et al., 2007) were as follows: statements were accepted when 70% or more of the panel entirely (score 1) or mostly (score 2) agreed with their relevance; statements were rejected when 70% or more of the panel mostly (score 6) or entirely (score 7) disagreed with them. A mostly in-between score showing no widespread acceptance or rejection was taken to indicate that the statement needed reformulation. And for this, the authors drew upon the comments provided by the panel members.

### ***Ethical considerations***

Ethical approval was obtained from the scientific board of the mental health care organization (GGZ Noord-Holland-Noord). All of the panel members agreed to participate in the study by replying to an email or a telephone call.

## **Results**

We started the Delphi procedure with 28 panel members. Delphi round one concerned the definition of PS. Delphi rounds two and three mainly concerned the activities and contextual variables judged to be of importance for using PS as a mental healthcare nursing intervention.



**Tabel 2: Characteristics of panel-members**

<b>Characteristics of panel-members</b>	<b>Mean (yrs)</b>
Age (n=26 <sup>1</sup> )	51 (range 35-68)(s:8,6)
Practice-experience in psychiatric nursing (n=26)	19 (range 1-35)(s:8,4)
Educational experience in psychiatric nursing (n=24)	12 (range 3-25)(s:6,6)
Scientific experience in psychiatric nursing (n=22)	9 (range 0-25)(s:7,6)
<b>Other characteristics of panel members</b>	
Gender (n=26)	50/ 50 male/female
Educational background in psychiatric nursing	BA, MSc/Phd and/or MANP
Nationality	
The Netherlands	17
USA	2
Australia	2
Switzerland	2
Malta	1
Norway	1
Sweden	1
Finland	1
Czech Republic	1

<sup>1</sup>2 of 28 respondents did not give all data on these topics

## ***Respondents***

In Table 2, the characteristics of panel members are summarized.

For the first Delphi round, the response rate was 93% (26 out of the 28 panel members responded within four weeks). For the second round, it was 96% (25 out of 26). And for the third round, it was 84% (21 out of 25).

## ***Delphi rounds 1 and 2: Definition of PS***

In the first Delphi round, 11 statements concerning the definition of PS were presented to the panel members. None of the 11 statements were rejected; 7 were agreed upon by 70% or more of the panel; and the remaining 4 had to be reformulated.

The panel experts agreed that the definition of PS should refer to helping the patient with a day rhythm, with internal structure and with regaining personal control. They further agreed that nurses must interact with the patient, observe the reactions of the patient, and monitor the patient's state of mind for effective PS and that both the nurse and patient should reflect upon the patient's behavior.

"Establishing a working alliance between nurse and patient" with a score of 65%, did not reach the cut-off point for acceptance of the statement as agreed upon. In the comments provided by the panel experts, alternative formulation of the statement was suggested for the following reasons. A working alliance is necessary for PS but needs to be built up gradually by the nurse listening to the patient without prejudice. A working alliance can be seen as a prerequisite for PS but not specific to PS. Establishing

**Table 3: Statements presented in Delphi rounds 1 and 2 for definition of PS**

<b>Statements</b>	<b>Score in D1 (Accepted If score &gt; 70%)</b>	<b>Reformulated and accepted in D2</b>
The definition of providing structure should refer to “establishing a working alliance between nurse and patient”	65%	
RS: A prerequisite for PS is that a working alliance is established between nurse and patient		72%
The definition of providing structure should refer to “helping the patient with day-rhythm”	72%	
The definition of providing structure should refer to “helping the patient with his internal structure”	73%	
In the definition of PS, reference should be made to the adherence to rules	46%	
In the definition of PS, reference should be made to the adherence to regulations	43%	
In the definition of PS, reference should be made to the adherence to agreements	61%	
RS: An activity of PS is that the nurse helps the patient to “Find a balance in dealing with his treatment agreements and the ward rules, and regaining personal control”		88%
The definition of PS should refer to helping the patient regain personal control	89%	
To provide structure, the nurse interacts with the patient	88%	
To provide structure, the nurse observes specific patient’s reactions	88%	
As part of Providing Structure, the nurse monitors the patient’s state of mind	80%	
Part of providing structure is that nurses and patients reflect on patient’s behavior	73%	

RS: Reformulated Statement following the original statement above

a working alliance takes a mutual effort; it is nevertheless possible to use PS without the presence of a working alliance. The reformulated statement was accepted during the second Delphi round by 72% of the panel members: “A prerequisite for PS is that a working alliance be established between the nurse and patient.”

The statements about rules (46%), regulations (43%), and agreements (62%) did not produce sufficient agreement in round one, but were also not rejected. According to the experts, “rules” and “regulations” were very similar words and a general preference for use of the word “rules” was expressed. Patients may be unable to cope with rules and experience problems with this in daily life. Nurses work with rules as part of PS, and therefore “rules” should be part of PS. In addition to use of the term “rules” as opposed to “regulations,” the experts preferred explicit use of the word “agreement” because agreement better captures the engagement between the nurse and patient. In the second Delphi round, the following reformulated statement was accepted with 88%: “For the definition of PS, part of finding a balance concerns dealing with agreements and rules.”

### *Delphi rounds 2 and 3: Identification of important activities for PS*

In Delphi rounds 2 and 3, the focus was on those activities and contextual variables that are important for PS.

In Delphi round 2, 17 statements concerning activities of presumed relevance for PS were presented to the panel members. No statements were rejected; 5 were agreed upon by 70% or more of the panel; and 12 had to be reformulated on the basis of the comments provided by the panel members and re-assessed in Delphi round 3 (=D3).

The statement that the nurse should help the patient adhere to treatment (initially 56% agreement) was later accepted, after reformulation, in D3: “The nurse supports the patient to remain committed to the treatment plan” (91%). The experts suggested that the style of support for remaining committed to treatment is important, especially when the patient is not willing to remain committed. The style of support should be invite to participate in the treatment plan and discuss with the patient when the treatment plan needs changing

Instead of helping the patient understand the treatment plan (68%), the experts showed a clear preference for the nurse helping the patient understand what the treatment entails by giving them sufficient information (95%).

For the statement “to moderate the patient’s thinking” (68%), the experts suggested the alternative wording: “To support the patient to arrange his thinking”. The experts widely accepted (81%) the idea of keeping the patient focused on the flow and present reality within the psychiatric unit, on the one hand, and keeping the patient’s focus on the current conversation.

“Help to establish personal control” was reformulated as “the nurse supports the patient to establish personal control” (86%).

The experts commented that “To confirm the positive attitude demonstrated by the patient while practicing skills” does not specifically relate to PS. This statement was therefore reformulated as: “The nurse provides confirmation when the patient is able to or at least attempts to stick to an agreement” (81%).

All of the activity statements concerned with stopping the behavior of a patient required reformulation. Especially these stopping activities need emphasis that applying an activity depends on the nurse to assess the patient’s state of mind on a given occasion. Activities aimed at stopping the behavior of the patient can vary, namely, from least restrictive (e.g., interact with the patient) to most restrictive (e.g., use of restraint) depending on circumstances. The statement concerned with interaction and redirection was therefore revised to become: “to try to stop the behavior, the nurse interacts with and supports the patient to change their behavior” (91%). The experts confirmed that a conversation, distraction, and use of humor can interrupt behavior when timed right. For the statement about “Mirroring the patient’s behavior and setting a boundary” (68%), the experts suggested rephrasing

**Table 4: Statements presented in Delphi rounds 2 and 3 for identification of activities of importance for PS**

Statements	Accepted in D2 (70%>)	Reformulated accepted or not in D3
An activity of PS is that the nurse helps the patient to "Adhere to the treatment theme"	56%	
RS: An activity of PS is that the nurse supports the patient to remain committed to the treatment plan		91%
To explain the treatment process is an activity of PS.	76%	
To let the patient understand what the treatment entails is an activity of PS	68%	
RS: Giving the patient information to help the patient understand what the treatment entails, is an activity of PS		95%
To moderate the patient's thinking is an activity of PS	68%	
RS: As an activity of PS, the nurse supports the patient to arrange his thinking		81%
Support and encourage is an activity of PS	76%	
Help to analyze a complex activity and subdivide this in smaller activities together with the patient, is an activity of PS	88%	
To help to establish personal control for the patient, is an activity of PS	68%	
RS: To support the patient to establish personal control, is an activity of PS		86%
To confirm the positive attitude the patient showed in practicing skills, is an activity of PS	60%	
RS: An activity of PS is that the nurse confirms the patient's behavior when the patient was able or attempted to stick to an agreement		81%
For a nurse, a way to stop the behavior is to interact with the patient and redirect his behavior	64%	
RS: For a nurse, to try to stop the behavior is to interact with and support the patient to change his behavior		91%
To stop the patient's behavior, the nurse requests the patient to do or not do something	68%	
RS: To stop the patient's behavior, the nurse asks the patient to do or not to do something		62%
To stop the patient's behavior, the nurse may remind the patient of an agreement	72%	
To stop the patient's behavior, the nurse may mirror the patient's behavior and sets a boundary to his behavior	68%	
RS: To stop the patient's behavior, the nurse may verbalize an understanding of the patient's behavior and sets a boundary to his behavior		91%
To stop the patient's behavior, the nurse may try to distract the patient from his negative thoughts	60%	
RS: To stop the patient's behavior, and depending on the situation, the nurse may try to distract the patient from his negative thoughts		67%
To stop the patient's behavior, the nurse may confront the patient after the occurrence of an action	60%	
RS: To stop the patient's behavior in the future, the nurse and patient discuss the patient's behavior after the occurrence of an action		95%
To stop the patient's behavior, the nurse may prohibit the patient without room for negotiation	32%	
RS: To stop the patient's behavior, and in an unsafe situation, the nurse may prohibit the patient to do something		82%
To stop the patient's behavior, the nurse may use restraints	32%	
RS: To stop the patient's behavior, in a dangerous and unpredictable situation, the nurse may have to use restraints		52%

RS: Reformulated Statement following the original statement above

as: “the nurse may verbalize her understanding of the patient’s behavior” (91%). With regard to “confront after occurrence of an action” (60%), the experts suggested that it is important that “the actions are used to discuss the patient’s behavior with the aim of preventing the actions from happening again in the future” (95%). The statement concerned with prohibition (36%) became “the nurse in an unsafe situation may prohibit the patient from doing something in order to bring the behavior to a halt” and was subsequently accepted (82%).

Three other activity statements were neither accepted nor rejected in rounds 2 and 3 of the Delphi procedure: “Request to stop” (68%) was changed to “to ask to stop” , but still not widely accepted (62%). The comments on this statement emphasized that it is important to first understand and reflect upon the reasons for the patient’s behavior and then ask them to stop. The statement about distraction from the patient’s negative thoughts (60%) was judged to depend on the patient’s situation. Panel members commented that it is sometimes better to support the patient with emotions than try to distract them from their emotions; that it is sometimes better to validate a patient’s thoughts and feelings before suggesting alternative thinking. The reworded version of this statement almost showed sufficient agreement (67%) in D3. For the most restrictive way of stopping patient behavior, namely the use of restraint (32%), the experts recognized that this measure can be decided upon at times but only in a dangerous and unpredictable situation. Although this information was part of the revised statement, widespread agreement was still not found (52%).

### ***Delphi rounds 2 and 3: Identification of important contextual variables***

In Delphi rounds 2 and 3, the focus was further on the following research question: What contextual variables do the experts consider important for nurses providing structure?

