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FEATURE ARTICLE

‘Family in the waiting room’: A Swedish study of nurses’ conceptions of family participation in acute psychiatric inpatient settings

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ABSTRACT: *Family plays an important role in the care provided for patients in all areas of nursing. However, relatively few studies deal with the focus of the present study: the ways that nurses experience family participation in acute psychiatric inpatient settings. Data were collected by interviewing 18 nurses who had experience working in such settings. A phenomenographical approach was used to analyse the interviews. Three descriptive categories were found: family participation as a part of the caring process, barriers to family participation, and nurses’ resources in family participation. The findings show that the nurses’ conceptions of family participation varied, and that the family was not always a priority in this caring context. The implementation of family participation was often only based on the nurses’ own interests and insights. This could mean that family participation differed substantially, depending on which nurse a family encountered, and which unit the patient was admitted at. Finally, nurses had little professional autonomy, and organizational support and education were also lacking.*

KEY WORDS: *acute psychiatric inpatient setting, family participation, phenomenographical approach.*

INTRODUCTION

In recent years, nurses in Nordic countries have become increasingly interested in involving families in their clinical practice (Svavarsdottir 2006). Benzein *et al.* (2008) found that the majority of Swedish nurses have a positive attitude towards involving families in the care of their relatives. Families were generally seen as a resource in caring, although nurses working in hospitals had less supportive attitudes compared to those working in primary health care.

According to Gavois *et al.* (2006), nurses can assist the family through the process of experiencing a mental health crisis by being present, listening, sharing, and empowering. Nurses play an important role by being present in acute situations, providing both physical and emotional comfort and security. Furthermore, open communication and participation in planning care help the family to cope with the acute situation. The results from Nordby *et al.*’s (2010) study show that families have positive experiences with nursing staff. Their study highlights the importance of participation from the first contact, and stresses that the encounters should contain sharing information, guidance, support and hope to help families become a resource for the patient. Hultsjö *et al.* (2007) investigated the perceptions of psychiatric care among foreign- and Swedish-born patients with psychotic disorders. They found that while family participation was

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important for the patient, some relatives did not wish to participate. It is therefore important for nurses to identify the individual needs of families. Additionally, Schröder *et al.* (2007) argued that family participation is an element of the quality of care in psychiatric settings.

Both lack of and desire for family participation and support in psychiatric settings have been discussed by Stjernswärd and Östman (2008), van der Voort *et al.* (2009), and Wilkinson and McAndrew (2008). In Ewertzon *et al.*'s (2010) study, in which 70 family members participated, the results demonstrated that a majority of families had experienced a lack of confirmation and cooperation from professionals, and felt alienation in the care being provided.

Nurses play a unique and vital part in encouraging family participation in psychiatric settings (Goodwin & Happell 2007). At the same time, various barriers, such as time, working conditions, and impact of mental illness, can impede the implementation of family participation (Goodwin & Happell 2008).

Kjellin and Östman (2005), Stjernswärd and Östman (2008), Tranvåg and Kristoffersen (2008), and van der Voort *et al.* (2009) demonstrated how the mental illness of a family member can affect the entire family emotionally, and family members might develop health problems of their own. Their findings indicate that families frequently feel distress and a sense of burden, and that these feelings can be experienced in different ways. The distress that families experience in such situations has been studied both in the Nordic countries and internationally (Levine & Ligenza 2002; Pejler 2001; Rose *et al.* 2006). According to Östman *et al.* (2005), the family experiences burden in the situation of acute psychiatric illness, despite the diagnoses of the patients. Additionally, according to Salzmann-Krikson *et al.* (2008), mental illness and acute admissions might involve dramatic situations.

Furthermore, families' concern for children was brought to light (Skärsäter 2006), while for Hedman Ahlström *et al.* (2007), supporting and guiding the family, including children, should be seen as a central part of psychiatric mental health nursing. The experience of growing up with a parent who has a mental illness has also been studied previously. Children desire more initiative, contact, and information from nurses concerning their parents' mental illness. Grown-up children with a parent who has a mental illness highlighted the distress they had experienced in their childhood due to the lack of support and information from psychiatric services, both during the hospitalization of their parent and afterwards (Knutsson-Medin *et al.* 2007).

