“To see the person behind the crime, through the eyes of the person behind the keychain”

- Carers lived experiences of patient encounters in forensic inpatient care.

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Dedication

I dedicate this thesis affectionately to the following:

My wife Åsa

My daughters Alma & Astrid

My parents Ulf & Lena

My beloved sister Helena

And whom it may concern...
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Abstract

**Background:** Forensic psychiatric care (FPC) encompasses involuntary care and treatment of those who have committed a crime. On the one hand, FPC is constructed regarding the respect for the individual’s freedom and autonomy, and on the other hand, it is constructed on societal protection. Being a carer in FPC is intertwined with being faced with a distinct ethical dimension of care, as it involves caring for patients who are deprived of their freedom, meaning dealing with the tension of care and custody. Caring means often finding oneself in encounters with individuals with inevitable elements of rules, coercion, threats, and violence. In this complex environment, a caring relationship is to be established, which is intended to be built on trust, as a forensic nurse’s main purpose is creating wellbeing and care, based on the patient’s perspective. It is in the everyday encounters that occur often spontaneously that the carer–patient relationship should be established. It is in these encounters that the carer is given the opportunity to relive suffering. The encounter becomes the focal point where the lifeworlds of the carer and patient meet. Dealing with the duality of FPC and contradictory emotions requires a deeper understanding, which encourages to self reflect the meaning of these encounters and oneself as a carer. **Aim:** The overarching purpose of the thesis was to obtain a deeper understanding of carers’ lived experience of encounters with patients with mental illness in forensic inpatient care. **Method:** The thesis consists of four studies (I, II, III, IV) with qualitative design, based on ontological and epistemological reasonings of phenomenology and hermeneutics. The studies illuminated the lived experience and are conducted with phenomenological hermeneutics (I, III), hermeneutics (II), and reflective lifeworld research (IV). **Findings:** Encounters with patients are characterised with the duality of acting upon the patients’ needs and managing rules and norms stipulated in laws and regulations that govern FPC and societal protection. Encounters in FPC and being a carer is intertwined with being put in a position of power, where the carer also must be allowed
to be fragile and deal with vulnerabilities and not play a role. The encounter means being in a duality and having the insight of the tension of impressions of expressions of suffering, being in the “space in-between”. In this space, there is room and a possibility for carer’s personal growth, and achieving a phenomenological attitude and to truly embrace the patients’ lifeworld. **Discussion:** A comprehension of the studies (I, II, III, IV) revealed four topics, *having trust or feeling distrust, being compassionate or being indifferent, having courage or being afraid, and being genuine or pretending.* These were reflected upon against the theoretical framework of K. E. Lögstrup. The duality of FPC and the space in-between that arises in the encounter suggests that the carer is forced to be confronted with existential phenomena that constitutes one’s world. By being active in the space in-between and reflecting upon openness, the carer moves between this duality that exists in the continuum that the opposite phenomenon contains. The space in-between may become a place and a possibility for personal growth by being active and obtaining a phenomenological approach. This is obtained by an openness and consciousness to the impression by self-reflection to convey its meaning. If carers can do this by openness and compliance, there is a possibility for the encounter to become a place for personal growth, that encourages the sovereign utterances of life, and carers may to a greater extent understand themselves as well as patients’ expressions of suffering.

*Keywords:* Encounters, forensic nursing, hermeneutics, lived experience, nursing, phenomenological-hermeneutics, phenomenology, reflective lifeworld research.
Summary in Swedish

roll. Mötet innebär att vara i en dualitet och ha insikten om spänningsfältet som uppstår i intrynken av uttryck för lidande, att vara i “mellanrummet”. Det är i mellanrummet, det finns utrymme och möjlighet för vårdarens personliga mognad att växa, genom att vara aktiv och anamma en fenomenologisk attityd som tillåter vårdaren att se patientens livsvärld. **Diskussion:** En förståelse av studierna (I, II, III, IV) avslöjade fyra områden, *att ha tillit eller känna misstro, vara medkännande eller vara likgiltig, ha mod eller vara rädd och vara äkta eller låtsas*, som sedermera reflekterades mot den teoretiska ramen av K. E Lögstrup. Dualiteten av FPC och utrymmet däremellan som uppstår i mötet, gör att vårdgivaren tvingas konfronteras med existentiella fenomen som utgör ens livsvärld. Genom att vara aktiv i mellanrummet och reflektera över öppenhet rör sig vårdaren mellan denna dualitet som finns i det kontinuum som de motsatta fenomenen innehåller. Mellanrummet kan möjlig bätta plats för personlig växt genom att vara aktiv och anamma ett fenomenologiskt förhållningssätt. Detta erhålls genom en öppenhet och medvetenhet för intrynket genom självreflektion för att förmedla dess mening. Om vårdare kan göra detta genom öppenhet och följsamhet finns det en möjlighet för mötet att bli en plats för personlig växt, som uppmuntrar de suveräna livsytttriga och vårdare kan i större utsträckning förstå sig både själva samt patienters uttryck av lidande.
List of papers

This doctoral thesis is based on the following studies, referred to in the text by their Roman numerals:


Preface

Having prior clinical experience of forensic nursing to a great extent as an assistant nurse, registered nurse, and eventually a specialist nurse, I have always been intrigued by the ethical challenges intertwined with caring for patients within a forensic setting and the ambiguity of the task at hand, as it focuses both on the patient’s wellbeing and recovery as well as the protection of the society. At times, being faced with encounters characterised by threats and violence and at the same time trying to further develop alliances and carer–patient relationships are moments when forensic nursing presents its uniqueness. Having cared for numerous patients during numerous circumstances, it has always been in the encounters that constitutes everyday care where the “gift” of nursing is supposed to be given. Hence, embarking upon these research studies presented an opportunity to further understand the meaning of these relatively unexplored part of the care that seems to be its very foundation. Creating knowledge that may further assist other carers and be of use throughout our Swedish forensic hospitals, to further develop forensic nursing.
Introduction

The main objective of this thesis was to obtain a deeper understanding of carers’ lived experience of encounters with patients with mental illness in forensic inpatient care (FPC), as everyday encounters between carers and patients constitutes the platform and the foundation where the carer–patient relationship can arise, creating an opportunity to ameliorate the suffering of patients with severe mental illnesses, restoring health and helping them recover. Being a carer in a forensic setting is of great importance to the patient’s reintegration into society.

Being a carer in FPC is intertwined with being faced with a distinct ethical dimension of care, as it involves caring for patients who are deprived of their freedom, meaning dealing with the tension of care and custody and the asymmetry in the relationship between the two parties (Jacob, 2012) – a context where carers find themselves struggling to deal with the ambiguity of caring, dealing with the intention of doing what is best for the patient, and at the same time, addressing matters of security and societal protection (Hörberg, 2008). FPC is a unique and challenging context where carers play a vital role for the patient’s outcome, a setting where carers are faced with encounters with patients with a criminal history and dealing with conflicts is considered a part of everyday work (Laiho et al., 2016), as caring means often finding oneself in situations with individuals that
can be perceived as intimidating or dangerous, dealing with an environment with inevitable elements of rules, coercion, threats, and violence (Rytterström et al., 2020). A caring relationship, which is intended to be built on trust, is to be established (Gildberg et al., 2013). Being able to establish this trusting relationship is of importance when dealing with these conflicts and being able to base the caring actions on empathy (Nielsen et al., 2018). Helping patients deal with their illness and traumas while risking their own wellbeing while caring in a high security setting could lead to potentially causing harms in carers (Aiyegbusi & Kelly, 2015). How carers can cope and deal with these encounters is mainly dependent on how they themselves perceive others and their relationships with the patients (Gildberg et al., 2021).

Thus, devoting oneself to forensic nursing and embracing the role of a carer in this unique setting has been described as emotional hard labour (Beryl et al., 2018). This may pose a potential risk of the wellbeing of the carers, and their ability to deal and manage with the complexity and the emotions that arise in the encounters becomes of vital importance as it may impact the care given and consequently, the patients wellbeing (Berry & Robertson, 2019). Therefore, finding strategies, improving, understanding, and reflecting upon the multiple factors that affect themselves and their own motivation becomes a necessity (Oates et al., 2021).
Background

Forensic Psychiatric Inpatient Care

Forensic psychiatry encompasses investigative activities and care, treatment of offenders transferred to FPC, involuntary treatment of those who have committed a crime. Even though the principles and aim of forensic care can be considered universal, the laws and regulations governing the delivery of care differ greatly from country to country (Edworthy et al., 2016; Sampson et al., 2016). Swedish Agency for Health Technology Assessment and Assessment of Social Service (SBU, 2018) states that modern FPC is constructed regarding the respect for the individual’s freedom and autonomy in one hand, and on the other hand, society’s duty to protect those who lack the ability to protect themselves or those whose freedom needs to be restricted to protect other people’s lives and health. The society is built on legislation that supports compulsory care for seriously ill people who do not have the ability to make informed decisions regarding their own need for care, which is justified with reference to societal protection (SBU, 2018). The main purpose of FPC in Sweden is to improve the patients’ mental health and reduce the risk of recidivism (Strand & Holmberg, 2018). FPC is enabled by establishing an alliance and relationship with the patients (Rydenlund et al., 2019), reducing the probability of criminals reoffending by getting patients involved in their treatments and the care given, thus improving their mental
health and enabling them to take on societal responsibility (Olausson et al., 2019). SBU (2018) declares that FPC is regulated by the same laws that control Swedish healthcare and in part by penal laws. The care given is based upon the belief that the main purpose is to improve health and protect society whilst giving care at the same time.

A person who commits a crime may be transferred to care instead of prison if they suffer from a severe psychiatric illness, a term that in Sweden, is more of a legal term then a diagnosis. Anyone who is judged to have a severe psychiatric illness should not be sentenced to prison in the first instance (SBU, 2018). In order to decide on the legal consequence in a criminal case, a court may request a forensic psychiatric examination (RPU) of the suspect. A statement from the national board of forensic medicine is often of decisive importance to the judge to decide if the defendant who has committed a crime, if they should receive prison or be transmitted to care at a forensic clinic (National Board of Forensic Medicine, 2022). Approximately, in Sweden, there are about 300 persons per year, mostly men, who are transferred to care and require a setting with a high security level, and about 1800 inpatients receiving care in Sweden according to the Law on Forensic Psychiatric Care (LRV) according to the National Board of Health and Welfare (2020). LRV (1991:1129) treats the special conditions that apply in the case of forced psychiatric care for arrested, detained, and convicted persons who are transferred to forensic psychiatric care by the court as a criminal sanction. Care is primarily
delivered at five of Sweden’s regional clinics: Säter hospital, Sankt Sigfrid’s hospital in Växjö, the forensic clinic in Vadstena, the forensic clinic in Sundsvall, and Karsudden Regional Hospital (Strand et al., 2009). Aside from these major clinics, forensic care is also delivered at smaller wards around the country, primarily for individuals who are cared for under the act of Psychiatric Compulsory Care (LPT, 1991:1128), including individuals who are in immediate need of inpatient psychiatric care and have not committed a crime.

FPC is considered an environment that focuses on security and safety to great extent (Seppänen et al., 2018). Swedish forensic psychiatric clinics are divided into three security levels (very high, high and acceptable). If care is delivered at multiple wards, at the same premises, each ward must be classified on its own (SOSFS, 2006). The diagnostic panorama in FPC is broad, with a clear majority of patients receiving care for schizophrenia or various forms of psychosis and 51% having a lack of insight into their own mental illness (Innocenti et al., 2014). Most patients suffer from psychosis as their main diagnosis; it is also relatively common with personality disorder, autism spectrum disorders, substance abuse, and addiction problems (SBU, 2018). Most of the patients have previously been sentenced for some type of criminal act, which is often accompanied by a history of drug abuse (Krona et al., 2017).
Forensic Nursing and Values

According to Hörberg (2015), forensic nursing’s main purpose is creating wellbeing, and the care is based on the patient’s perspective, meaning that the focus is on the patients’ needs and the patient is to be perceived as an expert on himself. Since 2003, there has been a common set of values on which Swedish forensic psychiatric nursing rests; it reads according to the network of forensic nursing to see the person behind the crime and have the courage to remain in all situations. This is based on interpersonal love, authenticity, and the principle of goodness. As a carer, seeing oneself as a tool in building care relationships, time, trust, and security forms the basis so that the patient is given the opportunity for reconciliation (NÄTROM, 2022). For caring to have meaning and a purpose, a human-to-human relationship characterised by emotional commitment is required (Jacob, 2014), permeated by respect, honesty, and trust (Rask & Brunt, 2007). Due to the complexity of FPC, there is always a risk that caring instead is portrayed by control, surveillance, boundaries, and maintaining rules instead of trust and respect (Gildberg et al., 2010).