Four statements related to contextual variables were presented in the second Delphi round. Three of these were immediately accepted in D2, indicating agreement on the relevance of: the presence of the nurse, the nurse’s knowledge of the patient’s situation, and the patient-group interaction. The remaining statement, namely “rules and limits are part of the context in which nurses provide structure” (68%), was changed to “an explanation of the value of rules and limits on the unit as part of PS” and then accepted in D3 (100%). As a result of the rewording with its emphasis on “explanation”, this context variable became a concrete activity. The experts further emphasized the importance of continual explanation as patient responses may change during the course of hospitalization and thus require other or additional explanation. What first may be perceived by the patient as a welcome and protective rule may later be perceived as overly restrictive, for example. This needs to be understood by the nurse, who can then give additional explanation about dealing with rules and possibly change the individual agreements made with the patient to provide a more suitable structure.

**Tabel 5: Statements presented in Delphi rounds 2 and 3for identification of contextual variables of importance for PS**

Statements related to contextual variables	Accepted in D2 (70%>)	Reformulated accepted or not in D3
Rules and limits are part of the context in which nurses provide structure	68%	
RS: An explanation about the value of rules and limits on the unit, is part of PS		100%
The presence of the nurse is a part of the context in which nurses provide structure	88%	
Nurse's knowledge of the patient's situation is a part of the context in which nurses provide structure	96%	
The patient-group-interaction is a part of the context in which nurses provide structure	84%	

RS: Reformulated Statement following the original statement above

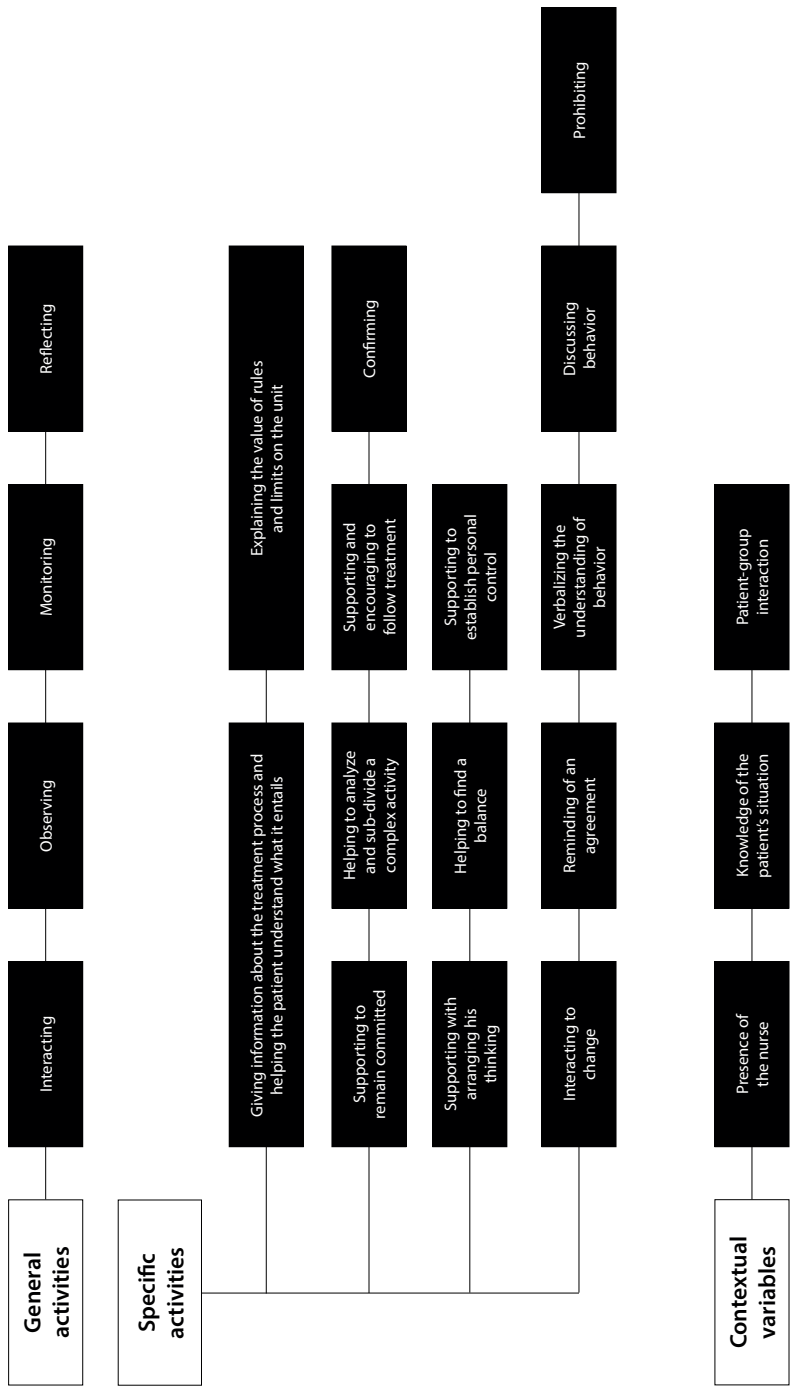
## Conclusion

The research questions motivating the presenting study were whether or not Delphi panel members can reach consensus on a definition of PS; on the general and specific activities that constitute essential components of PS; and on the contextual variables of importance for PS as a mental healthcare nursing intervention. On the basis of the scores and comments of the panel experts, we were able to formulate the following definition of PS.

*In psychiatric inpatient care, providing structure means helping patients with day rhythm and internal structure in addition to finding a balance between dealing with agreements and rules, on the one hand, and assisting patients with regaining personal control, on the other hand. For PS, a working alliance is established between nurse and patient with the nurse interacting with the patient, observing the reactions of a patient, monitoring the patient's state of mind, and reflecting upon patient behavior.*

In Figure 2, an overview is given of the general, specific activities, and contextual variables of importance for the effective use of PS as a mental healthcare nursing intervention. The experts in our Delphi study regarded the establishment of a working alliance between nurse and patient as a prerequisite for PS along with the following four general activities: interacting, observing, monitoring, and reflecting. In Figure 2, 14 specific activities identified as important are presented in no special (e.g., hierarchical) order. Some of the specific activities in Figure 2 can be seen to be related and form subgroups of activities such as: activities concerned with explanation; activities pointing out the need for commitment to the treatment plan; activities concerned with patient's

Figure 2. Providing Structure



control over situations; and activities concerned with the stopping of patient behavior. The first of the two activities concerned with explanation is to explain the treatment process and let the patient understand what the treatment entails. The second activity is explaining what the value of rules and limits are on the unit. Rules and limits can be perceived by patients as either a necessary and thus welcome protective structure or a source of undesired constraint and thus conflict. Explanation of the function of the rules and limits must therefore be repeatedly be given by nurses during hospitalization of a patient, which turned what we originally considered a contextual variable into a specific activity for PS.

The first of the four activities concerned with commitment to the treatment plan is that the nurse supports the patient to remain committed to the treatment plan. Patients emphasize the need for help with this from nurses. The second activity concerned with commitment to the treatment plan is the nurse helping the patient analyze and divide a complex activity into smaller, component activities together with the patient. The third activity is to support and encourage the patient to follow treatment as planned. And the fourth activity entails providing confirmation when the patient is able to stick to an agreement or when the patient shows a positive attitude towards attempting to stick to an agreement.

The first of the three activities concerned with patient control is the nurse support the patient with arranging his or her thinking, help the patient sort out thoughts, stay focused in a conversation , and delineate problems. The second of the three activities is that the nurse help to find a balance in dealing with ward rules and treatment agreements while regaining personal control. The third activity is that the nurse provide support for the patient to establish personal control — It refers to the coaching of the patient to find the structure that is needed.

The last subgroup of activities pertains to the stopping of certain patient behavior. The five component activities reflect a continuum of restrictiveness (Voogt et al., 2014). The least restrictive activity is the nurse who tries to stop a behavior by interacting with and supporting the patient to change the behavior. The nurse may furthermore try to stop the patient behavior by reminding the patient of a given agreement. Another way to try to stop the behavior is to verbalize the nurse's understanding of the patient's behavior and set a boundary on the behavior. An additional activity to prevent the reoccurrence of the patient behavior in the future is for the nurse and patient to discuss the patient's behavior after its occurrence. The last subtype of stopping behavior and more restrictive way of stopping patient behavior is for the nurse prohibiting the patient from doing something. When the patient remains restless after the use of less restrictive interventions or the situation appears unsafe, prohibition may be called for.

The experts on our panel confirmed the importance of the following three contextual variables for PS: the presence of the nurse, the nurse's knowledge of the patient's



situation, and the patient-group interaction. Presence of the nurse is related to the availability of the nurse on the ward and the connection between the patient and the nurse. It is also important for nurses to be well-informed about the patient's personal situation. This includes information about: the patient's personality, the patient's feelings, state of mind, current problems, and ways of coping with problems in addition to how the patient can and may interpret the behavior of others. The patient-group interaction is of obvious importance for PS. In a trusting group, patients are willing to do more on the ward and also for others. A trusting group can provide shelter for the individual who needs it, allowing them to leave others to speak at times or to practice with how to distinguish oneself from the other members of the group in an acceptable manner. Because the patients in a group do not know each other and do not know what to expect from each other, however, it is difficult to create a trusting group climate. Rules and limits can help to do this and also help to form a daily routine. As such, rules and limits provide structure.

## Discussion

This Delphi study can be viewed as the concluding part of the “development” phase in the design of a complex intervention (Medical Research Council, 2008). The development phase is aimed at the identification of relevant theory and an evidence base for the design of the complex intervention, on the one hand, and at the modelling of the processes and outcomes for the complex intervention, on the other hand.

The Delphi technique is characterized as a series of surveys interspersed with controlled feedback (Gill et al., 2013) in order to attain the collective opinion of a panel of experts. No statements were rejected outright in the present study although three statements related to the stopping of behavior did not attain sufficient agreement to be judged as accepted. The activity “ask to stop” was presented in the four previous studies as a regular question being posed in a situation without tension between the nurse and patient. In the comments of the panel experts, the importance of first trying to understand and reflect upon the reasons for the behavior of a patient before asking them to stop was emphasized. But even when this information was included in the statement to be evaluated, it did not elicit widespread agreement (62%). The most restrictive item, the use of restraints, showed the least agreement (52%). Based on the comments and scores reflecting “somewhat agree” (29%), the experts seem hesitant to agree to the use of restraint. In their comments they emphasized that it can be turned to as a last resort and thus in dangerous and unpredictable situations but then in a progression from the least to most restrictive stopping of patient behavior.

In line with the Guidelines of the Nursing Intervention Classification (Bulechek et al., 2010), PS can be described with a label, clearly defined, the activities it entails listed in logical order, and a short list of key background readings can be provided to support the intervention. For the formulation of PS as a mental healthcare

nursing intervention, we drew upon these guidelines. Experts commented that they saw a resemblance of the PS activities to some of the NIC activities, such as providing information on what the treatment of a patient entails and thus “teaching: procedure/treatment” (NIC 5618); confirm positive patient behavior and thus “role enhancement” (NIC 5370) or “coping enhancement” (NIC 5230); and distract from negative thoughts in relation to “cognitive restructuring” (NIC 4700). These suggestions from the experts may be helpful for the proposition that PS become part of the NIC in the future, but they also show that more research is needed to take this next step. The suggestion is to expand the development phase study to connect our current knowledge of PS to other theories of relevance for PS.