In view of the high levels of stress experienced by families during admissions and acute phases of illness, and the nurses' decisive role in supporting and facilitating family participation, it appears particularly important to investigate family participation in the acute context. Therefore, the aim of this descriptive qualitative study is to describe how nurses experience family participation in the acute psychiatric inpatient settings.

DESIGN

Ethics

The study was approved by the ethical committee at the University of Halmstad, Sweden. Participants received written and oral information about the aim of the study and the voluntary nature of their participation. They were assured that anonymity would be preserved and that the confidential handling of data protected informants from identification. Written consent was given. Finally, the participants were advised that they could withdraw at any time, without consequences. The interview guide was tested through two pilot interviews in order to ensure that the nurses understood the questions and felt comfortable with them, and to ascertain that the questions were suitable for use in the study. Since the pilot interviews did not lead to any modifications of the format, they were subsequently included in the total material.

Informants

The sample of informants consisted of 18 Swedish-speaking nurses. At the time of the study, the nurses were working with both inpatient and outpatient care in different psychiatric clinics, and all had experience of acute psychiatric inpatient care.

The acute psychiatric inpatient wards in Sweden are short-term assessment and treatment units, often integrated into general hospitals. Patients can be admitted to the same locked wards and be cared for on both voluntary and involuntary bases. They are mostly admitted in the acute phase of illness.

The informants had no relationship with the first author. Nursing managers were first informed, and nurses who met the criteria of participation were identified. The study aimed to obtain a wide range of variation in conceptions, and therefore, nurses were selected to represent different backgrounds with respect to age, sex, marital status, mean number of years as a nurse, specialist education, and mean number of years in psychiatry as a nurse (for the criteria used, see Fridlund 1998; Fridlund & Hildingh 2000). The first author then contacted the nurses by telephone and invited those who wanted to

participate. Eighteen nurses were asked and all were willing to participate. The informants themselves arranged a suitable time and place for the interview. The location for a personal interview was chosen by the nurses themselves so that they felt comfortable and would not be disturbed. The places they selected turned out to be the nurses' workplaces; a secluded and quiet room in the vicinity of the clinics. The participants were assured that the information they provided would be treated confidentially.

The mean age of the 18 informants was 44 years, with a range between 28 and 60; eight were female and 10 were male. Eight were married, five lived with a partner, two were divorced, and three were single. Ten nurses were educated in psychiatric nursing, six were specializing in psychiatric nursing at the time of the study, one had medical-surgical nursing training, and one had basic nursing training. None of nurses were educated in family therapy. Their mean length of time as nurses in the profession was 12.5 years, with a range between 2 and 33 years. The mean length of time as nurses in psychiatry was 12 years, with a range between 10 months and 30 years.

Data collection

In this study, a phenomenographical approach was adopted in order to explore qualitative variations in how nurses experience family participation in acute psychiatric inpatient settings. Over the last 20 years, phenomenographical methodology has mainly been applied to learning within higher education, as well as the fields of health-care education and nursing research (Fridlund & Hildingh 2000). There are basic differences between phenomenography and phenomenology. Phenomenography is substance oriented, searching for the essence in the form of the underlying structure of variance (identifying similarities and differences), while phenomenology is methodological and philosophical and searches for the essence in the form of the main common denominator (Barnard *et al.* 1999; Marton & Booth 1997).

The phenomenographical approach seeks answers to how human beings form their thinking and understanding about phenomena in qualitatively-varying ways. The second-order perspective (how something is perceived by the person) and qualitative variations between individuals are unique to phenomenography (Marton & Booth 1997; Wenestam 2000). In phenomenography, the characteristics of participants' thoughts about a given phenomenon are more important than the number of participants representing a particular attitude. The description of conceptions is based on each informant's statements about the

phenomenon. The method allows conceptions of a phenomenon contained in collected data to be explored by means of a successive process of analysis and interpretation, and sorted into descriptive categories (Marton 1981; Marton & Booth 1997).