Ascertaining a therapeutic carer–patient relationship requires a climate based on a humanistic view of healthcare (Zugai et al., 2015). Forensic nursing is to be conducted with the interest of the patient in focus, planned and carried out with the intention of what is best for the individual, in co-operation, patient participation and with the possibility for the patient to influence and experience self-
determination (Selvin et al., 2016). From the patient’s perspective, establishing an alliance and a relationship with the patient means feeling connected to the carer, which may ease the process of having to deliver negative decisions for the carer sometimes (Marshall & Adamas, 2018). Being a carer in FPC has its challenges, as it is intertwined with allowing patients to participate in care. Whilst care is mandatory, asking carers to act upon the patient’s best interest becomes even more challenging when that patient has committed a crime that is hard to comprehend (Magnusson et al., 2020). For carers to truly fulfil their mission, they must not only consider the patients’ nature, but also reflect upon their ideas and characteristics (Stevenson & Taylor, 2020).

Care is to be based on a patient’s rights and opportunities to influence the care and be involved in the decision-making through a dialogue with the carers (Castro et al., 2016). Rask and Brunt (2006) emphasise that carers perceive themselves as supporting the patients rather than being engaged in joint decision making or allowing the patients to participate in the care, suggesting that carers lack capabilities to communicate with patients. If the focus within a forensic setting switches to matters of security and restrictive actions, it is more likely that the care is perceived to be more custodial than caring (Tomlin et al., 2018, Chester et al., 2017). At times, patients themselves describe being in a context where they have no control,
lacking hope, and being trapped in a system they cannot come out of, to become a part of society once again (Hörberg et al., 2012).

There is much unknown about how carers respond to patients’ expressions (Myklebust & Björkly, 2019). Management of own emotions is an essential component in forensic psychiatry, which, if not addressed, can lead to negative psychosocial outcomes such as job stress and fatigue (de Castro et al., 2004). The way carers react to patients’ expressions is largely unspecified, especially how they cope with their own reactions in the face of problematic behaviour in clients (Looff et al., 2018).
Overview of Research on Forensic Nursing in Sweden

Research on forensic nursing in a Swedish context is sparse. However, there have been made contributions to improve care and give greater insight and understanding to nursing in FPC – Rask (2002), Sjögren (2004), Hörberg (2008), Rydenlund (2012), Olsson (2013) and Kumpula (2020), to name a few. Rask (2002) examines carers’ work in forensic psychiatry and the content of nursing, how patients and carers perceive various nursing activities, and supporting actions. This study also highlights responsibilities, actions, what carers focus on in conversations with patients, and how satisfied carers are with their work duties. Sjögren (2004) focuses on the care of patients who have committed sexual abuse against children. To provide effective care, caregivers need time for existential reflection to understand how they are affected by the patients they care for and to understand and encounter a different lifeworld. Hörberg’s (2008) aim was to describe care in forensic psychiatry based on how it was experienced by those who provide care and by those who are cared for in a maximum-security ward. The results showed that patients perceived psychiatric care as non-caring, adapted to the demands of the carers. Hörberg (2008) emphasises the corrective and disciplinary nature of forensic care and the balancing act in forensic nursing between care and fostering. Rydenlund (2012) contributed to a deeper
understanding of this with a hermeneutic analysis of the caring conversation between carers and patients who endure tremendous suffering. Olsson (2013) reflects on patient and staff experiences of the turning points in care that led to recovery and a reduced risk of violence, which were characterised by feelings of vulnerability. This is described as a sensitive process that needs to be supported by trusting relationships. Kumpula (2020) describes the complex interaction between protection and care from a gender perspective and states that male and female carers tend to be linked to different roles and duties, that protecting society tends be a higher priority than caring, and that males have a paternal role and females have a more maternal role.

**Being a Carer in FPC**

Being a carer in FPC means building and sustaining relationships with patients, social skills training, reality orientation interactions, and supporting and encouraging the patient (Rask & Brunt, 2007). It also means balancing custodial and coercive elements, while at the same time establishing alliances in everyday encounters (Gildberg et al., 2012). It also includes reflecting upon own abilities of empathy, kindness, flexibility, and responsiveness (Carlsson et al., 2006). Carers must also devote time to occupational therapy, social treatment, risk assessment, medical and psychological treatment (Strand & Holmberg, 2018). Being a carer in FPC differs from other psychiatric contexts as it means devoting oneself to these activities
during long periods of time (Livingstone et al., 2012). The care given is structured around contact teams, where each individual carer works alongside other carers, together forming a team that works close to the patient to convey hope, promote participation, and keep the patient’s best interests in mind, often being the ones who get to know the patient best (Olsson, 2013). In this thesis, carers refer to specialist nurses in psychiatric care, registered nurses, and assistant nurses working and having experience in FPC. They all take part in nursing, the care given, and the everyday encounters. In the first two studies (I, II), the term nurses were used. As this may be interpreted to only refer to registered nurses, the term carers has been used in the following studies (III, IV) and throughout this thesis.

**Encounters in a Forensic Setting**

An encounter is depicted as two individuals getting close to each other (Carlsson 2010), and the carer must ensure that the encounter is based on trust and supports the patients’ health process (Dahlberg & Segesten, 2010). The term encounter is often depicted within nursing theories and literature; it is a concept with different meanings (Holopainen et al., 2019). Travelbee (1971) states that encounters precede nursing care and develops through various stages. Martinsen (1989) describe the encounter as an abstract space among individuals with an explicit demand on the carer. Ford (1990) states that encounters are either caring or uncaring, and Bakke and King
(2000) depict encounter as an opportunity to create healing through human encounters. There is no consensus and conceptual clarity regarding the concept of encounters, hence, its meaning and significations are at risk to be lost (Holopainen et al., 2019).

FPC is characterized by long hospital stays (Vorstenbosch et al., 2014) where carers work close to the patients providing nursing care in everyday encounters; an interaction that can never replace medication or therapy, but can fill the void where therapy is insufficient (Harris et al., 2015). Being able to care for and establish a relationship with the patient is essential for forensic nursing (Rydenlund et al., 2019), a relationship founded on compassion, empathy, and genuineness (Möllerhög & Os Stölan, 2018). In forensic care, as little as 30 minutes per day can be allocated to the actual delivery of treatment (Rask 2002); the remaining time is spent on different activities such as rest and various encounters with other carers or staff members (Sturidsson et al., 2007). Forensic psychiatry could be perceived as a context that focuses on treatment, psychopharmacological interventions, and psychological programs, but most of the therapeutic care is based on relationships in day-to-day encounters between carers and patients (Stockman, 2005). Papadopoulus et al.’s (2012) meta-analysis of 71 studies confirms that these encounters were the most frequent of all interactions. Encounters often occur spontaneously and are unpredicted, it is an
interaction that requires trust, and it is here the carer and the patient come into close contact with each other (Carlsson, 2010). The encounters present a possibility for carers to have an impact on the patients' health (Hellzen & Asplund, 2006) as it implies a communication between the two parties. If performed with the right intentions, the encounter may become a caring dialog (Rydenlund et al., 2019). It is in these moments the carer is given the opportunity to relive suffering, it is a central platform in the carer–patient relationship (Björck & Sandman, 2007). While the carer is exposed to a situation to relive the patient’s suffering by understanding their expressions of suffering, the carer needs to be equipped with the correct tools to manage the encounter (Kumpula & Ekstrand, 2013). This also means that carers are faced with the obligation of the encounter being a caring encounter, which reinforces the patient that the encounter be based on the patients’ requirements and lifeworld (Dahlberg & Segesten, 2010). Sensing responsibility in the encounters means understanding the patient, which is only achievable if the encounter involves a process of self-reflection regarding the carers' own pre-conceived notions (Todres et al., 2014). This means that self-reflection in the form of curious pondering is a requirement in encounters in FPC to comprehend the patient’s expressions of suffering and to truthfully witness the patient (Gustafsson et al., 2014).

Taking on the role of being a carer in FPC requires adapting a humane and relational approach and taking responsibility for rules
and regulations, being able to set own personal attitudes aside to establish a relationship and promoting patient participation (Söderberg et al., 2020), and finding a way to truly create a carer–patient relationship based on trust (Salzmann-Erikson et al., 2016). Despite being a vital element in nursing, encounters are a neglected area of research, hence relationships, interactions and the connections between carers and patients is warranted (Daffern et al., 2012). Further research and education that involves carers turning their gaze inwards and reflecting upon themselves, their role, and how they act in encounters could help to promote and enhance positive communication in the carer–patient relationship, thus minimising coercive actions (Jalil et al., 2020).
Central Concepts

The following section aims to briefly clarify some of the central concepts of this thesis to facilitate the readers’ understanding of the content.

Lifeworld

This is a concept originating from the early ontological reasoning from Husserl (1970), who depicted the notion of the lifeworld [Ger. Lebenswelt] as being intertwined with our lives, our world, and everything in between. It’s about our own world as we experience it, a world that we think is self-evident and take for granted. It is not in a sense a limited place, but means how we relate to this world and our reality (Dahlberg, 2019). The notion of lifeworld is elaborated by other great minds such as Heidegger [Ger. Sein und Dasein], Merleau-Ponty [Fr. être au monde] and in some sense, Gadamer, when trying to unravel the mystery of health, which despite different interpretations conclude that human beings cannot be understood if not perceived as sharing a common world, relating to one another, where we, as humans, experience objective things and signs that we understand and give meaning to (Dahlberg et al., 2008). Thus, the concept of lifeworld is perhaps best described as a perspective, an idea of our existence, a point of view from where we, as humans, try to understand the world, our experiences, and own
existence, how we partake in the world and interact with each other, and what it all means to us (Dahlberg, 2019).

**Lived Experience**

The concept of lived experience originates from Wilhelm Dilthey (1833–1911), who explains it as more felt than known, as an experience that is a part of life on a level beyond and before conscious reflection meaning. A lived experience is something we simply have, without concluding anything from it, and only when we express it through words or deeds do we understand what it is about (Lindseth & Norbergh, 2021). The lived experience is an original experience as it is lived by humans, affiliated to the world where we are already familiar with the meaning of all kinds of phenomena, and it is also prerequisite when revealing a world, a world with a meaning content (Lindseth & Norberg, 2004). Thus, lived experience helps us investigate what lifeworld phenomena really are about and how to come to terms with challenges in life by narratives about how it is to live with various phenomena. To understand life, we must first reflect upon the lived experience (Lindseth & Norberg, 2021).
Compassion

Compassion is becoming a major topic in modern health care (Tveit & Raustol, 2017) and is of great significance for carers to meet the patients demands and needs (Halifax, 2014), especially for carers caring for patients suffering from mental illness (Crawford et al., 2014). According to Strauss et al., (2016) compassion means recognising suffering, understanding suffering, feeling emotionally connected with the person who is suffering, tolerating difficult emotions, and acting to help the person. In this thesis, compassion means “noticing” another person’s suffering, “feeling” others’ pain, and “responding” to those suffering (Kanov et al., 2004), as it is more in line with the findings of this thesis. The concept of compassion is also viewed upon as a way to ease suffering through identifying others’ needs, understanding those needs, and acting upon that understanding (Sinclair et al., 2018). Compassion is also a concept with a theoretical foundation in Lögstrups ethical demand (1997) as a sovereign expression of life. It is a philosophical assumption intending that carers’ actions should be guided by their sensibility and compassion, thus being able to interpret the patients beyond words and actions (Lögstrup, 1983a).
Emotional Regulation

Managing one’s own feelings is an evident part when working in an occupation that focuses on other people. This a process named emotional labour, according to Hochshild (1983). Acting on this process is necessary and this means using a strategy either suppressing or re-evaluating these emotions (Gross, 1998), called emotional regulation (Gross, 2002). Being able to manage one’s own emotions could mean having a strategy of handling and minimising problematic behaviour (Hejlskov et al., 2017).