Following the development of a knowledge base and as part of the further development of a complex intervention, the MRC (2008) puts forth piloting, evaluation, and implementation as additional phases. PS is widely known and used as a psychiatric nursing intervention but not yet classified as a scientifically founded intervention in accordance with the requirements of the MRC framework (2008), and further research is thus needed.

## **Study strengths and limitations**

Based on the available literature, three Delphi rounds were judged to be necessary for the present study (Boelkedic et al., 2011). We thus informed the experts that their input and participation on the Delphi panel would last three rounds. This information presumably created clear expectations about the extent of required effort and time needed to respond. On the basis of this information and the enthusiastic reactions of the experts when they were asked to join the panel, we can understand the high response rates obtained for all of the Delphi rounds. However, this high responding may also indicate some response bias.

The statements presented in this Delphi study were based on a thorough review of the literature, an observational study, an interview study with patients, and an interview study with nurses. In other words, the statements represented a broad knowledge base for PS and a major strength of this study. Nevertheless, the Delphi panel consisted of 50% experts from the Netherlands and 50% experts from other countries. This may have led to a predominantly Dutch perspective on PS. The comments from the non-Dutch experts, however, showed similar recognition of both the relevance and challenges of PS.

## **Implications for practice and nursing research**

PS is often mentioned in nursing care plans, but practice is reported to be hindered by a lack of clarity about how to apply the intervention and inconsistent results of the application of the intervention. This implies that patients are likely to receive variable,

non-evidence informed, and sometimes conflicting care. The results of the present study show the complexity of PS with the variety of activities that it encompasses and the range of stopping behavior alternatives to be applied. At the same time, the results of the present study provide valuable insight into just how the activities and contextual variables of importance for PS are interconnected. Greater recognition of this interdependence can presumably enable the nurse to use PS more effectively. The current study offers a means for more systematic and thus reliable intervention with the presentation of a more uniform, empirically supported approach for a core psychiatric nursing intervention. The results of the present study may also allow nurses to discuss and define their approaches for PS. More detailed and more focused documentation of PS activities is also enabled (see Figure 2), thus allowing for greater clarity, continuity, and consistency of patient care plans.

The further importance of the present results is that they show that consensus has been reached on the definition of PS, core activities, and important contextual variables. The psychiatric nurse, but also other healthcare professionals and teams of healthcare workers, can use the information provided here to reflect on the occurrence and use of activities related to PS. And the insights provided by such reflection can help healthcare workers develop from novice to expert (Benner, 1982).

For generalizability, the empirical knowledge base for PS needs to be expanded. Nursing research concerned with PS therefore need to be replicated in open psychiatric settings and in community mental healthcare. In addition, research on PS as a mental healthcare intervention needs to progress to the next phases outlined in the MRC framework for the development and evaluation of complex interventions, namely the piloting, evaluation, and implementation of clearly formulated PS nursing interventions in the psychiatry. Despite the aforementioned limitations, we plan to proceed with a nursing study aimed at preparation of a submission of PS to be part of the Nursing Interventions Classification). The NIC (2010) does not presently include PS as an independent nursing intervention while available knowledge shows PS to be a valuable tool when used with care and a professional nursing attitude.

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# Chapter 7

## **Summary and General Discussion**







This chapter summarizes the main findings in relation to the three research questions and adds a discussion about Providing Structure as a nursing intervention in mental health care. The methodological considerations are discussed, followed by a discussion of strengths and limitations. Finally, practical implications for psychiatric nurses, suggestions for future research, and a final conclusion are described.

The main objectives of this thesis were to define Providing Structure (PS) as a nursing intervention in mental health care, and to provide for a proper design of PS as an intervention according to the requirements described in the MRC framework for the development and evaluation of complex interventions (MRC, 2008).

Three research questions were addressed throughout the research process:

1. What is the definition of PS?
2. Which activities are essential components of 'providing structure' as a nursing intervention in mental health care?
3. Which context-variables of PS are important for patients and nurses?

Answers to these research questions were given through the five studies, for which we summarize the main findings, following the research questions, below.

## The definition of Providing Structure

From our literature review (**Chapter 2**) suggested elements, goals, and effects of PS could be identified. Suggested elements of PS were the imposition and maintenance of rules and limits, the assessment of the condition of the patient, and interaction between nurse and patient. Goals of PS were formulated as the attainment of external security for the patient, making mutual expectations regarding the treatment relationship explicit, and promoting the experiences of better fitting into the world and recovery. However, no well-articulated studies about the effectiveness of PS could be found.

In the literature a continuum in the imposition and maintenance of rules and limits, seems of particular interest, namely the continuum that goes from general rules and limits up to very explicit rules and limits. On the basis of the literature the following provisional definition was formulated:

*The aim of PS is to create a workable, well-organized situation between nurse and patient in which both can work purposefully and effectively towards the strengthening of ego-functions, towards the attainment of external security for the patient, towards explicit mutual expectations within the treatment relationship, towards participation in different life areas and recovery on the*

*part of the patient. In order to do this, the nurse uses interaction, assesses the patient's condition, and imposes and maintains rules and limits in a balanced manner.*

Based on our observational study (**Chapter 3**) the process of PS could be described. In each phase of this process activities of both nurse and patients could be depicted. In this study we described three phases of a PS-event: the start of the interaction, the intervention phase, and the end of an interaction. We learned that the first response of the patient to a nurse was often a turning point in the event, which then could either escalate or remain peaceful.

As expected, it was impossible to understand how patients and nurses experienced the PS-events from observations alone. Therefore, we decided not to change the provisional definition at this stage.

In the following two studies we interviewed the main stakeholders, both nurses and patients. The interview study with patients (**Chapter 4**) revealed that patients expected the nurse to be aware of their being a patient and feeling vulnerable, to take them seriously and to allow them to take responsibility for ward routines, to inform them of what to do, and to be aware of their need to maintain autonomy. Patients rather talked about a relationship of trust with the nurse, about how to maintain autonomy and about the importance of explicate mutual expectations. Patients mentioned several nursing activities as part of PS, such as: gaining knowledge of the patient's situation; connecting with the patient; dealing with ward rules, times, and habits; applying the treatment plan; explaining and making the patient understand; and the moderation of the patient's thinking. The patients' expectations became part of our working definition of PS.

The interview study with nurses (**Chapter 5**) focused on their description, use and explanation of PS. Nurses discerned three purposes of PS, namely 1) to firmly adhere to established structures, rules, regulations and agreements, 2) to achieve rest, routine and hygiene, and 3) to promote the patients' personal control. Based on what nurses regarded important, the definition of PS was adapted with the addition of a working alliance between nurse and patient as an important element.

The fifth study (**Chapter 6**) was a Delphi-study with a panel of experts in the field of psychiatric nursing who were asked to rate statements about the definition, the activities and context-variables of PS. On the basis of the scores and comments on statements, we were able to formulate the following definition of PS:

*PS means helping with day rhythm and internal structure, and finding a balance between dealing with agreements and rules - on the one hand - and regaining personal control - on the other hand. To PS, a working alliance between nurse and patient is established, in which the nurse interacts with the patient, observes*

*a patient's reaction, monitors a patient's state of mind, and reflects upon patient behavior.*

On the basis of the guidelines from the Nursing Interventions Classification (Bulechek et al., 2010), we formulated the definition for use by nurses. The patient's expectations with regard to PS (Chapter 4), are not explicitly mentioned in this definition anymore, but remain an important aspect to guide nurses in the application of PS.

## Activities of providing structure

The second research question concerned the identification of activities as essential components of 'providing structure'.

In the literature review (**Chapter 2**) three elements or activities of PS were found: 1) imposing and maintaining rules and limits; 2) assessing the patient's condition; and 3) interacting. With regard to the first activity of Imposing and maintaining rules and limits, a continuum about least to most restrictive PS-activities was described. Least restrictive activities are verbal interaction and redirection. The most restrictive activities are seclusion and the use of restraints. Assessing the patient's condition is understood as assessing the patient's level of functioning using the elements of the Ego Competencies Model (Kerr, 1990a, 1990b). The last activity derived from the review – interacting –, was specified into the following sub-activities: relating to the patient, initiating a (non)-verbal interaction, exchanging mutual expectations, explaining the nursing care plan, and cooperating with patients.

On the basis of the observational study (**Chapter 3**) some nursing activities could be described in more detail. At the start of an event where providing structure takes place the nurse's activity is to ask a general or specific question. During the intervention-phase nurses may execute different activities, including: asking a patient for specific information; explaining something to the patient; supporting and encouraging the patient; or stopping behavior. At the end of the interaction, a nurse may reflect on the patient's behavior, act as agreed upon, concede to a patient to prevent further escalation, or set a clear boundary to stop behavior.

When we asked patients about their views on PS (**Chapter 4**), they mentioned six specific activities for nurses. Patients specifically mentioned that the nurse must inform herself about different aspects of the patient's situation and that the nurse must apply an individual approach (1) and remain connected with the patient (2). Furthermore patients described that nurses should deal with the combination of ward rules, times, and habits for the benefit of the patient (3), apply the treatment plan (4), and explain and make the patient understand it (5). As an important activity, patients introduced that nurses should help the patient to moderate his thinking, help delineate problems, and search for solutions (6).

The interview-study with nurses (**Chapter 5**) resulted in an overview of 4 general

activities, and 14 specific activities. The general activities nurses mentioned were: Interacting, observing, monitoring, and reflecting. The specific activities were called 'specific' because nurses' descriptions of them were more detailed and precise. Six of the 14 specific activities were aimed at establishing a working alliance: reassuring and explaining, inviting, finding a balance, dividing attention, keeping order in agreements, and maintaining or adapting rules. The other eight activities seemed to be aimed at helping with a day-rhythm and structure: adhering to the treatment theme, confirming behavior, mirroring behavior, breaking through behavior, explaining or checking appointments, analyzing activities, establishing personal control, and the moderation of thinking.

In the Delphi-study, the activities found from the four previous studies were analyzed to formulate statements about PS for panel members to score and comment upon (**Chapter 6**). In the last Delphi-round panel members reached consensus on the four general activities mentioned in the previous study, ten specific activities, and another 5 specific activities related to the stopping of behavior. The ten specific activities were: giving information to enable understanding of what the treatment plan entails, explaining the treatment process, explaining rules and limits, supporting and encouraging, remaining committed, arranging the thinking, analyzing and sub-dividing, finding a balance, confirming, and establishing personal control. The five specific activities related to the stopping of behavior were: interacting to change, reminding of an agreement, verbalizing behavior, discussing behavior, and prohibiting.

## Context variables of providing structure

In the literature review (**Chapter 2**) no explicit context variables were found, but, related to the goals of PS, suggestions to context were found, such as: a climate of trust, a trusting relationship between patient and nurse, an intrapersonal feeling of safety, and a physically controlled environment.

On the basis of observations (**Chapter 3**) we were not able to describe context variables of importance for the application of PS.

Patients mentioned three context variables of importance for PS (**Chapter 4**): the closed ward itself; the presence of the nurse; and the patient-group interaction. The closed ward is regarded as a protective structure, and can be a source of conflict at the same time. The presence of the nurse represents a feeling that the nurse stands beside the patient. The patient-group interaction is essential to be able to practice competencies safely. For patients it can be difficult to build a climate of trust with all these different patients and problems.