In the present study, an interview guide and semistructured interviews were employed with two opening questions, following usual phenomenographical practice (Fridlund & Hildingh 2000). The opening questions were first asked and they were then supplemented with closely-related, follow-up questions, such as: 'How do you consider the significance of the family in your work?' 'How do you understand the participation of family when working in acute psychiatric inpatient settings?' Additional questions were also used in order to deepen the interview and to find out more about how nurses had experienced family participation in the context of acute psychiatric care. Data were collected during the academic year 2004–2005 in southwest Sweden. The interviews lasted between 30 and 90 min. They were all tape-recorded and transcribed verbatim by the first author.

Data analysis

The co-author was well versed in the research approach employed and acted as a co-analysar during the whole categorization process. The analysis of the data followed Dahlgren and Fallsberg's (1991) recommendations:

1. Familiarization: we read through the transcripts several times in order to become familiar with the data and to obtain a sense of the whole material. The interview transcripts consisted of 146 pages.
2. Condensation: we reduced longer statements to find the core of each dialogue. The material contained 648 statements that were directly related to the aim of study.
3. Comparison: the analysis was continued by searching for variations in or agreement with statements and identifying similarities and differences, resulting in 20 preliminary conceptions. The data were considered 'saturated' after 15 interviews when no new conceptions appeared in the analysis. Nevertheless, all 18 interviews were analysed.
4. Grouping: we brought similar answers together. The preliminary conceptions could therefore be grouped into 11 more comprehensive conceptions.
5. Articulation: the 11 conceptions were compared and grouped on the basis of differences and similarities. The analysis then moved back and forth between this step of analysis and the preceding one, leading to three descriptive categories covering 10 conceptions of the

phenomenon 'family participation in the acute psychiatric inpatient settings'.

6. Labelling: we scrutinized the conceptions and named the descriptive categories. The content of the conceptions that formed each category was discussed with the co-author.
7. Contrasting: we compared the categories in order to find the unique characteristics of each category.

FINDINGS

We found three descriptive categories that summarized the material, with respect to how the nurses perceived family participation in acute psychiatric inpatient settings: Family participation as a part of the caring process, barriers to family participation, and nurses' resources in family participation.

Family participation as a part of the caring process

This descriptive category comprised four conceptions: understanding the family at the acute psychiatric ward, family as a resource in caring, encountering family, and seeing the family's own well-being.

Understanding the family at the acute psychiatric ward

The nurses believed that the concept of 'family' could be defined and described in many different ways: as a nuclear family, those who are closest to the patient, and those with whom the patient is living with. Many nurses considered it important that the patient was given the opportunity to define his/her family freely by him/herself. The nurses also stated that the family could include friends. Some nurses reflected on how the concept of 'family' changed over time, along with changes in society.

Those who are the nearest and dearest around . . . those who the patient feels belong . . . I think that it is important to find out which person the patient includes in his/her family and not (as a nurse) have a picture of family oneself. (Participant 11)

Some nurses reflected that family could signify both the good and bad things of life. Although the family could be a source of security/confidence for many patients, it might also involve a number of conflicts, and therefore, could not always be seen as a resource for all patients.

Family as a resource in caring

In this conception, the nurses described the family as a support in psychiatric caring and as a helper who made their caring easier. Some nurses found it important that

they received a great deal of information concerning the patient by talking with the family. They felt that families could increase their understanding about the patient because families have known the person for a long time.

By talking with the family, I can receive much information that helps and explains and gives answers to questions, so that it becomes easier to get a picture of the whole. . . . (Participant 6)

Encountering family

This conception draws attention to the nursing care activities and family–nurse interactions, which were practised by nurses at the acute psychiatric ward. The nurses described many ways in which they met families. Encounters often took place spontaneously while the family was visiting the patient during the period of admission.