According to Swedish Municipalities and County Councils, (2018) all 20 Swedish forensic psychiatric units work actively with prevention regarding threats and violence. The majority of these units and clinics have implemented a strategy called RESIMA, based on the so called Bergen-model, originating from the Norwegian TERMA training model established at the Haukeland University Hospital, Department of Forensic Psychiatry in Bergen, Norway (Björkdahl et al., 2013). The Bergen-model is strongly influenced by the City model (Bowers 2002), which is a theoretical nursing-based framework that describes three staff factors that are considered vital when reducing conflicts and containment in psychiatric wards. One is self-regulation of emotional responses, which includes awareness and control of feelings, especially fear and anger. According to Björkdahl et al. (2013), this strategy is in a Swedish context labelled as “low affective”,

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meaning being able to prevent conflicts from arising by being able to calm down and not acting out on initial emotion.

Regulating oneself is a phenomenon described by the research participants, especially in the thesis’ studies (I, III), as coming into contact with one’s own shortcomings and vulnerability – a concept similar to emotional regulation. As caring in a forensic setting is intertwined with dealing with emotions, carers describe this strategy not only in relation to themselves, but also the patients’ expressions of suffering.

**Vulnerability**

Another central concept of this thesis is the phenomenon of vulnerability. Vulnerability is seen as obvious and self-explanatory, but not often described (Sellman, 2005). A concept with philosophical assumptions according to Lögstrup (1997) and Ricoeur (1995). Lögstrup (1997, 1978) states that vulnerability is a fundamental condition of human life, meeting another person is an interhuman act, as encountering another person means being guided by perception and vulnerability. Ricoeur (1995) depicts vulnerability as a part of humans’ very existence, both being a burden and a resource, a source for creativeness and variation, encouraging an ethical approach to the carer–patient relationship (Stenbock-Hult & Sarvimäki, 2011). Vulnerability is described as something that is difficult for carers to separate from their personal life, as facing vulnerability in the
workplace often means transgressing their personal boundaries (Angel et al., 2020). Vulnerability is depicted as having emotional, cognitive, and physical expressions (Boldt, 2019).

**The Space In-between**

An essential idea of phenomenology is that it is a philosophy that portrays existential human existence and how we, as people, relate to and are dependent to the world around us. It is a notion founded in the reasoning by Husserl, that our lifeworld is to be perceived as being in the tension between different opposites that exists in our lifeworld. Being in a caring relationship with someone means dealing with dualities in the form of similarities and differences. Having a phenomenological standpoint means mediating between these opposites and recognising a phenomenological attitude as a philosophy of dealing with this tension between dualities, the “space in-between” [Sv: mellanrummet] (Dahlberg, 2019). The space in-between refers not only about the duality to other people, but also the duality within one’s own body that occurs when encountering others. It is by becoming aware of this space in-between and being active in the movement between two dualities that one may become aware of one’s relation to oneself and others, and health may grow. The dualities that arise in the encounter with others should not be considered as opposites to each other. On the contrary, they should be seen as in relation to each other. To understand the visible, we must
also understand the invisible, to understand health, we must also understand illness (Dahlberg & Dahlberg, 2019b).

The Theoretical Perspective of the Thesis

The purpose of this section is to clarify the thesis’ theoretical starting points and the view of caring and treatment in FPC. The present thesis has a caring perspective with the lifeworld as a basis, which is based on the fact that as a carer in forensic psychiatric inpatient care, you often encounter patients, which is intertwined with self-reflection. Since forensic psychiatric care often involves significant and long-term interventions in a person’s life and autonomy, care must be seen as problematic from an ethical perspective. Lögstrup’s philosophy is close to the situation with a focus on the interpersonal encounters where something happens – a philosophy that opens up for a wonder more than an answer (Martinsen, 2012a). Knud Eiler Lögstrup (1905–1981), professor in ethics and religion elaborates upon a phenomenological analysis on human encounters and the mutuality that exists among humans (Lögstrup, 1997), his theory and reasoning are about the ethical demand that we as humans are dependent of each other to evolve and live, that we are each other’s destiny and exist in a common and shared lifeworld. This so-called demand is radical,
unspoken, and refers to us as humans being there for one another; being able to interpret an encounter means being able to good for the other person (Lögstrup, 1997).

According to Martinsen (1993), while norms and rules are based on good intentions, they are nonetheless generated by human beings. Contrary to these norms and regulations, there are aspects of life that are not created by man, such as trust, mercy, openness, hope, joy, and love, which Lögstrup (1997) calls the sovereign utterances of life. Being guided by these utterances of life is intertwined in a caring context with basing one’s actions on compassion and sensibility, interpreting the patient beyond words or actions, being able to view the patient from where he or she stands, thus gaining access to what is considered personal and private, and being able to see each other as humans in a person-to-person encounter (Lögstrup, 1983a). As the Danish philosopher Lögstrup states (1997), it is of importance to not neglect these ideas as it exists as constructs not made by man, that we, as humans, must reflect upon and restrain our naturalistic intentions, making it possible to truly see each other. Lögstrup (1994) states that we as humans initially face each other with trust until we are proven otherwise, that the encounter is based on the “good”. The unspoken demand stems from accepting that we share a common lifeworld, that encountering other humans means “having the other person’s life in one’s hand is a demand to take care of this hand”. According to Lögstrup (1983a), sensing [Dk: sansning] is an independent, distance-
free access to the world, to the contexts we are embedded in. Sensing
touches something that cannot leave us untouched, in sensing we are
always touched by the situation we are in. “The mind is tuned below
the threshold of consciousness” (Lögstrup, 1983a). The mood of the
senses is not unauthorised for our emotions, it is open to our emotions
for the emotions that Lögstrup calls “seeing emotions” or “asset-
giving emotional possibilities” (Lögstrup, 1987). They give us access
to the world and to our historical creation in its relational context.

Rationale

Prior research regarding encounters in a forensic setting
highlights the fact that encounters constitute a major part of the care
given, that the carer–patient relationship is the very foundation in
forensic nursing and that it is in these encounters the gift of nursing
can be given and an alliance and relationship may appear. The
opportunity to have an impact on the patient’s life is given in these
encounters, by alleviating suffering and to equip the patient with the
necessary tools to recover and once again live a safe, independent, and
productive life in society. Being a carer in today’s forensic psychiatry
is intertwined with helping people who have committed crimes, and
providing care based upon compassion, understanding, and
participation, often while being exposed to threats, violence, and
sometimes incomprehensible expressions of suffering for extended
periods of time. It is also a fact that prior research regarding what exactly an encounter is, what it means and how it is experienced by the carers is limited. This thesis hopefully can help fill the gap by adding more knowledge, which may assist carers to further develop the care given and support their everyday work.

Forensic psychiatric care in Sweden has recently been evaluated by the The Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU, 2017). It states that more research is needed in order to develop forensic psychiatry, and that it is of ethical importance. The evaluation concluded that it is of clinical importance that research may further improve forensic nursing, treatment and especially carer–patient encounters and that there were no adequately sufficient amount of research and articles depicting these encounters in a Swedish context. It adds that more research of essence is needed to draw any form of conclusions, preferably in the form of a meta-analysis, which requires research to a greater extent.

Nursing and encounters are a necessity, and the very foundation for the patient’s recovery and initiatives to develop this further is greatly encouraged in the described evaluation. It is also reasonable to assume that research that focus on carer–patient encounters could generate knowledge that may be used to develop best possible care and contribute to prevent negative consequences
such as use of coercion, burned out carers, deteriorating patient health and recruitment challenges in forensic psychiatry care.

Challenging encounters is not something exclusive for forensic psychiatry, on the contrary, it is evident that all fields and contexts in nursing are filled with ethically challenging encounters. However, when researching a phenomenon in what is considered an extreme context, it is probable to believe that the phenomenon’s patterns will reveal itself more clearly (Dahlberg et al., 2008).

Forensic nursing is based on the value of “seeing the person behind the crime”, and getting to know the person requires the carers to create alliances and relationships through the encounters that constitute a major part of the care given. It is in these alliances the carer may help the patient to flourish, grow as a person, and recover. The knowledge gap described above (SBU, 2017) further emphasises the particular importance of nursing research in Swedish forensic psychiatry regarding psychosocial interventions, such as encounters, especially studies with a qualitative approach. This type of research is of relevance to describe and further understand what encounters really means for the carers. It makes their voice heard as carers and they are given an opportunity to express their lived experience of what it really means to act as both guards and care providers at the same time, and defines the framework and content of what falls under the umbrella of forensic psychiatry.
This thesis hopefully will provide more in-depth knowledge about the phenomenon of encounters in FPC, and nursing can hopefully develop even more. Knowledge and deeper understanding encourage self-reflection, which may be of assistance during the risk of destructive behaviour, and it may potentially contribute to a decrease in recidivism, which is the main objective of forensic psychiatry. For carers to truly fulfil their task of improving mental health and preventing recidivism, it can be assumed that forensic nursing should be based upon person-centred care. If carers truly base their caring actions on a person-centred approach, it should be founded upon the patient’s lifeworld. Thus, knowledge of what constitutes an encounter from a carers’ perspective is of importance to unravel its meaning and to understand if carers possibly have a phenomenological approach in their carer–patient encounter and if it is possible to fully embrace the patient’s lifeworld and depict the many challenges that face the carers in their everyday work. Knowledge that is called for that may further develop forensic nursing.
The Purpose of the Doctoral Thesis

The overarching purpose of the thesis was to obtain a deeper understanding of carers’ lived experience of encounters with patients with mental illness in forensic inpatient care. To answer the overall purpose and be faithful to the scientific theoretical point of view, the focus is on the encounter as the intentional object (I). To achieve a deeper understanding, carers’ underlying experience structures of the encounter are then sought (II, III, IV). The thesis consists of four papers with the following aims:

Paper I to illuminate the meaning of nurses’ lived experiences of encounters with patients with mental illness in forensic inpatient care.

Paper II to gain a deeper understanding of nurses’ compassion in providing forensic psychiatric inpatient care.

Paper III to illuminate the essential meanings of carers’ lived experience of regulating oneself when caring for patients with mental illnesses in forensic inpatient care.

Paper IV to describe the phenomenon of vulnerability as experienced by carers in forensic inpatient clinics.
Scientific Approach and Research Process

This segment clarifies and describes the philosophical assumptions that this thesis and the research process rests upon. It illuminates the ontological and epistemological starting points to further elucidate how knowledge is created and how it is achievable to understand the lived experience of the participants and to obtain a deeper understanding of carer–patient encounters with patients with mental illness in forensic inpatient care.

Phenomenology

Phenomenological as well as hermeneutic philosophy can be seen as an opposing movement that has emerged as a response to the ideal of positivism, a science that was considered all-encompassing in its time (Dahlberg et al., 2019). Phenomenology was first ascribed value by Edmund Husserl (1970) in the early 19th century, where he raised criticism to his own scientific background. He is, by many, considered the founding father of what we today consider to be phenomenology (Carlsson, 2003). Husserl (1970) developed the concept of the lifeworld perspective and problematised the naturalistic intention by raising a critical voice and consciousness to what is considered “taken for granted”, a necessary reflection on our relation to our surrounding world, our “lifeworld” – our world which
we live in, speak about, and experience (Bengtsson, 2001). As Heidegger (1993) states, phenomenology means “what appears or is obvious”. This means taking an epistemological standpoint to study the phenomenon as it is experienced and “going to the things” to be able to understand them, letting the phenomenon show itself and manifesting itself to us a researcher (Dahlberg et al., 2008). Considering that everything and everyone is connected to one another, that we all bring or own personal experiences, activities and way of conduct into this shared world, according to Merleau-Ponty (1968), these experiences and activities is “the flesh of the world”, an elaboration of the concept of lifeworld, which also considers each individual’s background and the importance of making it visible. Bengtsson (2001) emphasises, perhaps controversially, that a scientific approach that is not rooted in the lifeworld concept can even risk becoming irrelevant for the common man. Thus, the phenomenological lifeworld perspective is compatible to a great extent within nursing (Dahlberg et al., 2003).