Nurses also referred to context-variables of PS (**Chapter 5**). Based on their views, we could formulate these as prerequisites for PS: The nurse must be visible, the nurse stands with the patient (metaphorically speaking), the nurse is well-informed about

the patient's character and personal situation, and the nurse allows the patient to talk about personal experiences, emotions, and frustrations.

Finally in the Delphi-study panel members reached consensus about three proposed context-variables (**Chapter 6**): presence of the nurse; patient-group interaction; and knowledge of the patient's situation.

## Discussion

### *PS and the NIC*

Frauenfelder et al. (2013) compared nursing interventions in journal articles on adult psychiatric inpatient nursing care to the interventions from the NIC, and found that 83% of the interventions were covered by the NIC, thus indicating that 17% of the interventions are not covered by the NIC. In the preparation of the literature review the search for keywords related to PS proved difficult. However, related keywords as limit/setting or use of structure indicated relevant sources to inform the elements of PS. One of the reasons that PS itself was not found was probably the lack of consensus and consistency on elements, activities and context-variables regarded to be attached to PS. Although psychiatric nurses might use the elements, activities and context-variables on a regular basis, the definition of PS and its activities are not available through standard nursing terminologies, for which the NIC is the most prominent guidance. With the study of Frauenfelder et al. in mind and with a view to their aim to learn how well the NIC-classification covered the realities of nursing in inpatient psychiatric settings, PS seem to belong to the missing 17% of interventions that are not described in the NIC. One of the reasons for this omission in the NIC could be that PS was seen as too complex to be studied, to unravel, to analyze and to describe, or –alternatively- rather taken for granted as too obvious to be a formal intervention.

### *The assessment of the patient's condition*

The assessment of the patient's condition was one of the key elements we found in the literature review. It was argued that a balanced use of PS could only occur after assessment of the patient's condition. Assessing the patient's condition is understood as assessing the patient's level of functioning using the elements of the Ego Competencies Model (Kerr, 1990a, 1990b). Patient's needs can be described after the assessment of nine ego-functions: impulse control, mood, judgement, reality testing, self-perception, object relations, thought processes, mastery of activities of daily living, and stimulus barrier. The Ego Competency Assessment Scale (ECAS) was found to be of use for nurses' assessment of ego-strengths and –deficits (Kerr, 1990a, 1990b). However, the validity of this instrument for

the assessment of the patient's condition, is not established. Other sources in the literature similarly emphasized the need of assessing the patient's condition (Delaney et al., 2000; Garritson, 1983; Kozub & Skidmore, 2001; Lancee, McCay, and Toner, 1995; Lowe, 1992; Lowe et al., 2003; Mohr, Mahon, and Noone, 1998; Morales & Duphorne, 1995; O'Brien et al., 2001; Olsen, 2001; Ransohoff et al., 1982; Vatne & Fagermoen, 2007), but no suggestions for other validated assessment instruments were done. However, in the interview studies, the need for assessing or monitoring was suggested by patients, and mentioned by nurses and nursing experts.

### ***Working alliance and interaction***

In the interview study with nurses both working alliance and interaction are mentioned and related to each other (See Figure 1, page 91). To establish a connection with the patient and thus achieve a professional working alliance with the patient, can be seen as an aim of PS. When this aim is attained, it increases the probability of the patient accepting proposed or imposed structure. One of the general activities we identified is that a nurse purposefully interacts with the patient. Although patients did not explicitly mention 'interaction', they referred to the need for interaction with nurses when they described the need to 'remain connected with the nurse'. The idea that 'interaction' should be consciously applied by nurses, is supported in the literature. Kozub and Skidmore (2001) regard interaction as one of the least restrictive verbal interventions, and describe interaction as referring to mutual expectations, explaining the nursing care plan, and cooperating with patients. Delaney (2009) relates interaction with health care providers to self-management and active participation of the patient in his own care. The importance of a working alliance and interaction is evident. From our studies, the first response of patient or nurse after the start of their interaction, proved a turning point in a PS-event which could either escalate or remain peaceful. Finally, the experts agreed that 'interaction' is a separate activity of PS. We therefore argue that in order to effectively apply PS, a working alliance must be established, and that interaction is applied as a PS-activity within the existing working alliance.

### ***Context variables***

The role of the context variables with regard to PS, is evident for patients and nurses. But, in our studies, the importance of the presence of the nurse, knowledge of the patient's situation, and patient-group interaction, is seen from the perspectives of closed wards. Nurses on similar wards must be aware of their importance for the application of PS. In other settings, the importance of these variables must be re-assessed, and possibly more context variables may appear. Yet unawareness of the context-variables may be a problem itself. Delaney (2009) for instance, refers

to ingrained role behaviors of staff; role behaviors that are acquired over time, unconsciously learned from behavior of role-models, usually more experienced peers who work alongside the novice staff members.

### *Similarities and differences in the studies*

In the literature review we found the continuum from least (interaction) to most restrictive interventions (use of restraints and seclusion) as important when considering PS. Reference to such a continuum was also found in the observational study and the interview study with nurses. The nursing activities in the observational study started with asking a patient for specific information and could end with stopping of behavior. Nursing experts in the Delphi-study were most explicit with regard to the stopping of behavior which could start with interacting in order to change the patient's behavior, and end up with prohibiting something. In contrast, patients did not refer to such a continuum or to nurses stopping their behavior. Patients emphasized supporting activities such as explaining and facilitating understanding, or moderation of thinking. They explicitly expected nurses to take their being a patient into account.

The four activities of interacting, observing, monitoring, and reflecting appeared in similar wordings in all studies, and therefore were regarded general activities in the application of PS by nursing experts in the Delphi-study.

In two of the five studies on PS, reference was made to PS as a process in which a variety of sub-activities can be applied. In the observational study on PS this was most explicit. In the literature a process of PS is described as ranging from attaining security (Benfer &

Schroder, 1985; Björkdahl et al., 2010; Vatne & Fagermoen, 2007; Vatne & Holmes, 2006; Vrale & Steen, 2005) to recovery from illness (O'Brien, 2000; O'Brien et al., 2001;

Vatne & Fagermoen, 2007; Vatne & Holmes, 2006). Nurses must therefore be aware that the PS-activities can be applied in different phases of the PS-process.

Noticeable is that, besides the PS-activities, both patients and nurses emphasize the importance of 1) patients' expectations towards nurses, and nurses' expectations towards patients, and 2) prerequisites for nurses to PS. Patients explicitly described that nurses should treat them with care (the patient being vulnerable but also needing to keep autonomy), and be there for them. Nurses acknowledged the importance of their visibility for patients, to be informed about their situation and personality, and to be able to talk about almost anything. Therefore, it seems that, most of the time, patients and nurses stand on the same side, except in tense situations. Then cooperation between patient and nurse becomes difficult, and PS-activities are difficult to execute.



## Methodological considerations

A qualitative approach was adopted to inform PS as a complex intervention. A literature review, participant observation, interviews with stakeholders and use of expert-panels proved a useful combination of approaches. These approaches helped to 'unravel the black box, which is the main challenge in modeling a complex intervention (Sermeus, 2015)'.

During the observations of PS reported in chapter 3, for the observer, the challenge was to be unobtrusive in order not to disturb usual ward routines. This required a certain distance from events, which could have led to incomplete observation and thus descriptions of events. Furthermore, observations were done at moments when 'events' of PS were most likely to take place, but events at other times could have been missed. A lack of variety in events could have resulted in incomplete descriptions of active components and their relations. The interviews reported in chapters 4 and 5 immediately followed the observed events to gain insight into the patients' and nurses' perceptions of the behavior of the individuals involved, and the significance of that behavior for the stakeholders. During the analytic process, we checked if data-saturation was reached. That point came when no additional information emerged from the data (i.e. codes and coding categories). Yet this saturation relates to the populations targeted. We regarded patients and nurses as the most relevant stakeholders. It could be argued that for a thorough description of components other stakeholders should have been identified such as physicians and psychologists. The observations and interviews were executed on two inpatient wards of one mental health care institute in the Netherlands. The data obtained on these wards and the analysis of these data was used for the preparation of the Delphi-study. But we may not assume that the results of these studies capture PS fully and the generalizability may be limited. With concern to the collection of data on two inpatient wards, generalizations cannot be made to outpatient settings, other wards and hospitals, other regions or country.

For our Delphi-study, the international experts were selected for their extensive knowledge in this field. However, the composition of the Delphi-panel with 50% experts from The Netherlands and 50% experts from other countries, may have led to a predominantly Dutch perspective on PS. The structure of the Delphi-study in three rounds was to reach consensus about the definition, activities and context-variables of PS. Although three rounds were judged to be necessary for a Delphi-study (Boelkedi et al., 2011), this in fact resulted in two remaining rounds to reach consensus about activities. This could have led to a lack of consensus for some activities related to the stopping of behavior.

With the overall research process and the subsequent research designs, the general aim to unravel the black box of PS, is partly reached. Although active components are



identified, questions remain if the overview of active components is fully complete, how the active components are inter-related, and what the effects of PS are. Also, in this qualitative research approach, the researcher had to be continuously aware of the danger of researcher bias in the selection of literature, observations, interviews, and experts, and in the analysis and interpretation of data. Because of this danger, for each study we thoroughly described the steps of the research process, and regularly reflected on these steps with the researchers involved.

The strength of the overall research process is that the design of the studies delivered the information from five different sources. With the combination of studies in this qualitative approach, data triangulation was reached and we were able to provide a comprehensive description of PS; a definition, the activities and context-variables.

## Practical implications for psychiatric nurses

When nurses consider the use of PS, they now must be aware that PS consists of general and specific activities, which must be applied in the light of contextual variables. Greater recognition of this interdependence can presumably enable nurses to use PS more effectively. The use of the term PS in treatment plans only, could cause confusion about what to do exactly in a given situation, what goals nurses aim for, and what effects they expect. Mentioning a specific activity in the treatment plan as part of PS, a goal related to that activity and expectations of its effects would probably contribute to more clear and precise aims for nursing care and contribute to effective negotiations with the patient about treatment. The activities listed as the results from the studies in this thesis could be used for this. Also, nurses can help shedding light on effects of PS by reporting the effects of their actions in patient records and by explicitly reporting on PS and its effects in the discussion of patient cases or treatment plans. Our studies offer a means for more systematic and thus reliable provision of structure with the presentation of a more uniform, empirically supported approach for a core psychiatric nursing intervention. The results of our studies may also allow nurses to discuss and define their approaches for PS.

Frauenfelder et al. (2013) mentioned that nurses should understand why and through which activities they perform interventions. Our study contributes to the recognition that PS is not sufficiently covered by the NIC, where elements of PS can be recognized from activities in various interventions, but where a coherent and comprehensive provision of structure recognized as a complex intervention with explicit goals in itself is lacking.

The psychiatric nurse, but also other healthcare professionals, can use our research and consensus based definition of PS and its activities and context variables to reflect on PS, as insights provided by such reflection can help healthcare workers develop from novice to expert (Benner, 1982). The description of PS enables psychiatric nurses to relate their activities, theories, and concepts in psychiatric nursing. When

they connect their knowledge to PS they themselves can contribute to the knowledge-base of PS, and can help fine tune treatment for a specific patient.

On the basis of our current research results on PS, a submission to the Nursing Interventions Classification can be prepared.