In some cases, the nurses found it important that family participated in care planning from the beginning of hospital treatment. Other nurses explained that they played down what had happened at the time of admission if it was dramatic, as in the following excerpt:

The family members are very upset and think that it is terrible and scary, and that I must somehow neutralize it . . . like calm them down . . . try to . . . when they got very nervous . . . that this is not as dramatic as it may seem. . . . (Participant 11)

These nurses tried to find a quiet time to sit down with the family; listen to their stories, experiences, and thoughts concerning their situation, and how they felt and coped over the last few months. They gave emotional support in the form of comforting and consoling.

Some nurses stated that families needed a great deal of information in the acute phases. They provided educational information about mental illness, medication, treatment, discharge, and the early symptoms of recurrence. According to these nurses, information increased the family's sense of security, and therefore, influenced the patient positively, promoting mental health. This type of information sometimes had to be provided several times, considering the crisis the family was experiencing.

Some nurses explained that they contacted families by telephone whenever a family member was anxious or concerned about the patient. The nurses described the family's role in mental health promotion and how they attached great importance to family in their communication with patients. Nurses could remind the patient of her/his family on purpose, so that the patient had something positive to go back to, but also because their family could be connected to reality for the patient. However, some nurses remarked that family participation in the

acute phase of care was not always appropriate because the patient and family are not always in a position to take advantage of it.

It is noteworthy that nurses did not mention any encounters with children in the patients' families during acute admission, although they frequently described the concept of 'family' as a nuclear family including children.

Seeing the family's own well-being

This conception concerned how nurses saw patients' families in a crisis, and tried to understand how the families reacted when a family member had an acute mental illness. The nurses talked about situations where patients might possibly have been in a mental health crisis a very long time before admission to hospital. The nurses understood that this crisis affected and influenced the whole family life.

All families are a system . . . they affect each other . . . if there is one that is not feeling well, it therefore becomes like ripples in the water. . . . (Participants 11)

Many nurses emphasized the importance of recognizing the families' own well-being. They saw how the patients' families were tired and exhausted as a result of the burden before admission, and for this reason, they recommended that the families should relax, sleep, and relieve the pressure. Some nurses described situations where they had advised families to take a vacation as time for themselves or take the opportunity to devote some time to their children if they had been neglected previously.

Some nurses reflected that family should be taken seriously; that the family was able to deal with knowledge of what was happening during the admission and should be informed about what treatment was planned. Some nurses explained how families needed to share their experiences about the acute mental illness, and that time needed to be set aside for families to ask any questions they had. According to some nurses, the family also needed to be given hope concerning the patient's chances of recovery.

Barriers to family participation

This descriptive category comprised three concepts: only the patient is in focus, lack of competence, and lack of professional autonomy. These concepts described how the family was not a primary focus in caring processes. The nurses described that they worked under various constraints and found it difficult to involve family when providing care in acute psychiatric care settings.

Only the patient is in focus

Based on this conception, some nurses expressed their thoughts about the history and tradition of psychiatric care as a barrier in family participation. An individualistic, patient-centred perspective in psychiatric care still had a certain impact. The nurses told stories of how family members were not allowed to visit the inpatient and how staff earlier tended to put the blame on parents and families. However, the nurses also remarked that this individualistic approach has been changing over the past few years.

Some nurses believed that nurses should not have contact with family during the patient's acute phase. These nurses added that family participation was not constructive in acute care, and stated that they did not find any reason to involve family. Instead, they felt that they should wait and see. Some nurses suggested that family members get support from outpatient care in order to cope, while the nurses focused on the patient instead.

We are here for the patient's sake, and the family members can take care of themselves or receive their support from outside. (Participant 14)

Some nurses explained that children were not allowed to visit the psychiatric ward because there was not any room for family to see each other, and that the focus in caring was only on the inpatient him/herself.