The narratives of carers caring for patients with mental illness in forensic inpatient care were focused on the lived experience of each individual. The basis of phenomenology is the lived experience, as it is in this experience that we can examine all sides of a phenomena (Husserl, 1970). It is in this sense according to Husserl’s reasoning that we can truly understand existential phenomena such as health or illness and love or loneliness. It is by recognising and moving between
these dualities that comprise of human existence, in the tension between opposites that we create understanding. Hence, phenomenology is referred to as the philosophy of the “the space in-between” [Sv: mellanrumnets filosofi] (Dahlberg, 2019). In relations between humans and encounters with others it is in this tension that the possibility for health is created, which requires the two parties to become aware of one’s similarities and differences (Dahlberg & Dahlberg, 2019a). In other words, it is in the space in-between where each human is attributed, where we become aware of the duality in the lifeworld and our coexistence with others. In the tension that occurs when encountering others, we truly understand ourselves (Ekerbergh, 2019). Embracing the term of the space in-between and its philosophical assumptions is intertwined with existential questions regarding our perceived reality and our existents as human beings, embracing phenomenological ontology, epistemology, and methodology and problematising and reflecting upon our pre-conceived notions and our lifeworld that we often take for granted (Dahlberg, 2019).

Our lived experience is based on the individual experiences of the lifeworld and cannot be regarded as something objective that can be reconciled with a true picture of the phenomenon. Instead, the lifeworld can be defined as the reality of everyday life and something we take for granted (Bengtsson, 1998). Through narratives, we gain access to people’s lived experiences and the emotional reactions that
result from these experiences. The fundamental purpose of phenomenology is to present the common meaning, i.e., the reduction of the individual experiences of a phenomenon or concept to a meaningful whole, thus presenting the universal essence of the phenomenon (Creswell & Poth, 2018) by investigating and discovering what is constant in all the variations of the phenomenon (Lindseth & Norberg, 2004). According to Ricoeur (1976), who was greatly influenced by Husserl, a central question in phenomenology concerns the meaning of the lived experience of a phenomenon, i.e., an interpretation of what a text is saying and what it is talking about (Ricoeur, 1995). According to Ricoeur (1976), we can never understand another person’s experience, but we can understand the meaning of others’ experiences.

One’s lived experience is private, and its true meaning can only become comprehensible and public when expressed in text, which is analysed in order to grasp not only what the text is saying, but also what the text is talking about. Only then will the true meaning of the lived experience unfold, called the utterance meaning, which is acquired from the individual’s lifeworld (Ricoeur, 1976). A phenomenon exists in our lifeworld, in our natural attitude, and is described by (Husserl, 1970), as a display of numerous items organised in space and time for us to perceive, always there, and the foundation for all shared human experiences.
According to Husserl (1989), phenomenological understanding of corporeality means an important difference between the lived body as a starting point for experience and the objective body as an object of attention. Intentionality is a central concept in phenomenology, i.e., man is directed towards the world and things in the world, which have meaning for him or her before seeing it. Based on our corporeality, this means that he or she do not see things in the world from all sides at once but from a particular perspective, its inner and outer horizons (Husserl, 1978). Husserl (1978) wants to describe the world as we perceive it, but he also wants to describe how it is possible to perceive it. He wants to describe human subjectivity. Husserl (1978) claims to have a key that gives us access to hidden secrets. That key is called intentionality, it is a direction of our state of consciousness to know what the phenomenon is “about”, its “meaning”. The phenomenon to which the state is directed is called the “intentional object”. To imagine something, to see something, to believe something, to fear something, and so on are various examples of what phenomenologists call intentional acts (Husserl, 1989).
Taking on a Reflective Stance

Through the research process, avoiding making what is indefinite, definite, was seen as necessary, which is made possible by reflecting upon an approach to refraining one’s own judgement (Dahlberg & Dahlberg, 2003). Husserl (1970) originally elaborated on this process which he entitled \textit{(epoché)}, meaning we take different phenomena for granted, and to understand a phenomenon’s true meaning, we need to dispense with our previous understanding. Only then may the phenomenon be revealed and show its essential meaning – its essence (Husserl, 1995). Moustakas (1994) adds that this approach also requires setting aside personal experience in order to become truly objective, thus perceiving a phenomenon or concept for the very first time. Riceour diverges from Husserl and reaffirms the assertions of Heidegger, arguing that one’s preunderstanding cannot be completely disregarded, for it is only through our preunderstanding that we can understand the meaning of the other (Kristensson Uggla, 1994). Being self-aware, being able to self-reflect, means having an openness to the “flesh” of the world, realising that all humans carry a background that needs to be dealt with, or as Dahlberg et al. (2008) states, in order to grasp de complexity of the lifeworld, one must use the concept of “bridling” and thus problematise one’s natural attitude.

The main author of this thesis is well acquainted with the studied context, both from a caring and nursing perspective, as an assistant nurse, registered nurse, and specialist nurse in psychiatric
care. Having this prior knowledge of forensic nursing is relatively rare since few fields within nursing involve encounters with patients with severe mental illness and individuals who have committed crimes, for extended periods of time. Having experience of forensic inpatient care is intertwined with patient encounters that has certainly influenced how the carer’s professional role and encounters with patients are perceived. Being able to problematise one’s natural attitude and intention, having an openness and dealing with pre-understandings and preconceptions has been a vital part of the research process, demanding an ongoing process of self-reflection. Having this prior knowledge and experience of the studied context, as well as being familiar to some of the research participants could be viewed from different points of view. It can be viewed from one side as a strength, as it hopefully enabled the participants to speak honestly and with trust, without becoming hesitant and afraid of revealing their shortcomings, thus revealing sensitive information that otherwise would not be accessible. And in one sense, it is challenging, as it also could mean that the participants refrained from revealing weaknesses, or that during the interview or process of analysis, the main author became insensitive to conditions and circumstances that seemed obvious, thus, making it a challenge when problematising one’s own pre-understanding and possibly missing out on hidden messages during the interviews. Overall, the main author’s preunderstanding
has therefore presented a challenge, but it has been viewed generally as more of an asset than an obstacle.

**Hermeneutics**

Hermeneutics is a philosophy of understanding what is feasible by three basic meanings, first expressing something out loud, second clarifying the expressed spoken word, and finally, interpreting or translating the clarification to an understandable meaning (Palmer, 1969). Studying human conditions and humans themselves is difficult to reduce to a single method and even more problematic to understand with a set of measurements (Dahlberg et al., 2008). Words are polysemic, meaning they have more than one meaning, and to understand different meanings requires interpretation (Kristensson Uggla, 1994). The origin of Hermeneutics dates back to ancient Greece and is derived from the word *hermeneuein*, meaning “to interpret”, and *hermeneutike* (*techné*), meaning “the art of interpretation” (Honderich, 1995). It is expressed by Schleiermacher to have been a tool to interpret biblical texts with a more systematic approach, becoming aware of the author behind the text, conceptualising the movement between the parts and a whole, a hallmark of hermeneutic research often referred to as the “hermeneutic circle” (Dahlberg et al., 2008). According to Mackey (2005), Heidegger is often presented as a predecessor to modern hermeneutics, as his philosophical assumptions is more synonymous with an ontological reasoning than Husserl’s
epistemological reasoning of phenomenology, as Heidegger introduced his view on interpreting phenomenology.

Hermeneutics is defined by (Ricoeur, 1991) as “the theory of operations of understanding in their relation to the interpretation of texts”. The main objective for the hermeneutic author is to understand the meaning of the text, liberating the utterance’s meaning, which is not to be confused with recognising the utterer’s meaning (Ricoeur, 1976). The process of understanding goes through “what the text is saying to what it is speaking about” (Ricoeur, 1982). As narratives always have more than one meaning, it is always probable to assume that there is always more than one interpretation that is possible (Ricoeur, 1976), deciphering the language from a manifest content to beyond the text, to a hidden or latent meaning (Palmer, 1969).

Hermeneutics implies reflecting upon one’s ability to understand and reflect on knowledge; it is not possible to dismiss one’s pre-understanding; instead Gadamer (2004) suggests that it is only through becoming aware of one’s preunderstanding and recognising it, that we can truly understand. We strive towards openness in order to make what was previously unknown become known, thus making it possible to thematise the reality behind the spoken language (Ricoeur, 1976).

Gadamer (2004), who further expanded the reasoning of Heidegger, states “how is understanding possible?” and suggests that it is not possible to view history objectively, as we all play a part in our
own history and that all humans carry experiences of life that should not be neglected (Ricoeur, 1976). He adds that taking our prior knowledge, experiences and historical awareness instead could be seen as an asset, perhaps even necessary to gain an understanding (Fleming et al., 2003). Consciousness is instead determined by the fusion of the individual’s horizons (Gadamer, 2004). This distinction and point of view of the concept of pre-understanding is one of the main differences of the Gadamerian philosophical hermeneutic tradition and phenomenology based on Husserl’s opinion of reduction (Fleming et al., 2003).

A Fusion of Horizons

A new understanding that may appear as a “fusion of horizons” is developed between the researcher and participant (Fleming et al., 2003). Horizon [Ger: Horizont] means a range of vision, what we can grasp from a certain vantage point, the very limits of what one can see and understand, the whole of what can be grasped or understood by a person at a certain point in time in a specific situation. Once our pre-understandings, language, openness to meaning, and imagination are explored, we can combine horizons, past and present, to create a “fusion of horizons” (Gadamer, 2004). Ricoeur (1991) implies that interpretation is thus a form of movement where the text can only be understood when each part is connected
back to the whole, and the whole can thus only be understood from its parts, a dialectic movement between the past, present and the future.

To gain a more profound understanding of the participants’ lifeworld and lived experience, this thesis is partly based upon the traditions of Gadamerian philosophical hermeneutics as the main author intended to interpret these experiences through a hermeneutic framework. This means that creating an understanding and managing our own pre-understandings is not possible without gaining insight into one’s cultural horizon from which we interpret ourselves and our surroundings (Gadamer, 2004), as one’s pre-understandings, one’s prior experiences finds expressions through the form of stories about life itself (Ricoeur, 1982).

Understanding humans’ means to capture the expressions of existence (Gadamer, 2004), even though Gadamer did not present a scientific method, it is feasible to assume that only dispensing our pre-understanding is not enough to create this understanding (Dahlberg et al., 2008). Understanding participants’ narratives meant getting in touch with one’s own knowledge and previous experience with the context being studied (Frank, 2004). New knowledge arose and was merged with old knowledge to create a “hermeneutic circle”, where the whole could not be seen without its parts and the parts not without its whole, creating and presenting a “fusion of horizons”, a new understanding (Gadamer, 2004).
Methodological Assumptions

In order to gain knowledge about a sought-after phenomenon, the researcher must first seek clarity in the field of theoretical theory, i.e., its ontological and epistemological assumptions before seeking methodological distinctions. Scientific knowledge must therefore be based on decisive choices of an ontological and epistemological nature, i.e., choices based on what kind of world (ontology) and what kind of knowledge (epistemology) one seeks and not primarily how to proceed (methodology).

According to Eriksson and Wiedersheim-Paul (2014), the two epistemological approaches positivism and hermeneutics can be seen as two extremes on a continuum where in one extreme, the positivist position, one assumes that reality is objective and can be measured while the other position, the hermeneutic, emphasises the purely subjective notion that meanings require interpretation. In the present thesis, the ontological and epistemological fields are based on idealism and philosophy of existence, i.e., that reality is of a comprehensible and spiritual nature and that the phenomena we can gain knowledge about are constituted by thinking or consciousness, which means that knowledge is induced from the unique human lifeworld (Åsberg, 2001).