## Suggestions for future research

Future research should aim to further inform the inclusion of PS as an independent nursing intervention in the Nursing Intervention Classification (Bulechek et al., 2010), and to expand the empirical knowledge base for PS at the same time. Four suggestions for future research are proposed:

- The assessment of the patient's psychological condition is an important starting point for PS. Therefore, a study on assessment instruments should be undertaken and could compare available instruments on their relevance for PS.
- For reasons of generalization, the development-phase (MRC, 2008) should be replicated in outpatient settings and in community mental health care.
- To expand the knowledge-base for PS, a qualitative study can be conducted to relate other concepts in psychiatric nursing to the current description of PS, for example PS in relation to principles of cognitive behavioral therapy.
- In line with the description of PS in this thesis, early studies on the effectiveness of alternative activities within PS could be set-up as a first step in building evidence on PS.

## Final conclusion

By unraveling and building a psychiatric nursing intervention, the thesis adds to the insights about PS and psychiatric nursing. The definition of PS is:

*PS means helping with day rhythm and internal structure, and finding a balance between dealing with agreements and rules - on the one hand - and regaining personal control - on the other hand. To PS, a working alliance between nurse and patient is established, in which the nurse interacts with the patient, observes a patient's reaction, monitors a patient's state of mind, and reflects upon patient behavior.*

The essential components of PS are described in Figure 2 (page 117), together with the general and specific activities of PS, and its relevant context variables. With this description of PS, a part of the uncertainty about what PS is, has disappeared. These studies contributed to the knowledge base of psychiatric nursing, and should help nurses to underpin their activities to provide structure.

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# Chapter 8

**Samenvatting en discussie**







In dit hoofdstuk vatten we de resultaten samen met betrekking tot de drie onderzoeksvragen over ‘Structuur bieden’ als verpleegkundige interventie in de geestelijke gezondheidszorg. In de discussie-paragraaf beschouwen we deze onderzoeksresultaten en het gehele onderzoeksproces. Daarbij komen de sterke punten en beperkingen ervan aan bod. Tot slot worden de praktische implicaties voor psychiatrisch verpleegkundigen aangegeven, suggesties gedaan voor vervolgonderzoek, en een conclusie getrokken.

De belangrijkste doelen van het onderzoeksproject waren om Structuur bieden als een verpleegkundige interventie in de geestelijke gezondheidszorg te definiëren, en om een degelijk ontwerp van de interventie Structuur bieden te maken volgens de richtlijnen van het Medical Research Council ten behoeve van de ontwikkeling en evaluatie van complexe interventies (MRC, 2008).

Voor het onderzoeksproces zijn drie onderzoeksvragen geformuleerd:

1. Wat is de definitie van Structuur bieden?
2. Welke activiteiten vormen een essentieel onderdeel van de Structuur bieden als verpleegkundige interventie in de geestelijke gezondheidszorg?
3. Welke context-variabelen van Structuur bieden zijn voor patiënten en verpleegkundigen belangrijk?

Met behulp van vijf studies zijn antwoorden op deze drie vragen geformuleerd. De samenvatting van deze antwoorden wordt in onderstaande tekst beschreven.

## De definitie van Structuur bieden

Op basis van het literatuur-onderzoek (**Hoofdstuk 2**) konden de elementen, doelen en effecten van Structuur bieden worden geïdentificeerd. Die elementen van Structuur bieden zijn beschreven als het toepassen en behoud van regels en beperkingen, het inschatten van de conditie van de patiënt, en de interactie tussen verpleegkundige en patiënt. Doelen van Structuur bieden zijn als volgt geformuleerd: Er is een veilige omgeving voor de patiënt gecreëerd, de wederzijdse verwachtingen over de behandelrelatie zijn expliciet gemaakt, en er is expliciet aandacht besteed aan de persoonlijk ervaring van de patiënt met betrekking tot diens herstel en dat hij beter aan de maatschappij kan deelnemen. Helaas zijn er geen expliciete studies over de effecten van Structuur bieden gevonden.

In de literatuur valt één specifiek continuüm op bij het toepassen en behouden van regels en beperkingen, namelijk het continuüm dat reikt van generieke regels en beperkingen tot aan zeer expliciete regels en beperkingen. Op basis van de bevindingen uit de literatuur, is een voorlopige definitie geformuleerd:

*Het doel van Structuur bieden is om een werkbare, goed georganiseerde situatie tussen de verpleegkundige en de patiënt te creëren, waarin beiden doelgericht kunnen werken aan het versterken van ego-functies, aan een veilige omgeving voor de patiënt, aan expliciete wederzijdse verwachtingen binnen de behandelrelatie, en aan participatie op verschillende levensgebieden en herstel. Om dit te kunnen bereiken gebruikt de verpleegkundige interactie, schat de conditie van de patiënt in, en regels en beperkingen worden op een evenwichtige wijze toegepast en behouden.*

Gebaseerd op de observatie-studie (**Hoofdstuk 3**) kon het proces van Structuur bieden worden beschreven. Binnen elke fase van dit proces zijn activiteiten van zowel de verpleegkundige als de patiënt onderscheiden. Het gaat om de volgende drie fases: de start van de interactie, de interventie fase, en het einde van de interactie. Met name bleek dat de eerste reactie van de patiënt op de verpleegkundige een draaipunt was binnen de fasen van het contact tussen verpleegkundige en patiënt. De situatie tussen hen kon dan ofwel leiden tot escalatie ofwel vredig verlopen.

Zoals verwacht kon op basis van observaties alleen onvoldoende duidelijk worden hoe patiënten en verpleegkundigen zulke situaties ervaren. Daarom is naar aanleiding van de observatie-studie de voorlopige definitie niet aangepast.

In de daarop volgende twee studies zijn patiënten en verpleegkundige als de voornaamste belanghebbenden geïnterviewd. De interview-studie met patiënten (**Hoofdstuk 4**) onthulden verwachtingen van patiënten over verpleegkundigen, namelijk: Patiënten verwachten dat de verpleegkundige zich bewust is dat hij patiënt is en zich kwetsbaar voelt, dat de verpleegkundige hem serieus neemt en hem toestaat verantwoordelijkheid te nemen voor afdelingstaken, dat hij geïnformeerd wordt wat hij moet doen, en dat de verpleegkundige zich bewust is dat de patiënt zijn autonomie wil behouden. Patiënten praten bij voorkeur over een vertrouwensrelatie met de verpleegkundige, over hoe hij autonomie kan behouden, en over het belang dat wederzijdse verwachtingen worden uitgewisseld. Zij noemden verschillende verpleegkundige activiteiten als onderdeel van Structuur bieden, zoals: kennis vergaren over de situatie van de patiënt, verbinden met de patiënt, leren omgaan met afdelingsregels, -tijden en -gewoonten, het behandelplan toepassen, uitleggen en ervoor zorgen dat de patiënt dingen begrijpt, en het ordenen van de gedachten van de patiënt. De verwachtingen van de patiënt zijn onderdeel geworden van de werkdefinitie van Structuur bieden.

De interview-studie met verpleegkundigen (**Hoofdstuk 5**) richtte zich op hun beschrijving, het gebruik en de uitleg van Structuur bieden. Verpleegkundigen onderscheidden drie doelen van Structuur bieden: 1. Krachtig vasthouden aan vastgestelde structuren, regels, regelementen en afspraken, 2. Het bereiken van rust, routine en reinheid, en 3. Het stimuleren van persoonlijke controle van de patiënt.

Op basis van wat de verpleegkundige van belang vonden, is de definitie van Structuur bieden aangepast, en is als belangrijk element de term 'samenwerkingsrelatie tussen verpleegkundige en patiënt' toegevoegd.

De vijfde en laatste studie betrof een Delphi-studie (**Hoofdstuk 6**). Een (Inter) nationaal panel van experts in de psychiatrische verpleegkunde heeft stellingen over de definitie, activiteiten en context-variabelen beoordeeld. Op basis van deze scores en commentaren van experts, is de definitie van Structuur bieden aangepast.

*Structuur bieden betekent helpen met het dag-ritme en interne structuur, en het vinden van een balans tussen het omgaan met afspraken en regels aan de ene kant, en het verwerven van persoonlijke controle aan de andere kant. Om Structuur te bieden is een samenwerkingsrelatie tussen verpleegkundige en patiënt opgebouwd, waarin de verpleegkundige interacteert met de patiënt, de reactie van de patiënt observeert, de psychische gesteldheid van de patiënt monitort, en reflecteert op het gedrag van de patiënt.*

Op basis van de richtlijnen van de Nursing Interventions Classification (Bulechek et al., 2010), is deze definitie voor verpleegkundigen geformuleerd. De verwachtingen van de patiënt ten aanzien van Structuur bieden (**Hoofdstuk 4**), zijn niet meer expliciet in deze definitie opgenomen, maar vormen een belangrijk aspect bij de toepassing van Structuur bieden door verpleegkundigen.

## Activiteiten van Structuur bieden

De tweede onderzoeksvraag betrof het beschrijven van de activiteiten van Structuur bieden. In de literatuur-studie (**Hoofdstuk 2**) zijn drie activiteiten gevonden: 1. Het toepassen en behouden van regels en beperkingen, 2. Het inschatten van de conditie van de patiënt, en 3. Het interacteren. Met betrekking tot het toepassen en behouden van regels en beperkingen, is een continuüm van minst naar de meest beperkende activiteiten van Structuur bieden beschreven. De minst beperkende activiteiten zijn verbale interactie en omleiden (van het denken en van gedrag). De meest beperkende activiteiten zijn het afzonderen en het gebruik van beperkende maatregelen (zoals polsbanden, een zweedse band enz.). Het inschatten van de conditie van de patiënt richt zich op het niveau van functioneren vanuit de elementen van het Ego Competencies Model (Kerr, 1990a, 1990b). De laatste activiteit betreft het interacteren, welke bestaat uit de volgende specifieke activiteiten: je met de patiënt verbinden, een (non-) verbale interactie uiten, wederzijdse verwachtingen expliciteren, het verpleegplan uitleggen, en samenwerken met patiënten.

De observatie-studie (**Hoofdstuk 3**) leidde tot meer gedetailleerde beschrijvingen van verpleegkundige activiteiten. Bij de start van een situatie waarin structuur werd geboden, de verpleegkundige activiteit is het stellen van een algemene of specifieke

vraag. Gedurende de interventie-fase passen verpleegkundigen vervolgens andere activiteiten toe, zoals: de patiënt om meer specifieke informatie vragen, de patiënt iets uitleggen, de patiënt ondersteunen en aanmoedigen, of juist het stoppen van diens gedrag. Op het einde van de interactie, reflecteert de verpleegkundige met de patiënt op diens gedrag, acteert zoals met hem afgesproken, geeft aan de patiënt toe om escalatie te voorkomen, of stelt een heldere grens om het gedrag te stoppen.

Toen we patiënten naar hun visie op Structuur bieden vroegen (**Hoofdstuk 4**), noemden zij 6 specifieke activiteiten van verpleegkundigen. De verpleegkundige moet zich goed informeren over de verschillende aspecten van de situatie van de patiënt en een individuele benadering gebruiken (1), en in verbinding met de patiënt blijven (2). Verpleegkundigen moeten omgaan met de combinatie van afdelingsregels, -tijden, en -gewoonten ten behoeve van het welzijn van de patiënt (3), het behandelplan toepassen (4), en ervoor zorgen dat de patiënt dat ook begrijpt (5). Ook horen verpleegkundigen de patiënt te helpen bij het ordenen van gedachten, problemen goed in kaart te helpen brengen, en te helpen naar het zoeken van oplossingen (6).