Statements placed in this category described the acute psychiatric inpatient setting as a place where patients of all ages were admitted immediately at any time of day or night, when the patient's mental illness was at its worst. Short hospital treatment periods were typical for inpatients with all kinds of psychiatric diagnoses. The psychiatric ward was characterized by these nurses as a messy and sometimes chaotic place where they had difficulties in finding any continuity in the care of patients. The nurses worked under considerable stress for certain periods when they were occupied with many caring activities at the same time, while they could have relatively peaceful periods after this. They often worked in shifts, and found that this way of organizing work limited possibilities for family participation. Some nurses reflected that for these and similar reasons, families were sometimes set aside in the steady flow of new patients and in the immediate acute nursing care activities.

Lack of competence

This conception illustrated how psychiatric care in acute caring contexts lacked clarity and adequate nursing structures. The nurses found it difficult to determine what was 'enough' and what was expected of their psychiatric caring

practice. They also attempted to strike a balance between family participation and the requirements of professional secrecy, in compliance with the Swedish Public Access to Information and Secrecy Act (National Board of Health and Welfare 2009).

They felt uncertain as to how to handle the patient's rights to self-determination and autonomy. How could they support the inpatient and at the same time meet the family? (However, it is not impossible that this problem might have been used as an excuse to avoid contact with families.) The nurses additionally expressed a lack of time and continuity due to shift work, which prevented them from meeting with the families. They sometimes had a different approach to family participation than the norm in their working culture. Nurses observed that the manner and extent to which they met families depended on their personal initiative and motivation. In other words, family participation was not supported by work structures. The nurses represented in this category described their own lack of competence, felt great insecurity in encounters with families, and found knowing how to communicate with family demanding. They also expressed a weakness in personal communications skills suited for work in a group like a family.

I think that there frequently exists a great insecurity in how to handle this, and when more people are involved . . . that there is a fear that you maybe are not able to clear this up and if difficult things crop up. . . . (Participant 3)

The nurses openly admitted that they did not know how to deal with difficult emotions that appeared in connection with collaboration with families, and explained how this made them avoid such encounters. The nurses said that it required courage to face families' emotional expressions, such as frustration and fury. One nurse said that it was emotionally disturbing to think about the children in families.

Lack of professional autonomy

Based on this conception, the nurses described how family participation in the acute psychiatric caring context was guided by physicians. In many cases, nurses perceived that the extent to which the patient's family was taken into account, as well as the manner in which family participation took place, depended on which physician was on duty at the time. The nurses expressed that approaches informed by physicians significantly influenced and guided their everyday nursing and caring practice with families.

Often it is the chief physician who directs this in my experience . . . it is seldom that the nursing staff pursue this (family participation) themselves. (Participant 3)

Some nurses found that it was hard to influence the standard clinical practice towards a more participatory view concerning families. An individualistic, patient-centred perspective dominated the working culture of their units.

Nurses' resources in family participation

This descriptive category comprised three conceptions: theoretical knowledge, personal life experience and experience from psychiatric care, and coaching. Statements placed in this category described how encounters with family were possible, and how it became progressively easier for them to integrate family participation in their clinical practice. Here, nurses explained how they found the courage to interact with families when they had theoretical knowledge, life experience, caring experience, and coaching.

Theoretical knowledge

This conception described how nurses found it important to have theoretical knowledge concerning family participation and communication in a group like the family. They expressed the importance of education in this area. Some nurses stated that through education, it was possible to change the manner of thinking, modify attitudes, and also receive new knowledge. One nurse observed that education influenced the way of seeing the children in families:

This I have learnt as time went and this thing about children in families, when one of the parents is hospitalized, that we have so much we can do for them also. This I have understood later . . . read more and was at a conference about this. . . . (Participant 3)

Personal life experience and experience from psychiatric care

This conception described how nurses found it helpful when they met families in the acute caring context if they had personal lived experiences and insights as a family member themselves. They also reflected that this experience provided them with more knowledge and courage to interact with families, and was one of the reasons why they preferred family participation during acute inpatient care. They also highlighted the importance of professional experiences as a psychiatric nurse, which made them feel more secure in their role, and made it easier to manage contacts with families.