Methodology is about the approach, i.e., what choice or path the researcher must make to achieve knowledge of the sought
phenomenon. The choices of the theoretical nature of science that the researcher makes determines the methodology, i.e., the approach to knowledge solves the question of the relationship between the subject (researcher) and the object (phenomenon) (Eriksson & Wiedersheim-Paul, 2014) whereby data, numerical or non-numerical data, reflects the phenomena’s properties.

To be able to answer the overall purpose of this thesis, to obtain a deeper understanding of carers lived experience of encounters with patients with mental illness in forensic inpatient care, a hermeneutic and phenomenological methodology has been chosen. Hermeneutics and phenomenology have been intertwined through texts by the German philosopher Martin Heidegger (1889–1976). To understand a complex human phenomenon, knowledge of phenomenological and hermeneutic philosophy and methods is required, as these approaches seek answers to questions about human existence and related questions. However, the two approaches have a slightly different focus: phenomenology emphasises rigor and the importance of a descriptive approach that does not include interpretation, while hermeneutics emphasises interpretation and methodological flexibility (Dahlberg, 2019). Based on previous reasoning about the thesis’s ontological and epistemological points of view, idealism and philosophy of existence, hermeneutics can primarily be seen as a theory of knowledge, epistemological approach based on existential philosophical and ontological attitude while phenomenology includes
an ontology and epistemology of idealistic character with a conscious philosophical starting point assuming that the world is constituted within the subject’s consciousness. Both traditions, hermeneutics and phenomenology, emphasise existential values and emphasise humans as a seeker of meaning. Theoretically and philosophically based assumptions are a prerequisite for being able to answer the thesis’ research question on why meaning analysis cannot and should not be replaced by content analysis or other methodological procedures (Dahlberg & Dahlberg, 2019).
Methods

Design

A qualitative design was chosen for this thesis regarding the overall aim and the four sub-studies (Table 1). When studying an issue that needs explaining or a deeper understanding, originating from firsthand descriptions of individuals, a qualitative design is appropriate (Creswell & Poth, 2018). Implementing qualitative research is intertwined with a reflexive process as it means having multiple procedures going on simultaneously, data collection, analysing data, adjusting the aim of the research, reflections and discussions regarding ontological and epistemological assumptions, a procedure where one affects the other (Mays & Pope, 2000). When planning the research and the design of this thesis, emphasis has been on rigour and consistency regarding ontological, epistemological, and methodological assumptions of the various studies (I, II, III, IV), based upon phenomenology and hermeneutics. This means that this thesis is not only founded on the methodological assumptions of phenomenology and hermeneutics, but also on philosophical traditions.
Table 1 Overview of the four studies in the thesis

<table>
<thead>
<tr>
<th>Paper</th>
<th>Aim</th>
<th>Participants</th>
<th>Data collection</th>
<th>Analysis method</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Illuminating the meaning of nurses’ lived experiences of encounters with patients with mental illnesses in forensic inpatient care.</td>
<td>2 RNs¹, 3 SRNs² and 8 ASNs³.</td>
<td>Narrative interviews, 2018/09-2018/10.</td>
<td>Phenomenological-hermeneutic approach (Lindseth &amp; Norberg, 2004).</td>
</tr>
<tr>
<td>III</td>
<td>to illuminate the essential meanings of carers’ lived experience of regulating oneself when caring for patients with mental illnesses in forensic inpatient care.</td>
<td>1 RNs¹, 5 SRNs² and 3 ASNs³.</td>
<td>Narrative interviews, 2020/09-2020/12.</td>
<td>Phenomenological-hermeneutic approach (Lindseth &amp; Norberg, 2004).</td>
</tr>
<tr>
<td>IV</td>
<td>to describe the phenomenon of vulnerability as experienced by carers in forensic inpatient clinics.</td>
<td>3 RNs¹, 3 SRNs² and 3 ASNs³.</td>
<td>Narrative interviews, 2021/04-2021/09.</td>
<td>Reflective lifeworld research (Dahlberg et al., 2008).</td>
</tr>
</tbody>
</table>

¹ Registered nurses, ² Specialist nurses in psychiatric care, ³ Assistant nurses with special training in psychiatry.
Settings

All participants worked at a major forensic hospital (clinic) in the middle part of Sweden. The clinic is one of Sweden’s regional clinics and is one of the larger clinics with national admission. The regional clinic was classified as a high security clinic with one department classified as very high. Approval for the study was obtained by the head of clinic. Participants were informed and recruited through email and phone calls; all interviews were carried out with consent. The clinic accommodated approximately 180 employees and 100 patients across eight wards, each housing approximately 12 to 15 patients at the time this study was conducted. Most patients are men aged 25–45 years who were convicted of some type of violent crime. Approximately 60% of the patients have schizophrenia or another psychotic disorder transmitted to involuntary inpatient forensic psychiatric care due to some sort of violent crime in accordance with the Forensic Mental Care Act (LRV 1991:1129), rather than being incarcerated within the penal system. The carers work with a so-called “contact personnel system”, where two or more carers work especially close with a specific patient. The carers work closely with the patients, as spending time together is a fundamental part of the nursing care provided. Other tasks involve administering medications, helping patients with difficulties in day-to-day living routines, and assisting patients on parole. A psychiatrist
makes his or her round at least once a week, and most patients are assigned a specific psychologist. During these meetings or rounds, the carers may often assist or participate in a variety of ways.

Participants

Participants – Study I & II

The participants were all recruited with the help from the first line manager, from the same forensic clinic with a purposive sample of having experience of FPC as an inclusion criterion. Participants consisted of ten men and three women [median (Md) age = 36 years, age range = 28–67 years]. Participants had worked in forensic psychiatric care between five and 46 years (Md=11 years), and there were five registered nurses, three of which were specialist nurses in psychiatric care, and eight assistant nurses, all with special training in psychiatric care.

Participants – Study III

The participants were all recruited with the help from the first line manager. Participants were informed and recruited via email and phone calls from the same forensic clinic with a purposive sample, with the inclusion criteria of having experience of forensic inpatient care of patients with mental illness. The study consisted of a total of nine participants. The age of the participating carers ranged from 30
to 66 years (Md=41.6 years) and their experience of forensic inpatient care ranged from two to 32 years (Md=12 years). The participants consisted of five males and four females; among these, five were specialist nurses in psychiatric care, one was a registered nurse, and three were assistant nurses. In this study, all participants are referred to as “carer” in order to conceal identities.

**Participants – Study IV**

Nine participants were recruited with the help from the first line manager with a purposive sample of having experience of FPC as an inclusion criterion, all participants worked at the same major forensic hospital (clinic) in Sweden. The clinic is one of Sweden’s regional clinics and is one of the larger clinics with national admission. The study participants consisted of four men and five women between 31 and 67 years of age (Md=39 years). In this study, the participants represented different wards to a higher degree. The amount of experience in forensic inpatient care differed between the participants and ranged from three to 33 years (Md=13 years). Among the participants, there were three specialist nurses in psychiatric care, three registered nurses and three assistant nurses. In this study, all participants are referred to as “carers” to conceal their identities. A summary of the characteristics and demographic data of the participants from the four studies are described in Table 2.
Table 2 Demographics of the research participants

<table>
<thead>
<tr>
<th>Paper</th>
<th>Participants</th>
<th>Profession</th>
<th>Gender</th>
<th>Age</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>13</td>
<td>2 RNs(^1,) 3 SRNs(^2) and 8 ASNs(^3).</td>
<td>Male=10, Female=3</td>
<td>Md 36 years</td>
<td>Md 11 years (5-46 years)</td>
</tr>
<tr>
<td>II</td>
<td>13</td>
<td>2 RNs(^1,) 3 SRNs(^2) and 8 ASNs(^3).</td>
<td>Male=10, Female=3</td>
<td>Md 36 years</td>
<td>Md 11 years (5-46 years)</td>
</tr>
<tr>
<td>III</td>
<td>9</td>
<td>1 RNs(^1,) 5 SRNs(^2) and 3 ASNs(^3).</td>
<td>Male=5, Female=4</td>
<td>Md 41.6 years</td>
<td>Md 12 years (2-32 years)</td>
</tr>
<tr>
<td>IV</td>
<td>9</td>
<td>3 RNs(^1,) 3 SRNs(^2) and 3 ASNs(^3).</td>
<td>Male=4, Female=5</td>
<td>Md 39 years</td>
<td>Md 13 years (3-33 years)</td>
</tr>
</tbody>
</table>

\(^{1}\) Registered nurses, \(^{2}\) Specialist nurses in psychiatric care, \(^{3}\) Assistant nurses with special training in psychiatry.

Data Collection

Data Collection – Study I

Invitations were mailed to the heads of the clinic and each ward with information about the study and an approval form. Consent was gained from the head of clinic. Carers were recruited with a purposive sample. All participants in the study had experience caring for patients with mental illness in forensic inpatient care. In the presentation of the results of the study, all staff were referred to as “nurses” to conceal their identities. All interviews were conducted at

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the forensic clinic at a location chosen according to the participants’ preferences. Even though the interview locations were chosen by the participants, they were encouraged to select a quiet atmosphere without any distractions, an environment where the participants felt safe and could speak as openly as possible. The narrative interviews were one-on-one interviews that consisted of open-ended questions in line with (Mishler, 1986). Mishler (1997) defines narratives as “a descriptive presentation that aims to illustrate a coherent sequence of events”. The interviews were recorded and transcribed verbatim by the main author. The verbatim transcriptions of the audiotaped interviews were validated, i.e., the texts and the tapes were compared, and any non-verbal information was added to the transcribed interviews (for example laughter, silence, changes in tone of voice).

The interviews lasted from 41 to 60 minutes (M=48min). The participants were encouraged to share their stories about their lived experiences of encounters with patients with mental illness in forensic inpatient care. Questions asked during the interviews were, “Tell me about an encounter with a patient that evoked negative feelings?” and “Tell me about an encounter with a patient that evoked positive feelings?” Further questions included, “How did you feel?”, “Tell me more?”, and “Has that happened before?” The main questions were designed in such a manner that they could be perceived as either positive or negative. This was done intentionally to trigger the participants’ recollection of situations connected to their lived
experiences and to hopefully gain access to their narratives and life stories. The line of thinking is that it can be easier to recall experiences that have been emotionally moving and asking about specific situations is a technique that is proven to be effective when conducting narrative interviews (Drew, 1993).

**Data Collection – Study II**

The second study was a supplementary secondary analysis of the data collected in the previous study (Paper I). Life stories represent unique data in that they are collected primarily for single use but can also be stored for secondary use in future research. A secondary supplementary analysis is not based solely on reusing data but an effort to reshape data in an in-depth investigation of an issue from a primary study (Heaton, 2004).