De interview-studie met verpleegkundigen (**Hoofdstuk 5**) bood een overzicht van 4 generieke activiteiten en 14 specifieke activiteiten. Generieke activiteiten zijn: interacteren, observeren, monitoren, en reflecteren. De specifieke activiteiten zijn in hun formulering meer gedetailleerd en precies. 6 van de 14 specifieke activiteiten waren gericht op bereiken van een samenwerkingsrelatie: geruststellen en uitleggen, uitnodigen, een balans vinden, aandacht verdelen, volgorde houden in de uitvoering van afspraken, en het behouden dan wel aanpassen van regels. De andere 8 activiteiten leken gericht op het helpen met een dag-ritme en structuur: Vasthouden aan de rode draad in de behandeling, gedrag bevestigen, gedrag spiegelen, gedrag doorbreken, uitleggen of controleren van afspraken, activiteiten analyseren, persoonlijke controle bereiken, en ordenen van gedachten.

In de Delphi-studie (**Hoofdstuk 6**) zijn de activiteiten uit de vorige studies geanalyseerd om stellingen te kunnen formuleren over Structuur bieden zodat panelleden konden scoren en commentaar leveren. In de laatste Delphi-ronde bereikten panelleden consensus op 4 generieke activiteiten, 10 specifieke activiteiten, en nog 5 specifieke activiteiten ten aanzien van stoppen van gedrag. De 10 specifieke activiteiten zijn: het geven van informatie om de patiënt in staat te stellen te begrijpen wat het behandelplan inhoudt, het uitleggen van het behandelproces, het uitleggen van regels en beperkingen, ondersteunen en aanmoedigen, betrokken blijven, de gedachten ordenen, analyseren en onderverdelen, een balans vinden, bevestigen, en persoonlijke controle bereiken. De 5 specifieke activiteiten ten aanzien van het stoppen van gedrag zijn: interacteren om te veranderen, herinneren aan een afspraak, gedrag verwoorden, discussiëren over het gedrag, en iets verbieden te doen.

## Context variabelen van Structuur bieden

In de literatuur-studie (**Hoofdstuk 2**) zijn geen expliciete context variabelen genoemd, maar wel verwijzingen naar context variabelen gerelateerd aan de doelen van Structuur bieden, zoals: een klimaat van vertrouwen, een relatie van vertrouwen tussen verpleegkundige en patiënt, een innerlijk gevoel van veiligheid bij de patiënt, en een fysiek veilige omgeving.

Op basis van de observatie-studie (**Hoofdstuk 3**) waren we niet in staat om belangrijke context variabelen te beschrijven die relevant zijn voor de toepassing van Structuur bieden.

Patiënten noemen drie belangrijk context variabelen om structuur te kunnen bieden (**Hoofdstuk 4**), namelijk: de gesloten afdeling op zich zelf, de aanwezigheid van de verpleegkundige, en de interactie tussen patiënt en de patiëntengroep. De gesloten afdeling kan als een beschermende structuur worden gezien, maar het kan tegelijkertijd een bron van conflicten zijn. De aanwezigheid van de verpleegkundig wordt ervaren als een gevoel dat de verpleegkundige letterlijk en/of figuurlijk naast de patiënt staat. De interactie tussen patiënt en de patiëntengroep is essentieel om veilig te kunnen oefenen in de ontwikkeling van competenties. Maar voor patiënten kan het erg moeilijk zijn een vertrouwensklimaat op te bouwen met alle verschillende patiënten en hun problemen.

Ook verpleegkundigen noemen een aantal context variabelen van Structuur bieden (**Hoofdstuk 5**). Verpleegkundigen spreken dan over noodzakelijke voorwaarden om structuur te kunnen bieden, zoals: de verpleegkundige moet zichtbaar zijn, de verpleegkundige staat figuurlijk gezien naast de patiënt, de verpleegkundige is goed geïnformeerd over het karakter van de patiënt en diens persoonlijke situatie, en de verpleegkundige laat de patiënt over zijn persoonlijke ervaringen, emoties en frustraties praten.

Tot slot bereikten panelleden in de Delphi-studie consensus over drie voorgestelde context variabelen (**Hoofdstuk 6**): De aanwezigheid van de verpleegkundige, de interactie tussen patiënt en de patiëntengroep, en de kennis over de situatie van de patiënt.

## Discussie

### *Structuur bieden en de NIC*

Frauenfelder et al. (2013) vergeleken verpleegkundige interventies genoemd in wetenschappelijke artikelen over de verpleegkundige zorg bij volwassen psychiatrische patiënten op een gesloten setting met de interventies uit de Nursing Interventions Classification (NIC). Zij vonden dat 83% van die verpleegkundige interventies in de NIC werden genoemd. 17% van de interventies zijn dus niet in

de NIC te vinden. Bij de voorbereiding van de literatuur-studie was het moeilijk om relevante zoektermen in relatie tot Structuur bieden te vinden. Maar met daaraan gerelateerde zoektermen, zoals grenzen stellen, of het gebruik van structuur, zijn literatuurbronnen over de elementen van Structuur bieden gevonden. Een van de redenen dat Structuur bieden op zichzelf als zoekterm niet beschreven was, was waarschijnlijk het gebrek aan consensus en eenduidigheid ten aanzien van de elementen, activiteiten en context variabelen die zijn verbonden aan Structuur bieden. Hoewel psychiatisch verpleegkundigen de elementen, activiteiten en context variabelen regelmatig gebruiken, zijn de definitie en de activiteiten van Structuur bieden niet beschreven in de standaard verpleegkundige terminologieën, zoals de NIC. Met de studie van Frauenfelder in het achterhoofd en hun doel te ontdekken hoe goed de NIC-classificatie de relatie van de psychiatisch verpleegkundige op gesloten settings beschrijft, blijkt Structuur bieden te horen bij die 17% van de interventies die niet in de NIC zijn beschreven. Een van de redenen hiervan zou kunnen zijn dat Structuur bieden te complex is om te bestuderen, om te ontrafelen, te analyseren en te beschrijven. Structuur bieden is zo gewoon dat het niet als een belangrijk interventie wordt gezien.

### *De inschatting van de conditie van de patiënt*

De inschatting van de conditie van de patiënt was een van de belangrijk elementen uit de literatuur-studie. Een evenwichtig gebruik van Structuur bieden was alleen mogelijk na een inschatting van de conditie van de patiënt. Het inschatten van de conditie van de patiënt is geïnterpreteerd als het inschatten van het niveau van functioneren van de patiënt volgens de elementen van het Ego Competenties Model (Kerr, 1990a, 1990b). De behoeften van de patiënt konden worden beschreven door middel van de inschatting op negen ego-functies: impuls-controle, stemming, beoordelingsvermogen, reality-testing, zelf-perceptie, object relaties, denkprocessen, ADL, en stimulus barriere. De Ego Competencies Assessment Scale (ECAS) leek bruikbaar voor verpleegkundigen om ego-sterkten en ego-tekorten in te schatten (Kerr, 1990a, 1990b). Maar, de validiteit van dit inschattings-instrument bleek niet onderbouwd. Andere literatuurbronnen benadrukten op vergelijkbare wijze de noodzaak om patiënten-behoeften in te schatten (Delaney et al., 2000; Garritson, 1983; Kozub & Skidmore, 2001; Lancee, McCay, and Toner, 1995; Lowe, 1992; Lowe et al., 2003; Mohr, Mahon, and Noone, 1998; Morales & Duphorne, 1995; O'Brien et al., 2001; Olsen, 2001; Ransohoff et al., 1982; Vatne & Fagermoen, 2007), maar geen van hen noemden andere vormen van gevalideerde inschattings-instrumenten. In de interview-studies werden door zowel patiënten, verpleegkundigen, als de verpleegkundige experts de noodzaak van het inschatten of monitoren van de conditie van de patiënt ten behoeve van het Structuur bieden, genoemd.

## *Samenwerking en interactie*

In de interview-studie met verpleegkundigen zijn samenwerking en interactie in relatie tot elkaar genoemd (Zie Figuur 1, blz. 91). Een doel van Structuur bieden kan zijn om een connectie met de patiënt te maken en een professionele samenwerking met de patiënt te bereiken. Als dat doel is bereikt, verhoogt dat de waarschijnlijkheid dat de patiënt de voorgestelde of opgelegde structuur accepteert. Een van de generieke activiteiten van Structuur bieden is dat de verpleegkundige bewust interacteert met de patiënt. Hoewel patiënten zelf niet de interactie met de verpleegkundige expliciet noemen, verwezen zij er wel naar en noemden dat de behoefte om met de verpleegkundige verbonden te zijn en te blijven. Het idee om 'interactie' als verpleegkundigen bewust toe te passen, wordt door de literatuur bevestigd. Kozub en Skidmore (2001) beschouwen 'interactie' als een van de minst beperkende verbale interventies. Zij beschrijven interactie als een verwijzing naar het expliciteren van wederzijdse verwachtingen, het uitleggen van het verpleegplan, en het samenwerken met patiënten. Delaney (2009) verbindt interactie door hulpverleners met zelfmanagement en actieve participatie van de patiënt bij zijn eigen zorg. Het belang van samenwerking en interactie is duidelijk. In onze studies bleek de eerste respons van de patiënt of van de verpleegkundige na de start van hun interactie, een cruciaal moment in een situatie waarin structuur werd geboden. Op dat moment kon de situatie escaleren dan wel rustig blijven. Tot slot stemden de verpleegkundig experts in met 'interactie' als een op zich zelf staande activiteit binnen het Structuur bieden. Om in staat te zijn effectief Structuur te bieden, pleiten we ervoor dat een samenwerking tussen patiënt en verpleegkundige moet zijn ontstaan, en dat daarbij interactie als activiteit van Structuur bieden, bewust toegepast moet worden.

## *Context variabelen*

De rol van de context variabelen van Structuur bieden is voor patiënten en verpleegkundigen evident. Maar in onze studies, wordt het belang van de aanwezigheid van de verpleegkundige, de kennis van de situatie van de patiënt, en de interactie tussen patiënt en de patiëntengroep, gezien vanuit het perspectief van de gesloten afdelingen. Verpleegkundigen die op vergelijkbare afdelingen werken moeten zich bewust zijn van het belang van deze context variabelen bij de toepassing van Structuur bieden. In andere settings moet het belang van deze context variabelen opnieuw worden ingeschat, en misschien zullen dan meer context variabelen verschijnen. Maar als men zich niet bewust is van deze variabelen, kan dat een probleem op zichzelf vormen. Delaney (2009) bijvoorbeeld refereert aan gedragingen van verpleegkundigen die gedurende langere tijd onbewust zijn ingesloten, die onbewust worden doorgegeven aan pas beginnende verpleegkundigen via rolmodellen c.q. de over het algemeen ervaren verpleegkundigen op de afdeling.