I noticed myself that when a family member has fallen ill, I will always be there . . . I am more secure myself . . . it is maybe more difficult for a recently-graduated nurse to talk with family . . . that it is not easy to answer questions when they do not have so much life experience themselves . . . not to see their (family's) desperation behind it all. . . . (Participant 1)

Coaching

This conception described how the nurses reflected on the importance of receiving coaching from colleagues who were engaged and committed to involving families. They stressed the necessity of time for reflection together with these colleagues concerning a course of action, ways of seeing the situation, or clinical practice. Some nurses stated that they learnt from one another, supported each other, and found it extremely helpful to work together with another nurse in connection with their contacts with families.

That I had a colleague who was . . . ardent for families . . . she was coaching me, gave information, we had many conversations about this (family) . . . her way of thinking provided much knowledge and experience . . . she was very important for me in this time, like by helping me in how I was thinking . . . (we) tried to help each other. . . . (Participant 5)

DISCUSSION

Discussion of method

According to Fridlund (1998) and Fridlund and Hildingh (2000), the research process in qualitative studies can be discussed in terms of applicability, reasonableness, trustworthiness, and conscientiousness. Eighteen informants were chosen according to certain criteria to include a diversity of backgrounds, and thereby obtain a wider range of conceptions. All had experience in working in acute psychiatric inpatient settings. The phenomenographical approach is commonly used in health sciences in order to discuss the different ways nurses think about and understand various phenomena they encounter (Wenestam 2000). Therefore, the approach used in this study and the mode of selection of the informants were both relevant and appropriate with respect to the research aims. The first author, an experienced psychiatric nurse, conducted all of the interviews. This enhanced the study's reasonableness by increasing sense of confidence and openness in the interviews. Trustworthiness was increased by using two pilot interviews. The concepts were determined before all of the interviews had been analysed, which strengthened the reasonableness. An

interview guide was used to achieve a clearer delimitation of topics. Trustworthiness of data collection and analysis were additionally strengthened by the fact that the first author performed and transcribed all of the interviews. The co-author acted independently as a co-analysist during the whole categorization process in order to ensure accuracy in all steps of the analysis. Interview excerpts were introduced in every descriptive category to ensure transparency and facilitate interpretation (Sjöström & Dahlgren 2002). Although the findings are not intended to be generalized, they could be applicable in similar contexts. Findings primarily aim to serve as a point of departure for discussions concerning practice in acute settings. Ways of improving practice can be considered based on the nurses' perceptions of conditions for and obstacles to family participation in their experience.

Discussion of findings

The results indicate that the acute psychiatric caring context limits possibilities for family participation to a certain extent. The lack of control over nursing practice and continuity in inpatient settings were also found by Fourie *et al.* (2005). Goodwin and Happell (2008) had similar results; their study identified the systemic barriers to consumer and carer participation.

In the present study, the nurses described their caring activities with families. The activities that were mentioned in the interview material essentially corresponded with the activities identified in earlier studies (see Engqvist *et al.* 2007; Gavois *et al.* 2006). According to Sjöblom *et al.* (2005), nurses verified the importance of family, and observed that family increased their understanding of the inpatient by giving information, which was also noted in the present study. Earlier research additionally suggested that information given and received has great value in psychiatric care, and can reduce the families' feelings of shame and guilt (Schröder *et al.* 2007; Sjöblom *et al.* 2005). The findings from the present study indicate that contact with families often took place spontaneously while the family was visiting, or by telephone. Sjöblom *et al.* (2005) highlighted that contact was frequently initiated by the family. Another aspect noted by the nurses was the importance of seeing the family's own health as well. This corresponds to the findings of Engqvist *et al.* (2007) and Schröder *et al.* (2007).

Nurses observed that a number of factors constituted barriers to involving the family in the caring process. These included work culture and tradition based on an individualistic view of caring, handling issues of professional secrecy, insufficient competence, and work practice directed by physicians. The Swedish Board of Health and

Welfare stresses that health professionals should provide opportunities for families for involvement, psychosocial support, information, and education to reduce the burden (National Board of Health and Welfare 2010). However, some nurses in the present study felt that family involvement was not always appropriate.