**Data Collection – Study III**

Narrative interviews with open-ended questions were conducted with the aim of achieving high information power, as described by Malterud et al. (2015). The participants received information and were recruited by email and telephone with a purposive sample, with the inclusion criteria having experience of forensic inpatient care of patients with mental illness. In this study, all participants are referred to as “carer” in order to conceal identities. The interviews were all conducted digitally with video and audio
recording, with regard to the restrictions due to the COVID-19 pandemic that prohibited the first author to personally visit the participants. The interviews lasted between 39–51 minutes (Md=44 min) and were in line with Mishler (1986), who emphasises that the role of the researcher does not include find narratives, and that instead, we create them, as the researcher is also narrator, who constructs a story with plot, based on the research objects’ descriptions through analytical paraphrases using concepts, methods, data selection, delimitations and interpretive perspectives (Mishler, 1997.) Participants were encouraged to share their narratives about their lived experience of regulating oneself when caring for patients with mental illnesses in forensic inpatient care. The open-ended questions asked were, “Does this seem familiar?”, “What does regulating oneself in encounters mean to you?”, “Tell me about an encounter where regulating oneself has worked well?”, “Tell me about an encounter where regulating oneself has not worked well?”, with follow up questions, such as; “How did that make you feel?”, “Please tell me more” and “Can you give me an example?”. Each interview was transcribed verbatim by the first author.
Data Collection – Study IV

Participants were informed about the study and recruited through email and phone calls; all interviews were carried out with consent. Participants were recruited with a purposive sample, and the inclusion criterion was experience in forensic inpatient care. Due to the ongoing COVID-19 pandemic, all the interviews were conducted by the first author digitally with video and audio recording via a video chat platform. The interviews were conducted with the aim of achieving high information power, as described by Malterud et al. (2015). The narrative interviews lasted between 40 and 60 minutes (md 42 min). The recorded interviews were later transcribed verbatim by the first author. The transcribed interviews were also validated by comparing text and recordings as any non-verbal information, such as laughter, silence, or changes in tone, was added. The narratives comprised open-ended questions in line with Mishler (1986). The interviewees were initially asked to describe what it had been like to start working in the department and about how they thought they had developed as carers. In the rest of the interview, the main questions were: Tell me about one or more encounters that have been difficult to handle? What happened? How did you feel? How do you think you were perceived as a carer? How do you think others’ perceptions of you as a carer have changed over time? How might the job affect you as a person? Follow-up questions were asked to encourage the participant to elaborate and share more.
Method of Analysis

**Phenomenological-Hermeneutic interpretation – Study I & III**

Paper I and III were analysed according to Lindseth and Norberg’s (2004) concept of phenomenological-hermeneutic interpretation, where the process of interpretation and analysis of text goes through three phases: a naive understanding, structural analysis, and comprehensive understanding. This process can be viewed as a movement between understanding and explaining, a movement between the whole and parts of the text, and a movement between what the text is actually saying and what it is indicating. During the naive understanding, an overall awareness of the text is constructed by reading the text over and over, which ends in a formulation of the initial understanding of what the text is about, a process that may be repeated numerous times until a satisfactory formulation appears (Lindseth & Norberg, 2021). The next step according to Lindesth and Norbergh (2004) the structural analysis, is a more precise form of analysis used to reveal parts and patterns and seeking to clarify the text through outdistance and a critical way of being. This was achieved by analysing all the meaning units, which were then sorted into themes and subthemes, this subsequent part of the analysis either validates or invalidates the prior naive understanding (Lindseth & Norberg, 2021). The last and final phase in establishing a
comprehensive understanding is an analytical, in-depth interpretation of all three phases (Lindseth & Norberg, 2004). Altogether, this interpretation produces a comprehensive view of what the text represents as a whole. It also considers a theoretical perspective implying the author to use his or her critical talent to form a more in depth understanding (Lindseth & Norberg, 2021). In this third step of the analysis, a deeper overall understanding of the phenomenon is sought in relation to the research question and the studied context through reflection on the naive understanding and the explanation of structural analysis in relation to the researcher’s own understanding results from other studies and theories relevant to the phenomenon.

**Hermeneutic Interpretation – Study II**

Paper II was analysed using hermeneutic interpretation according to Fleming et al. (2003). The text was analysed in four steps. In the first step, the text was read as a whole and was expressed as a fundamental meaning. Gaining an understanding of the text as a whole was the starting point of the analysis; the fundamental meaning influences every other part of the text. The second step exposes a meaning of understanding, which is done by examining each sentence of the subject matter. These are formalised and sorted into subthemes, with the author being aware of and challenged by his or her preunderstanding. During the third step, attention is brought to the hermeneutic circle and fusion of horizons, where the text is seen as a
whole that is dependent on its parts and parts that are dependent on
the whole. All sentences, subthemes, and themes were related to the
initial fundamental meaning. Once the understanding is expanded to
a whole once again, the meaning of the parts can broaden. The final
step involved finding passages that could explain the text and create
a deeper understanding. These steps were repeated numerous times
until the authors could settle upon a shared understanding of the text.

Reflective Lifeworld Research – Study IV

The fourth and final study of this thesis aimed to illuminate
and describe the meaning structure of the phenomenon of
vulnerability as experienced by carers in forensic psychiatric inpatient
care. This meant using phenomenological analysis, namely reflective
lifeworld research (RLR), according to the principles as described by
Dahlberg et al. (2008). RLR is a systematic analysis, which refers to
initially becoming acquainted with the data, gaining an
understanding of the whole by reading the transcribed interviews and
comparing the text with the digital recordings. Once acquainted with
the text, to gain a more in-depth understanding of the data, the text
was divided to reduced segments, so called meaning units. To find
patterns, similar meaning units were later merged into clusters. The
clusters were reflected upon by the researchers, thereby elucidating
the phenomenon’s essential meanings and overall structure. At this
part of the analysis, the importance of bridling one’s pre-
understanding and keeping an open mind is made evident, as avoiding making definite what is indefinite became even more apparent. The concept of bridling could be perceived as an individual process but is facilitated by discussions among the authors. Bridling meant restraining one’s pre-conceived notions and problematising one’s natural attitude, allowing the phenomenon’s multiplicity to show itself (Dahlberg et al., 2008). Eventually, when the data was perceived as thoroughly reviewed and the meanings were tidily organised into clusters, the process of analysis moved on to the next step: returning the parts to a whole. This time, with a better understanding of the phenomenon studied, its true essence was described along with its meaning constituents. Together, the essence and meaning constituents describe the meaning structure of vulnerability as experienced by carers in forensic psychiatric inpatient care.

**Ethical Considerations**

The necessities that shape the foundation for the design of the thesis are based on research ethical guidelines regarding information, consent, confidentiality, and right of use according to the Swedish Research Council (2017). The four studies in the present study have been carried out in accordance with the ethical principles of the Declaration of Helsinki (World Medical Association, 2013), meaning that I as a researcher have a legal, ethical, and moral responsibility to
protect the health and rights of the individuals that participate in the study. The project was approved by the Regional Ethical Review Authority (No. 2018/157-31). Conducting this research, thesis and its studies meant facing major ethical challenges. Due to this thesis’ ontological and epistemological foundation, an emphasis on phenomenological openness and objectivity when illuminating the lived experience and searching for “the other’s otherness” meant an ethical basic attitude that has infused the entire research process. To fully comprehend the research participants narratives of their lived experiences, it was also seen as a necessity to underscore the importance of respect during the interviews. Another important condition was to get acquainted with the term of the lifeworld concept and compliance and objectivity that is synonymous with the concept. This may assist the research participants to feel trust and preserve their dignity, thus being able to reflect and fully address the emotions that arouse during the interviews. This process meant that it was not only the research participants that had to turn their gaze inwards. The interviewee also had to reflect upon own naturalistic intentions as self-awareness in the form of an ability to observe oneself became an ethical issue.

Narrative interviews were conducted with carers who provided informed consent to participate after receiving written and verbal information. All the interviews comprising this thesis was conducted with written and verbal consent. Throughout the research
process, there was always an intention to highlight caution and sensitivity, not to pressurise the participants to feel the need to tell more than they wanted. Thus, participation was voluntary, and the carers could withdraw at any time without consequence. Before each interview, the carers were provided with information concerning the interview and were again asked if they were willing to participate.

According to Kvale and Brinkmann (2014), the social relationship between the interviewer and the interviewee is of importance for the knowledge that emerges through research interviews. This requires the interviewer to be aware of the interview environment. Kvale and Brinkmann (2014) emphasise the importance of creating an environment that promotes a balance between the knowledge of the interviewer and feelings of independence among the participants. As a major part of the interviews was conducted via digital media with video recordings due to the ongoing COVID-19 pandemic, participants were encouraged to express any thoughts about uncertainties regarding using digital media or being recorded, and the importance of the participants finding an environment and place for the interview that allowed them to feel safe and being able to speak trustfully and freely without being interrupted was also emphasised.

An interview situation also requires constant awareness of ethical concerns. Transparency requirements have been met by informing the study participants about the intention of the study, its disposition, and any potential risks and benefits of participation. The
participants’ right to self-determination has been observed, as the participants had the opportunity to decide whether they wanted to participate, on what terms participation took place, and how long participation would continue. All participants were encouraged to take a pause of they felt it was necessary. In this study, the participants participated fully on a voluntary basis. Furthermore, I clearly informed participants of the opportunity to withdraw from interviews at any time if they so wish, given the potential consequences of participation – negative and positive. This is an aspect that is of great importance, as the relationship between the two parties should be characterised by trust and trustworthiness (Dahlberg et al., 2008). As an interviewer, I took measures to minimise the risk that a dependent would develop between myself and the interviewees. The requirement to maintain anonymity has been observed with regard to the use of collected empirical data. Information that can reveal a participant’s identity will not be published. All interviews were unidentified, and the transcribed interviews along with the digital and audio recordings was safely stored by the author.

Sharing one’s lived experience of encounters with patients in a forensic setting was likely a concern of distress. If the interviews happened to arouse feelings of unease, there was a plan for the participants that included contact with the unit manager and authors of the study, something each participant was informed about at the beginning of each interview along with contact information for the
persons mentioned above. As this could be viewed as a potential risk and disadvantage of conducting the interviews and data collection, it was pondered upon constantly thorough the research process, concluding that the benefits of carers making their voice heard and putting words on their emotions outweighed the conceivable disadvantages. Each interview ended with a moment of reflection of how the interview was experienced, to ensure that no uneasy emotions occurred. In this aspect, my prior clinical experience of interpreting and being attentive to patients’ expressions of distress was seen as an asset as it may been of help to pick up on any signs of anguish.

**Findings**

**Controlling Emotions Nurses’ Lived Experiences**

**Caring for Patients in Forensic Psychiatry – Paper I**

Paper I illuminated the meaning of nurses’ lived experiences of encounters with patients with mental illnesses in forensic inpatient care. The structural analysis comprised of four themes: *being frustrated, protecting oneself, being open-minded, and striving for control.*

The theme *being frustrated* referred to carers’ feeling distressed because of the internal struggle between their own expectations and will, and realistic expectations and what they could do for the patient, including emotions of perceiving oneself as strong,
taking on responsibility, acting independently, and sometimes falling short in the case of unachievable demands. These feelings of confusion were rooted in the struggle to get through to the patient while being faced with the reality of the patient’s criminal past, which often involves actions that seemed unjustifiable. Carers’ stories revealed a sense of perplexity, resignation, and hopelessness when they did not see results from their hard work manifested as progress in the patient’s condition. This often left the carers feeling powerless and not in control. The fact that they so often needed to process feelings of disappointment seemed unfair at times, though this was a part of the carers’ work, something that they just had to “live with”. Being faced with the responsibilities and expectations made the carers aware of the importance of being understanding towards the patient, often resulting in a sense of failure. Being repeatedly rejected when intending to do good was a major concern and led to a sense of frustration among the carers.

The theme protecting oneself mainly consisted of encounters with patients that aroused negative emotions. Caring for patients with mental illness in forensic psychiatry also means encountering individuals who have committed criminal acts, sometimes violent crimes against children or other crimes that are violent in nature. This could mean that carers found it difficult to know how to approach the patient, as they are filled with a feeling of uncertainty and doubt. When encountering patients with a history of violence, where carers
could not predict when or if the patient was going to act out, carers were not prepared to pay the potential emotional price and to handle intense emotions that could arise if a violent incident did occur. Instead, carers found themselves being on their guard, trying to stay one step ahead. Caring also meant being humiliated in front of others, not being able to change the situation and stand up for themselves further intensified feelings of being exposed, of being unable to act as the way they should.

Carers pointed to trust as a major aspect of a caring relationship, and this meant having the courage to open up and take the patient seriously. Trust also meant becoming predictable, adjusting the balance of power within the carer–patient relationship as the patient became more involved in their care, enhancing togetherness, and decreasing paternalistic behaviour by **being open minded**. Developing compassion and seeing “the person” and not only “the patient”, thus letting the patient’s expressions make an impression, allowed carers to become conscious and identify the patient’s vulnerability. Recognising the vulnerability of the patient’s situation and feeling sympathy for the patient reinforced an empathic approach; the ability to reflect upon the patient’s expressions enabled a deepened understanding and relationship. Carers found themselves dealing with their own vulnerability when dealing with their patients’ vulnerability. Carers reported feelings of frustration, sadness, and loneliness, all of which represent a sense of compassion towards the
patients that allows empathy to guide their interactions with certain patients.