## *Overeenkomsten en verschillen tussen de studies*

In de literatuur-studie bleek het continuüm van minst (interactie) tot meest beperkende interventies (gebruik van vrijheidsbeperkende middelen zoals Zweedse banden of afzondering) van belang bij het Structuur bieden. In de observatie-studie en de interview-studie met verpleegkundigen werd ook aan zo'n continuüm gerefereerd. De verpleegkundige activiteiten in de observatie-studie startten met aan de patiënt specifieke informatie vragen, en konden eindigen met het laten stoppen van gedrag van de patiënt. Verpleegkundige experts in de Delphi-studie noemden expliciet dat het laten stoppen van het gedrag van de patiënt kon starten met het aangaan van een interactie om zo het gedrag te veranderen, maar kon eindigen met het verbieden om iets te doen. In tegenstelling tot deze bevindingen, werd zo'n continuüm niet door patiënten genoemd en noemden zij ook niet dat verpleegkundigen hun gedrag soms stopten. Patiënten refereerden eerder aan ondersteunende activiteiten zoals het uitleggen, het hen makkelijker maken om iets te begrijpen, of het ordenen van gedachten. Patiënten verwachten van de verpleegkundigen dat zij er vooral rekening mee houden dat ze patiënt zijn.

De vier activiteiten interacteren, observeren, monitoren en reflecteren kwamen in alle studies in vergelijkbare bewoordingen terug. Daarom beschouwden de verpleegkundige experts uit de Delphi-studie ze als generieke activiteiten bij het bieden van structuur.

In twee van de vijf studies, werd verwezen naar Structuur bieden als een proces waarin in gedurende dat proces verschillende activiteiten worden toegepast. Met name in de observatie-studie werd een proces van Structuur bieden duidelijk. In de literatuur beschreef men een proces van Structuur bieden met het zorgen voor veiligheid aan de ene kant (Benfer & Schroder, 1985; Björkdahl et al., 2010; Vatne & Fagermoen, 2007; Vatne & Holmes, 2006; Vrale & Steen, 2005) tot het herstellen van ziekte aan de andere kant (O'Brien, 2000; O'Brien et al., 2001; Vatne & Fagermoen, 2007; Vatne & Holmes, 2006).

Verpleegkundigen moeten zich er daarom van bewust zijn dat Structuur biedende activiteiten in verschillende fasen van een proces toegepast worden.

Bijzonder is dat naast de Structuur biedende activiteiten, zowel patiënten als verpleegkundigen het belang benadrukken van de verwachtingen van de patiënt naar de verpleegkundige (en v.v.), en de voorwaarden ten aanzien van verpleegkundigen om structuur te kunnen bieden. Patiënten benoemden expliciet dat verpleegkundigen hen met enige voorzichtigheid moeten begeleiden, omdat ze kwetsbaar zijn en tegelijk behoefte hebben hun autonomie te behouden. Verpleegkundigen moeten er vooral 'voor hen zijn'. Verpleegkundigen bevestigen het belang om zichtbaar te zijn voor patiënten, om goed over de patiënt (de persoonlijke situatie en diens persoonlijkheid) geïnformeerd te zijn, en over alles wat de patiënt bezig houdt te kunnen praten. Daarom lijkt het er op dat over het algemeen en meestal de patiënt



en de verpleegkundige aan dezelfde kant staan, behalve in spannende situaties. Dan wordt de samenwerking tussen hen lastiger, en zijn Structuur biedende activiteiten moeilijker uit te voeren.

## Methodologische beschouwingen

Om Structuur bieden als complexe interventie te gaan beschrijven, is een kwalitatieve onderzoeksbenadering gekozen, en verschillende deelstudies uitgevoerd m.b.v. onderzoek van literatuur, participerende observatie, interviews met betrokkenen, en een consensus-studie met een (Inter)nationaal samengesteld panel van verpleegkundige experts. De combinatie van studies hielpen om ‘de zwarte doos te ontrafelen, de voornaamste uitdaging in het modelleren van een complexe interventie’ (Sermeus, 2015).

Tijdens de observaties van Structuur bieden (Hoofdstuk 3) was het voor de observator de uitdaging om zo min mogelijk op te vallen om de normale gang van zaken op een afdeling niet te verstoren. Daarom bevond de observator zich op gepaste afstand van de situatie waarin tussen patiënt en verpleegkundige structuur werd geboden. Dat heeft mogelijk geleid tot incomplete observaties en dus incomplete beschrijvingen van die situaties. Verder zijn de observaties vooral uitgevoerd op tijden waarin het zeer waarschijnlijk was dat structuur-situaties zich zouden voordoen. Daarmee zouden structuur-situaties op andere tijden kunnen zijn gemist. Het gebrek aan variatie in structuur-situaties kan hebben geleid tot een incomplete beschrijving van (de relatie tussen) actieve componenten van Structuur bieden.

De interviews uit hoofdstuk 4 en 5 volgden direct op geobserveerde structuur-situaties om inzicht te verkrijgen in de beleving van patiënten en verpleegkundigen ten aanzien van het vertoonde gedrag van betrokken individuen, en de betekenis van dat gedrag voor betrokkenen. Gedurende het analytisch proces beoordeelden we of data-saturatie was bereikt. Dat moment werd bereikt toen er geen nieuwe informatie (nieuwe codes of code-categorieën) uit de data naar boven kwam. Maar de verzadiging van data is gerelateerd aan de onderzoekspopulatie waarin we de patiënten en verpleegkundigen op de onderzochte afdelingen als meest relevante betrokkenen beschouwden. Voor een meer doorwrochte beschrijving van componenten van Structuur bieden zouden ook artsen en psychologen kunnen worden betrokken.

De observaties en interviews zijn uitgevoerd op twee gesloten units in een psychiatrisch ziekenhuis in Nederland. De data die daarbij zijn verzameld en de analyse ervan zijn gebruikt voor de voorbereiding van de Delphi-studie. Maar we mogen er niet van uitgaan dat we op basis van de vijf studies Structuur bieden in zijn geheel hebben kunnen omvatten. Generaliseerbaarheid van resultaten kan daarom beperkt zijn, bijvoorbeeld ten aanzien van de toepassing van de resultaten in de ambulante geestelijke gezondheidszorg, op andere afdelingen en andere psychiatrische ziekenhuizen, of binnen ander provincies en landen.

Voor de Delphi-studie zijn (inter)nationale verpleegkundige experts benaderd die in bezit waren van uitgebreide kennis en expertise in dit werkveld. De experts waren voor 50% Nederlands en 50% uit andere landen afkomstig. Dat zou mogelijk geleid kunnen hebben tot een dominant Nederlands perspectief op Structuur bieden. De Delphi-studie bestond uit drie ronden om consensus te bereiken over de definitie, de activiteiten en de context-variabelen van Structuur bieden. Hoewel over het algemeen drie ronden in een Delphi-studie als voldoende worden beschouwd (Boelkedi et al., 2011), was het resultaat daarvan dat alleen ronde 2 en 3 konden worden gebruikt om consensus te bereiken over de activiteiten. Dat kan hebben geleid tot de verminderde consensus over activiteiten die aan het stoppen van het gedrag waren verbonden. Met behulp van het gehele onderzoeksproces en de onderliggende onderzoeksdesigns is het algemene doel om de zwarte doos te ontrafelen deels bereikt. Actieve componenten van Structuur bieden zijn beschreven, maar er blijven vragen over, zoals: Is het overzicht van alle actieve componenten compleet?, Hoe zijn de actieve componenten met elkaar verbonden?, en Wat zijn de effecten van Structuur bieden? Met de kwalitatieve onderzoeksbenadering moest de onderzoeker zich continu bewust zijn van het gevaar van onderzoekersbias ten aanzien van de selectie van literatuur, observaties, interviews, en experts, en tijdens de analyse van data. Vanwege dat gevaar, zijn de onderzoeksstappen zorgvuldig beschreven, en is regelmatig gereflecteerd op deze onderzoeksstappen met de andere betrokken onderzoekers. De kracht van het gehele onderzoeksproces is dat het design van de studies informatie uit vijf verschillende bronnen opleverde. Met de kwalitatieve onderzoeksbenadering en met de combinatie van studies is data-triangulatie bereikt. Daardoor waren we in staat een omvattende beschrijving van Structuur bieden te maken: over een definitie, de activiteiten, en de context-variabelen.

## **Praktische gevolgen voor psychiatrische verpleegkundigen**

Als verpleegkundigen Structuur bieden gebruiken, zullen zij zich nu bewust moeten zijn dat Structuur bieden uit algemene en specifieke interventies bestaat, die toegepast moeten worden rekening houdend met context-variabelen. Groter besef van de afhankelijkheid van activiteiten tussen elkaar en tussen activiteiten en context-variabelen kan ertoe leiden dat verpleegkundigen Structuur bieden effectiever kunnen gaan inzetten.

Wanneer in het behandelplan alleen de term Structuur bieden wordt genoemd, kan dat tot verwarring leiden over wat precies te doen in een bepaalde situatie, over wat je als verpleegkundige tot doel stelt, en welke effecten je verwacht.

Het noemen van een specifieke activiteit in het behandelplan als onderdeel van Structuur bieden, een doel noemen gerelateerd aan die activiteit en verwachtingen over de effecten ervan, zal waarschijnlijk bijdragen tot heldere en precieze doelen van verpleegkundige zorg en bijdragen tot effectieve onderhandelingen met de patiënt

over diens behandeling. De activiteiten die voort zijn gevloeid uit de vijf studies kunnen daarvoor worden gebruikt. Verpleegkundigen kunnen zicht krijgen op de effecten van Structuur bieden door de effecten in relatie tot Structuur bieden te rapporteren, en door expliciet over structuur biedende activiteiten en de effecten te discussiëren tijdens casuïstiek- en behandelbesprekingen.

Met behulp van de studies kan Structuur bieden systematische en betrouwbaar toegepast worden door een uniforme, empirisch ondersteunde benadering van een centrale psychiatrisch verpleegkundige interventie. De resultaten van de studies stellen verpleegkundigen in staat te discussiëren over Structuur bieden en de eigen benaderingswijze te bepalen.

Frauenfelder et al. (2013) stellen dat verpleegkundigen zullen moeten begrijpen waarom en via welke activiteiten zij interventies uitvoeren. Onze studie draagt bij aan het besef dat Structuur bieden niet voldoende is beschreven in de Nursing Interventions Classification (NIC), waarin elementen van Structuur bieden alleen te vinden zijn bij activiteiten van verschillende interventies. In de NIC ontbreekt een volledige en omvattende beschrijving van Structuur bieden als een complexe interventie met expliciete doelstellingen.

De psychiatrisch verpleegkundige, maar ook andere zorgprofessionals, kunnen onze definitie van Structuur bieden, de activiteiten en de context-variabelen, gebruiken om te reflecteren op Structuur bieden. De inzichten die dat oplevert kan hulpverleners helpen zich te ontwikkelen van novice to expert (Benner, 1982). De beschrijving van Structuur bieden stelt psychiatrisch verpleegkundigen in staat om hun activiteiten, theorieën, en concepten over in psychiatrische verpleegkunde met elkaar te verbinden. Wanneer zij hun eigen kennis verbinden met Structuur bieden, dan kunnen zij zelf bijdragen aan de 'knowledge base' van Structuur bieden, en zo helpen de behandeling van een specifieke patiënt te vervolmaken.

Op basis van de huidige onderzoeksresultaten over Structuur bieden, kan de indiening ten behoeve van de Nursing Interventions Classification voorbereid worden.