The nurses described a lack of professional autonomy and difficulties in changing the view of caring towards a more family-focused approach. In addition, the nurses found it demanding to attempt to comply with secrecy regulations, while providing support for both inpatients and their families. This is in line with earlier findings (see Sjöblom *et al.* 2005; Rose *et al.* 2004), where nurses lacked training and resources. However, according to the families themselves, considerations of confidentiality should not become an obstacle to their participation in the patient's care (Schröder *et al.* 2007). According to Goodwin and Happell (2007), open and clear communication leads to collaborative involvement.

The findings of the present study showed that the nurses' conceptions of family participation varied, and that the family was not always a priority in this caring context. What are the implications of such attitudes for families in clinical practice? In a recent study, Stjernswärd and Östman (2008) investigated the experiences of families living close to an individual with depression. They reported that families felt that they were not considered and met by health-care personnel. According to Wilkinson and McAndrew (2008), families frequently felt excluded from acute psychiatric settings, and desired greater participation with nurses.

It is noteworthy that the nurses in the present study did not describe any instances of including children in the contact they had with families. This contrasts with the fact that many nurses believe that the children 'carry an inhuman burden', supporting and taking care of a parent with a mental illness (Sjöblom *et al.* 2005). Östman and Hansson (2002) confirmed that it is essential in psychiatric care to include children.

Theoretical knowledge, personal life experience, as well as nurses' professional experience, all played a vital role when nurses interacted with families in acute psychiatric inpatient settings. The nurses found coaching helpful, and explained that it facilitated the implementation of family participation in clinical practice. Benzein *et al.* (2008) showed that nurses' personal experience of mental illness in the family might make it easier to communicate with families, and that newly-graduated nurses had a less positive attitude towards involving families. This is supported by Korhonen *et al.* (2008), who emphasized that nurses' personal insights, their characteristics,

and further professional education were significantly related to how they took into consideration the support network of families, and to which extent they worked with families.

The variation in nurses' conceptions of family participation, and certain contradictions in their conceptions, raise the question of whether families can be met equally well by nurses in the different clinics and units when a shared nursing approach and clarity are lacking. Do families get differing possibilities for working with the nurses, depending on the individual nurse or physician in charge, and are such differences potentially problematic? This is a great challenge for nurses and to the entire nursing leadership and organization in local settings.

The findings in this study increase the understanding of the various ways nurses experience family participation. Since nurses are a professional group who have most direct contact with both patients and families, a better understanding of their perceptions is needed to improve family participation and professional education in clinical practice.

LIMITATIONS

The findings in this study pertain only to a limited number of interviews. The aim was to get an idea of the range of variations in qualitatively-different conceptions about the phenomenon of family participation (Marton 1981). It goes without saying that generalization of the findings to a broader population should be undertaken. The findings of nurses' experiences come from a specific area of Sweden, and therefore, the results reflect the working culture, health-care organization, and forms of education that are typical of this area.

CONCLUSION

This study showed nurses' various ways of experiencing family participation in acute psychiatric inpatient settings, and variations in their approaches to family participation in practice. Investigating a wider range of nurses would be an interesting research project, but future research should also investigate the experiences of families in this acute context, seen against the background of nurses' perceptions.

It was apparent that family participation in this context depended more on the individual nurses' interests and insights, rather than being an institutionally-based part of acute psychiatric inpatient care. The weaknesses in the implementation of family participation in this caring context was surprising, in view of the numerous ways that

mental illness affects the whole family. As a result of such weaknesses, families can still be left in the waiting room.

Additional insights concerning the barriers and resources for improved practice might help nurses to develop active and systematic ways of providing adequate possibilities for family–nurse partnerships during acute admissions. Considering the negative impacts on both patient and family health, these issues should be of large scale and central interest for the whole organization and nursing leadership in local settings.

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