Caring in a forensic setting was described as complex due to the high-security environment and the balancing act between doing what was best for the patient and protecting society, which for the purposes of this paper is called *striving for control*. Along with the fact that patients were sometimes ill, provocative, or threatening, carers reported that they regulated their emotions so they would not lose control in certain situations. This meant taking a step back and finding a space to breathe.

Illuminating the meaning of carers’ lived experiences of encounters in forensic psychiatry revealed an environment where carers face threats, violence, humiliation, and resignation. Despite delivering care in what was described as a harsh environment with challenging encounters, where the carers’ very existence was sometimes threatened, the carers were able to let the patients’ expressions make an impression and develop a sense of mutual vulnerability. This involved regulating emotions and taking a step back when necessary, to get closer to the patient. The carers’ narratives also pointed to the development of trust and compassion, which guided their actions in encounters and became catalyst for decisions based on the patients’ needs. This meant that even if they were placed in a vulnerable situation that steered them towards self-reflection, situational assessment, and compassion for the patient, if they
overcame this moral challenge, the carers were able to control themselves, the situation, and the patient.

**The Path of Compassion in Forensic Psychiatry – Paper II**

This study aimed to gain a deeper understanding of carers’ compassion in providing forensic psychiatric inpatient care. The main theme of being compassionate in forensic psychiatry is described as an emotional journey, an ongoing inner negotiation between the patient’s expression of suffering and the carer’s own vulnerability, an inner negotiation that tries to make sense of patients’ pleas. And the way these pleas were perceived was crucial for the development of compassion and the delivery of care that avoided turning to control and rules to protect oneself. This emotional journey involved carers who face some of the greatest challenges in the medical/psychiatric field, but who also have tremendous opportunities to develop relationships with people who are suffering in numerous ways – physically, spiritually, and emotionally. Compassion was seen as one possible response to these expressions of suffering, something that was changeable over time and tended to fluctuate.

The initial theme, *recognizing suffering and need for support*, refers to the complexity of caring, the dualism between being a guard and a care provider. Expressions that made an impression also caused carers to turn their gaze inwards. Sensing that patients needed help
aroused feelings of compassion, for example when patients threatened to take their own lives. When expressions of suffering were not as obvious, the carers had to rely on their own knowledge and previous experience. Patients sometimes showed an unwillingness to receive help, often hiding in their rooms. This made it hard for carers to grasp what expressions of suffering meant, which was something the carers reported to be an important aspect in the development of compassion. Not being able to “get close” to the patient promoted feelings of frustration since carers had to repeat care activities over and over without receiving any form of feedback. When patients where perceived as confrontational or threatening, carers felt threatened, insecure, and afraid. Being exposed to violence or intimidation sometimes meant that carers did not know how to cope with the situation and was a source of anxiety that prevented carers from getting to the bottom of the patients’ suffering.

The second theme, responding to patients suffering, referred to carers trying to provide an adequate response when encountering the patients. When suffering was obvious and the patients showed a willingness to participate in their own care, carers responded with increased enthusiasm. In other cases, where the patients had no interest in participating in care, carers often found themselves in a position of having to persuade the patient. This was seen as a tiresome effort and had an influence on further engagement in the long run. The carers’ narratives were interpreted as being grounded in genuine
worry for the patients. Carers found themselves being flexible in erratic situations where they would not let their emotions take over. That they would not show emotions in front of the patient and would instead maintain a façade of calm and comfort. This façade was grounded in the best of intentions, not only for themselves but what was best for the patient. Controlling emotions was seen as an act of compassion. When they were unable to maintain this façade or even lose control to a certain extent, carers immediately took a step back, removing themselves from the situation and coming back later when expressions of suffering were better comprehended.

The third theme, *reacting to their own vulnerability*, made it evident that carers devoted a great deal of effort delivering the best possible care. The carers reported that this was easier at times, especially the times they received positive feedback. This was seen as a remedy for the carers’ own feelings of frustration and suffering that arose from the times patients rejected. In cases like these, carers instead found themselves more withdrawn and resigned. The tendency to become resigned also stems from the notion of failing as a carer and as a person, as someone unable to succeed with the task at hand. In addition, being exposed to negative comments for extended periods of time suggested that carers had to motivate not only the patient, but also themselves. Cares also reported that encounters that where perceived as threatening and intimidating, instead aroused a sense of shame that stems from not knowing how to handle these
patients by setting one’s own feelings aside. In these situations, carers reported that they did not feel that they were being compassionate.

There was much to be learned from carers’ feelings of compassion. Caring in forensic inpatient care sometimes meant facing incomprehensible expressions of suffering. Being able to understand seemed to be the key to developing and maintaining compassion. Understanding started a chain of events within the carer, not only in terms of interpreting suffering, but also in reacting to and acting upon suffering and the carer’s own vulnerability. This chain of events could lead to the carer becoming persistent, but it could also lead to the carer being resigned or feeling overwhelmed by a sense of shame. When carers reported that they did not understand suffering, they still stood their ground by being there for the patients, which could also be interpreted as a sign of compassion. Forensic psychiatry is unique in the sense that it is characterised by long hospital stays, which meant that carers inevitably had to turn their gaze inwards to deal with their own emotions and sensibility to make sense of an incomprehensible environment. The long duration of care also meant that compassion was not static and was instead changeable over time. Practicing and modelling compassion is fundamental to the well-being of all individuals, highlighting the fact that the role of compassion in forensic inpatient care reinforces the trend towards more compassion in care in general.
Regulating Oneself in Forensic Psychiatry – Paper III

Paper III illuminated the essential meanings of carers’ lived experience of regulating oneself when caring for patients with mental illnesses in forensic inpatient care. The structural analysis resulted in three themes, the first being “Preserving oneself as a carer”, “Building alliance with the patient” and “Maintaining stability in the community”.

The initial theme preserving oneself as a carer suggests how carers respond emotionally when managing own emotions by being active and confronting contradictory emotions, thus being able to take control at the situation at hand. These are emotions that otherwise could be perceived as an obstacle when dealing with stressful situations. This inner battle was evident in threatening and violent situations. Having prior knowledge about the patient at hand assisted the carer when addressing emotions like fear. The closer the carer–patient relationship was the easier carers were able to deal with their own fear by accepting it, but not necessary showing it. Also being present in the moment was essential to not reveal emotions such as disappointment, irritation, or anger. Being able to deal with own emotions was intertwined with dealing with own expectations of oneself as a professional. Being a professional carer meant doing a good job when emotions took supremacy, staying neutral and refraining from acting on such emotions. Remaining calm and controlled was a challenge as it also is intertwined with the
expectations of other carers and one’s ability to solve the situation. At times carers found themselves being unable to reappraise overwhelming emotions, instead abandoning the situation, suppressing conflicting emotions and leaving the patient stranded and alone, distancing oneself not only from the situation but also from fear or frustration.

The theme building alliance with the patient depicts the carers emotional response to the patients’ actions, mainly by being available, reliable, and involved. Which was achieved by turning the gaze inwards adapting to the patients’ needs by realising own weaknesses. Experiencing affinity in the unique situation stemmed from being able to share a bit of was considered personal thus getting closer to the patient and finding a common responsibility to sort out the situation. Revealing own flaws meant developing trust as being together with others, meant being accepted as human despite one’s own shortcomings. Making it acceptable to take a temporary step back to endure.

The third and final theme comprising the structural analysis maintaining stability in the community describes carers’ emotions in relation to the community, the ward. Maintaining peace and harmony in the community highlighted the importance of a care climate for carers. Being part of the community meant feeling safe, persevering, and being accepted for who you are. Being perceptive to the dynamics in the community meant being observant and having a sense of control
and becoming aware of own responsibilities. A responsibility of being accountable, being trustworthy and a safe companion, being able to take a step forward in a threatening situation. Was intertwined with being attentive, interpreting and alleviating the emotions of other carers when finding them in distress. Being able to do so stems from the courage to relieve others and feeling confident in oneself to endure instead of abandoning the patient.

Regulating oneself meant getting in touch with one’s own inadequacies and vulnerability, which proved to be a precondition, a strategy to getting to know the patient. Regulating oneself was not only used in relation to oneself and the patient’s expression of suffering but also in relation to other carers to preserve the stability of the ward, thus creating or maintaining a caring environment. To regulate emotions was a shared process and intertwined with being accepted for who you are, being human, no matter who you are.

Knowing Where the Boundary is When you Cross it – Paper IV

Paper IV aimed to describe the phenomenon of vulnerability as experienced by carers in forensic inpatient clinics. The meaning of vulnerability including its essence and variations in the form of the meaning constituents describe the phenomena as “not knowing where the boundary is until it has been exceeded”. As vulnerability is intertwined with carers trying to understand themselves. Facing
suffering brought to light what it means to be fragile and coming to terms with oneself, becoming aware of their own personal boundaries. This reflection of oneself is described in by the meaning constituents: “finding a balance between what is personal and private”, “struggling with being authentic and true to oneself” and “protecting oneself and avoiding harm”.

Finding a balance between what is personal and private depicts how vulnerability is expressed when struggling to find one’s own personal boundary that defines how genuine and personal carers can be. A sore point and an inevitable limit they became aware of once it was crossed. Being too private meant the relationships developing into something more than a carer–patient relationship, something that was difficult to handle, a situation that they could not get out of without damaging the relationship. In contrary carers could distance themselves from patients on an emotional level, not exposing themselves thus protecting their own vulnerability from being uncovered. Being in this tension, as assessing one’s vulnerability between these extremes was proven easier over time.

The meaning constituent struggling with being authentic and true to oneself referred to becoming authentic and not playing a role which was intertwined with a sense of insecurity in one’s professional role. Being inexperienced often meant finding a sense of belonging and “fitting in”, resulting in carers playing a role of a “prison guard”, not being true to oneself to deal with own insecurities. In contrary over
time, as the carers gain experience, a sense of security evolved. Allowing the carers to be more authentic and genuine, more themselves, entering the role of a “carer”.

The third aspect of vulnerability meant dealing with fear and threats from patients, protecting oneself and avoiding harm. Interpreting these expressions of suffering, being faced with violence, started an inner dialogue of staying present or escaping the situation. As fear became overwhelming, vulnerability was expressed through physical traits when shielding oneself from harm. Dealing with fear meant reflecting upon oneself and the patients’ expressions of suffering, an arduous process of letting expressions make an impression and thus gaining access to the patient’s lifeworld. Thus, making the patients actions predictable and allowing the carers to act compassionately and act upon their wish to do good.

Vulnerability could both be seen as a strength and a burden for carers. A burden as it is exhausting and inevitable. A strength as it allows the carers to approach a caring role. To be genuine, allowing carers to establish alliances and relationships and hindering coming to harm.
A Summary of the Findings

The overarching purpose of the thesis was to obtain a deeper understanding of carers lived experience of encounters with patients with mental illness in forensic inpatient care. The thesis consists of four studies who findings are presented separately. As this thesis is guided by the ontological, epistemological, and methodological reasoning rooted in phenomenology and hermeneutics it is necessary to view the findings as connecting to each other creating a whole instead of understanding the findings from each study (I, II, III, IV) as independent parts. To obtain this new understanding, the different studies were compared in the light of each other, reflecting upon them in relation to the research question, context, literature, and theoretical foundation of this thesis, arriving to a new understanding.

As forensic psychiatry aims to achieve its values in the treatment of the patient, to encounter patients is to see the person behind the crime based on expectations of authenticity, love, trust, with the courage to remain in the situation with a caring approach based on the patient’s best interests. At the same time encounters with patients is characterised with the duality of acting upon the patients’ needs and managing rules and norms stipulated in laws and regulations that govern FPC and societal protection. Encounters in FPC and being a carer is intertwined with being put in a position of power, being fragile, dealing with fear, disgust and not playing a role.
The encounter means being in a duality and having the insight of the “space in-between” these feelings and the duality of the mission that caring in FPC means. It is in the space in-between, there is room and a possibility for carer’s personal growth, and achieving a phenomenological attitude and to truly embrace the patient’s lifeworld.