## Suggesties voor vervolgonderzoek

In de toekomst kan onderzoek verricht worden om Structuur bieden als een onafhankelijke interventie op te nemen in de Nursing Interventions Classification (Bulechek et al., 2010), en om het kennisfundament over Structuur bieden uit te breiden. De volgende vier suggesties voor onderzoek worden genoemd:

- Het inschatten van de psychische conditie van de patiënt is een belangrijk startpunt voor Structuur bieden. Daarom is het nodig om een studie uit te voeren naar assessment-instrumenten en deze met elkaar te vergelijken op hun relevantie voor het bieden van structuur.
- Om te kunnen generaliseren zal het onderzoek uit de ontwikkelingsfase van de

interventie (MRC, 2008) herhaald moeten worden buiten klinische settings in de ambulante zorg.

- Om het kennisfundament uit te breiden, kan een kwalitatieve studie worden uitgevoerd om andere concepten in de psychiatrische verpleegkunde te verbinden aan de huidige beschrijving van Structuur bieden, zoals bijvoorbeeld Structuur bieden in relatie tot de principes van gedragstherapie.
- Volgend op de beschrijving van Structuur bieden in deze thesis, kunnen studies over de effectiviteit van activiteiten binnen Structuur bieden worden opgezet als een eerste stap om 'evidence' over Structuur bieden op te kunnen bouwen.

## Eindconclusie

Door het ontrafelen van en bouwen aan een psychiatrisch verpleegkundige interventie, draagt deze thesis bij aan inzichten over Structuur bieden en de psychiatrische verpleegkunde. De definitie van Structuur bieden is als volgt:

*Structuur bieden betekent helpen met het dag-ritme en interne structuur, en het vinden van een balans tussen het omgaan met afspraken en regels aan de ene kant, en het verwerven van persoonlijke controle aan de andere kant. Om Structuur te bieden is een samenwerkingsrelatie tussen verpleegkundige en patiënt opgebouwd, waarin de verpleegkundige interacteert met de patiënt, de reactie van de patiënt observeert, de psychische gesteldheid van de patiënt monitort, en reflecteert op het gedrag van de patiënt.*

De belangrijk componenten van Structuur bieden zijn beschreven in Figuur 2 (blz. 117), samen met de generieke en specifieke activiteiten, en de relevante contextvariabelen. Met behulp van de definitie van Structuur bieden is een deel van de onzekerheid over wat Structuur bieden precies is, verdwenen. De studies hebben bijgedragen aan het kennisfundament van de psychiatrische verpleegkunde, en zullen verpleegkundigen kunnen helpen de toepassing van structuur biedende activiteiten te onderbouwen.





# Chapter 9

**Dankwoord**

**About the author**

**List of Publications**







## Dankwoord

De primaire reden om te kiezen voor het vak psychiatrische verpleegkunde is dat ik graag mensen wil helpen, en met name de mensen met allerlei beperkingen om hun dagelijks leven vorm te geven. Na het gymnasium was het doel medicijnen te gaan studeren, maar de eerste jaren op de HBO-V Alkmaar waren zo inspirerend dat het de verpleegkunde werd. Direct na de HBO-V begon ik in Psychiatrisch Centrum St. Willibrord te werken. Daar hoorde ik van Piet Stevens, Cas Manshanden en Johan Oosterbaan, en van Peter Koopman de verhalen over het ontstaan van de psychiatrische verpleegkunde. De eerste beschrijvingen van de psychiatrische verpleegkunde verschenen vanuit het PC St. Willibrord. Op de kaft van de eerste beschrijvingen over psychiatrische verpleegkunde werden de handen gebruikt die nu ook op de omslag van het promotie-boek staan.

In PC St. Willibrord ben ik de eerste opleider voor de Stichting Opleidingsinstelling GGZ-VS geworden. Rob Offerhaus was toen directeur behandelzaken. Na vier jaar stapte ik over naar de functie van Hoofdopleider/directeur inhoud. Rob Offerhaus vertrouwde er steeds op dat ik daarin succesvol zou zijn. Het is erg fijn om in zulk vertrouwen te kunnen werken.

Inmiddels veranderde PC St. Willibrord in GGZ Noord-Holland-Noord. Toen ik opperde een promotie-studie te willen gaan doen over structuur bieden, kreeg ik alle medewerking. Er zijn teveel mensen in GGZ Noord-Holland-Noord om op te noemen en mijn dank te tonen, maar Mariet Burgmeijer en Ruud van Dongen noem ik specifiek. Zij droegen er aan bij dat er goede voorwaarden georganiseerd konden worden voor het promotie-traject. Tot op het eind mocht ik van de faciliteiten van de organisatie gebruik blijven maken, en vooral ook van de kennis en kunde van collega's. Met name Ralph Feenstra, de vormgever van tabellen, schema's voor alle artikelen, en het promotie-boek, dank ik. Maar het was vooral op de vrijdag, mijn onderzoeksdag (en krokettendag), altijd heel gezellig en leerzaam, met Marjolein, Fancy, Maarten, Rosalie, Truus, Evelien, Maarten en alle anderen.

Vanaf 2010 heb ik mijn promotietraject voortgezet binnen Philadelphia Zorg. Een grote steun was Margreet Roukema. Ik ben gelukkig dat ik binnen de GGD Zaanstreek-Waterland de gelegenheid krijg aan de laatste fase van mijn promotie te werken (met dank aan Ferdinand Strijthagen).

Speciale dank verdienen Annet Nugter, Theo van Achterberg en Peter Goossens. Zij vormden mijn promotie-commissie. Annet was de stabiele positieve factor en anker in GGZ Noord-Holland-Noord. Zij was er het hele promotie-traject bij, zag de grote lijnen, gaf expliciet aan dat het onderwerp belangwekkend was, ook als er een motivatie-dip was, bood uitweg in complexe situaties en zorgde voor realisme. Theo

van Achterberg, onze professor in de verpleegkunde, was erg stimulerend. Ook hij gaf regelmatig terug dat ik op de goede weg was. Dat zag ik zelf niet altijd, maar met de positieve woorden en concrete aanwijzingen van Theo, was het proces makkelijker vol te houden. Bij iedere “beoordeling” van mijn voorbereidende stukken, zorgden zijn opmerkingen voor werkelijke verbeteringen. Peter Goossens tot slot, bracht een cruciale wending in het promotie-traject. Door zijn aanwijzingen kwam de acceptatie van artikelen in een stroomversnelling. Hij wist daarmee de juiste snaren te raken bij reviewers. Ineens kwamen de artikelen los na 4 jaar continue investeren en vele afwijzingen. Hij zorgde ervoor dat ik zelf steeds meer overtuigd raakte van mijn aanvankelijk idee. Zijn positieve insteek en concrete tip niet direct te reageren op commentaar van reviewers bracht de nodige relativering. Ik was daar zeer door geholpen. Bij alle drie heb ik altijd het vertrouwen gevoeld dat het promotie-traject zou slagen.

Maar er is niet alleen het werk en persoonlijke deskundigheidsbevordering. Er is ook een gezin, met mijn vrouw Lucienne en de kinderen Merel, Laura en Marijn. Mijn moeder en overleden vader die waanzinnig trots zou zijn op wat ik heb gepresteerd. Mijn moeder is dat helemaal en het is mooi dat ze alle belangrijk momenten met ons meemaakt. Alle belangstelling van andere lieve familieleden was heel prettig. Ik koos ervoor om niet alleen met werk en studie bezig te zijn om vooral veel tijd aan mijn gezin te kunnen besteden. Ze hebben daarom niet onder mijn promotie geleden. We hebben in die tijd veel leuke dingen gedaan. Zij zorgden voor ontspanning, ook al was het niet altijd ontspannend. We konden zien hoe ze groeiden en ik ben heel gelukkig en trots dat ze sterke, optimistische en onafhankelijke mensen zijn geworden. Doordat ze er op hun manier waren, waren ze tot steun. Samen hebben we het verschijnen van artikelen gevierd met etentjes. Lucienne en ik hebben een goede samenwerking waar luchtigheid, vrolijkheid, vertrouwen, stabiliteit en genieten belangrijk zijn.

Tot slot wil ik mijn paranimfen bedanken Michel Flens en Jan Boogaarts. Michel is mijn beste vriend al vanaf de brugklas op het Jan Arentsz te Alkmaar. We hebben alle belangrijk momenten in het leven met elkaar meegemaakt: puberteit, avondjes thuis, vriendin, huwelijk, kinderen, jubilea, overlijdens, kinderen uit huis. Het is fijn dat je er nu ook weer bij bent. Het is altijd goed als we elkaar zien. Jan ken ik vanaf de HBOV, alhoewel hij een jaar later begon. We waren samen betrokken bij de studentenvereniging. Later troffen we elkaar vaker bij de GGZ Noord-Holland-Noord, in de Verpleegkundige AdviesRaad (VAR), en de opleiding GGZ-VS. Privé deelden we ook steeds meer. We zijn nu al jaren met de families verbonden, en delen vele interesses. We hebben een warme band.

## About the author

Amar Voogt was born in 1964 in Alkmaar as the first child of a first generation refugee Indonesian father and a Dutch mother. With his brother Mundo and sister Mencita he was raised in this typically Dutch city of cheese. During his secondary education he chose for a bachelor nursing study. After completion of this nursing study (1988), he started to work as a psychiatric nurse on an inpatient psychiatric unit for the elderly in Psychiatrisch Centrum Sint Willibrord, and progressed to study at the same time to earn a scientific nursing degree at the Maastricht University (1991). During his career in psychiatric nursing the subject of a Phd process emerged, and in 2007 he decided to start this process, first as a member of the research-group at InHolland, and later (2010) as a member of the Phd-group at the Radboud University in Nijmegen.



From 1995 to 2010 he was involved with the education for nurse specialist in mental health care. In 1998 he was one of the first five preceptors in Holland. From 2002 he became director/dean of this school of nurse specialists. During five years, until 2010 he worked as a nurse expert in psychiatric nursing. He also completed the education of the Nurse Specialist in Mental Health Care and received the degree Master Advanced Nurse Practitioner in 2011 at the Opleidingsinstelling GGZ-VS. As the Head of Care and Quality at Philadelphia Care (until 2015), an organization for the mentally disabled clients, he succeeded in enhancing the professionalism of health care employees and developed new cooperations to effectively cope in the prevention of crisis. He recently (2015) started to work as Sectormanager Strategy and Development at the GGD Zaanstreek-Waterland, an organization for public health care.

During his career he was involved in health care policies at a national level in his own profession of nursing, and related to other health care professionals. He is a member of a committee to investigate complaints of students at the Opleidingsinstelling GGZ-VS.

Amar Voogt is married to Lucienne van Doorn and has three children, Merel, Laura and Marijn. During the Phd-process, he combined his Phd with the upbringing and support to them to cope with their adolescence. And of course other hobbies needed to be done. He likes to cook Indonesian and Italian cuisine, to ride on his oldtimer Vespa motorscooter, to fitness, and follow his courses Italian. The family and friends (especially Michel, Jurgen and Jan and all their relatives) play an important part in enjoying life.

## List of publications

- Voogt, L.A., Nugter, A., Goossens, P.J.J., & van Achterberg, T. (2013). "Providing structure" as a Psychiatric Nursing Intervention: A Review of the literature. *Perspectives in Psychiatric Care*, (49), 278-287. DOI: 10.1111/ppc.12014
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- Voogt, L.A., Nugter, A., van Achterberg, T., & Goossens, P.J.J. (2016). Development of the Psychiatric Nursing Intervention Providing Structure: An International Delphi Study. *Journal of the American Psychiatric Nurses Association* (22), 100-111. DOI:10.1177/1078390316637049