Discussion

The thesis has been carried out within the framework of the research subject nursing science, which means that it focuses especially on contributing to the creation of knowledge for a care that aims at health and well-being. The four studies that form the basis of this thesis examines what happens in the relationship between carers and inpatients at a regional forensic psychiatric clinic. The overarching purpose of the thesis was to obtain a deeper understanding of carers lived experience of encounters with patients with mental illness in forensic inpatient care. To answer the purpose, four sub-studies focusing on different aspects of how the encounter was experienced have been described. The findings are based on the lived experience of carers working in forensic psychiatric inpatient care, which can be justified on the basis that nursing has an epistemological starting point that is characterized by a holistic view of humans. The holistic view is
also reflected in an ethical approach to the patient which means that
the patient should be seen and understood in their overall situation
(Dahlberg & Segesten, 2010). Such approach which means that the
patient cannot be separated from their lifeworld, hence this thesis has
its basis in the philosopher Edmund Husserl’s theory of the lifeworld
(Husserl, 1970, 1977). The findings of the thesis can thus be understood
as the carers’ voice about what it means to encounter patients in
forensic psychiatric inpatient care and the inherent vulnerability in the
meaningful context that follows from it.

Understanding the Findings of the Lived
Experience of Encounters in FPC

To answer the overall aim of this thesis, there are four sub-

studies focusing on carers lived experience of the encounter. First, the
participants’ lived experience of the encounter with forensic
psychiatric patients is discussed. The study shows that caring for
patients in forensic psychiatry means being faced with several
situations that threaten the carer’s professional identity. To let the
patient’s expression, make an impression, taking a step back to be able
to take a step forward by regulating their emotions, i.e., by using
strategies that create a temporary distance, it is possible to get closer
to the patients to alleviate suffering. Even though they sometimes face
threats, violence and humiliation, carers make decisions based on
compassion and the patient’s needs (I). Thereafter, compassion in
forensic psychiatric inpatient care is discussed. Caring for patients in forensic psychiatric inpatient care means that they are sometimes confronted with incomprehensible expressions of suffering. Being able to understand these expressions facilitates compassion and enables carers to provide adequate answers and simplify care. Time seems to be crucial and facing suffering for long periods of time entailed a risk of relating to rules and laws instead of becoming sensitive to one’s own vulnerability and patients’ expression of suffering and thereby realising the real intentions of the laws. To achieve a sense of trust and interdependence, it is important to create a permissive environment where carers are allowed to reflect and act on their own wisdom (II).

The third sub-study discusses the strategy of regulating emotions, as expressed by the participants as “regulating oneself”. The carers use the strategy to regulate themselves not only in relation to themselves and the patient but also in relation to other carers. With the aim of maintaining the stability of the department, conditions can be created for a caring climate. Regulating oneself meant getting in touch with one’s own shortcomings and vulnerability, which proved to be a prerequisite for getting to know the patient. Regulating oneself can be seen as a strategy for carers to get closer to the patient and thereby establish an alliance and trusting relationship. Dealing with and managing one’s own emotions is an important element in forensic psychiatric inpatient care (III). In the fourth sub-study (IV), vulnerability as experienced by carers in the encounters with forensic
psychiatric patients is discussed. Based on the carers’ lived experience, it emerged that vulnerability can be both a strength and a burden. A burden that is exhausting and inevitable, but also a strength in the sense that it can help carers to creatively approach the caring role. Vulnerability inevitably arises as something to deal with when encounters with patients force carers to undergo self-reflection. Getting close to patients and creating alliances means becoming aware of the boundary that defines how personal and private they can be. Vulnerability means that you can be genuine to others and yourself instead of having to play a role. Managing one’s own vulnerability enables carers to open up and get close to patients without increasing the risk of injury.

Through the investigated sub-studies, the importance of an additional perspective has emerged, a perspective that requires communication, based on the Danish philosopher K. E Lögstrup’s (1905 - 1981) ethics, where the independent and distance-free assets to the world and context in which man is embedded form the basis (Dk: samsning). In this context, the carer is a key person whose task is to shape the caring relationship into a “life-promoting room” for the patient, a room that requires an attitude on the part of the carer that recognises the patient’s lifeworld. The thesis ambition is to try to verbalise the journey towards the life-promoting space that Devik et al. (2013) call “room of awareness”. A room where a process towards recovery can be started if the carer is willing to let the patient’s
expression make an impression without the carer hiding behind their own preconceptions. By glancing into the “door” to a “room of awareness”, the precondition is given for recovery where the patient receives support to experience themselves as capable of managing life when needed. Receiving support to seek and find new solutions than previously used strategies. The thesis can thus be seen as a contribution to facilitating new understanding that can form a basis for the development of new tools that can benefit both carers and patients in the forensic psychiatric encounter.

The Duality of Forensic Psychiatric Inpatient Care

The answer to the overall aim should be seen as a preliminary guide for understanding the social and relational context in which a caring - patient encounter arises. A focus on a caring approach can be justified because previous research, e.g., Hörberg et al. (2011) believe that when the carer comes in close contact with the patient, they always understand the patient based on their own standpoint to the world. In the encounters the carer is often close to the patient but must always keep in mind, that in that moment, the encounter is related to both opportunities and the risk of harm. In care, there must always be a focus on the patient’s needs, i.e., to understand his or her unique standpoint and opening to the world (Dahlberg & Segesten, 2010).

The findings of the four study’s that comprise this thesis has made it evident that carers lived experience of encounters with
patients in FPC is not only characterised by the patient’s expression of suffering, but also the duality of both caring for the patients’ needs and societal protection (I, II, III, IV). Carers must constantly value their own response to these expressions based upon the intention of acting upon the values that founds forensic nursing and what is best for the patient and the legislations that surrounds and forms the framework of FPC (I, II, III, IV). It is in this duality, when dealing with these contradictory opposites, encounters in FPC shows it uniqueness.

It is in the shared space that arises in-between two counterparts where health and caring can be developed, a space that is relatively unknown and needs to be further understood (Rytterström et al., 2020). The space in-between refers to the encounter, where the patient’s expression makes an impression on the carer. It is in this impression; contradictions arise in the carers’ lifeworld. Here in the space in-between these contradictory impressions, not only the patient is intended to be perceived as a person, but also the carer is allowed to be seen as a human being, for the encounter to be ascribed a caring meaning (Holopainen et al., 2015). It is in the space in-between related to the overall duality of forensic care that the findings of this thesis will be further discussed when reflecting upon the complexity and trying to understand encounters as experienced by carers in FPC. Four dualities emerged from the findings: having trust or feeling distrust, being compassionate or being indifferent, having courage or being afraid and being genuine or pretending. Displayed in figure 1:
“the duality of the encounter and the space in-between”, a summary illustration to assist the reader, and explained in the following discussion.

Figure 1 “The duality of the encounter and the space in-between”

**Having Trust or Feeling Distrust**

The findings suggest that encountering patients in FPC is intertwined with expectations with developing trust (I) and not acting upon initial emotions of distrust that occurs when the patient is perceived as unknown, as carers often find themselves being on their guard for any sudden occurrences that may threaten their own or other patients’ existence (I). Establishing trust in the carer–patient relationship means making the relationship more predictable, enabling patient participation that in turn makes the relationship and
the encounters more symmetrical (I). An approach that requires that carers stay open and refrain from approaching the patient with prejudices (I). The carers’ narratives of encounters in this thesis is in line with previous research, that the encounter is intertwined with setting own emotions aside that may hinder the development of trust and a caring approach (Harris et al., 2015). Finding strength and commitment in the ethos of caring which could encourage trust and give possibilities to a caring conversation (Rydenlund et al., 2019).

When establishing a bond and an alliance based on trust, carers became aware that it is a process that will take time, requiring numerous encounters that is either greeted with respect and a sense of comfort or disrespect causing emotions of frustration, irritation, disappointment and despair (II). This was seen as an obstacle to overcome when encountering the patients and ascertaining trust in the relationship (III). Encounters with patients meant being accountable and someone to turn to, which was deemed as a necessity to approach a caring role (III). Accordingly, being trustworthy had meaning to invite the patients to share suffering, in an encounter that is permeated by being accepted for who you are (III, IV). Creating such an encounter requires for carers to turn the gaze inwards and reflect upon own vulnerabilities (IV). By sometimes managing contradictory emotions by regulating oneself and own emotions and not risk diminishing the trust in the relationship (III). Aspiring to become open for impressions and seeing the other in the encounter

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(Gustafsson et al., 2013). At the same time my findings depict carers narratives, describing encounters which reminded them of the severity and circumstances regarding some patient’s criminal history and capability (I). A conclusion in line with prior research, that an awareness of caring for patients in FPC can be a cause of distress that further nurtures distrust (Harris et al., 2015). Therefore, carers found themselves placing trust in the rules and regulations that govern FPC, which inevitably influenced the impression of the encounter. In the sense of shielding themselves from harm with the consequence that an initial feeling of mistrust about the patient prevented the development of trust between the two parties (III). Which according to findings from previous research (Maguire et al., 2014) is contradictory, as displacing trust in the relationship and the interaction between the two parties instead reduces the risk of aggression or use of coercive actions. Thus, empowering carers to meet the patients’ expectations of being caring and trustful (Tingleff et al., 2019). In addition to this reasoning the findings propose that facing and getting in touch with own vulnerability is intertwined with an opportunity for change (IV), moving past preconceived notions and pre-understandings, and thus being able to develop trust (Rytterström et al., 2020).
Being Compassionate or Being Indifferent

In this thesis, the lived experience of encounters means finding oneself in demanding situations (III) where one’s response to expressions of suffering is intended to be founded on compassion (II). Facing the expressions that occur in these encounters means understanding them and allowing them to make an impression when developing compassion, which is intertwined with seeing the patient as a person (I). Unravelling the meaning of these encounters is suggested, by my findings, as being difficult, as these expressions sometimes come in the form of verbal outbursts, nagging, threats or even apathy occurring during long periods of time (I). When suffering is hidden or hard to grasp, carers are faced with the risk of becoming indifferent and unresponsive due to frustration (III). Previous research depicts FPC as being either caring or fostering, meaning that patients must abide by the rules and norms set by the carers at the expense of participation and involvement in the care given (Hörberg, 2008). In addition, the findings (I, III) suggest that caring based on compassion, according to Kanov et al. (2004), should not necessarily view the infringements that fostering derives at as the antonym to caring and a compassionate approach. Instead, the narratives of the carers that comprise this thesis gives meaning to carers experiences of encounters, that their actions at times could be based on the patient’s best interest and compassion when forced to act and respond in the encounter and relationship based on the rules and norms that stipulate

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FPC (I, III). Encountering patients means doing so based on compassion and not paternalism, something that is particularly challenging in FPC due to the duality that constitutes the care (Young, 2018). However, the findings show that this dividing line between the above depicted dualities is not as obvious and visible as previously described; that acts and responses that occur regarding rules and restrictions can, after all, be based on compassion, due to being touched by suffering and acting rather doing nothing (III).

However, the experiences of these encounters awoke feelings of discouragement and a sense of lacking empathy due to patients’ expressions, which were intertwined with shame and an awareness of failing as a human and a carer (III). A belief that instead put the carers at risk of becoming indifferent and distanced in the carer–patient relationship (III). The findings of this thesis are in line with prior research, that contemplating and reflecting upon one’s responsibilities and role as a professional and person may bring clarity to such matters (Hem & Heggen, 2004). In a permissive environment where the carer can deal with their own suffering, sharing emotions with others may hinder further growth of blame and judgment upon oneself (Neff, 2003). The findings indicate a self-compassionate approach which might further the carer’s well-being and give strength and the essential tools to unravel the patients’ expressions of suffering, not being at risk of confusing own suffering with the patents and thus becoming indifferent (III).
**Having Courage or Being Afraid**

Devoting oneself to caring for patients in FPC means inevitably becoming aware of fear in encounters where expressions of suffering come in the form of potential dangers embodied by the forensic psychiatric patient (I, II, III, IV). Carers’ experience of encounters in this thesis describes being able to recognise suffering and patients’ need for support (II), which means ascribing meaning to an awareness of own fear. An awareness which is intertwined with an inner dialogue of staying with the patient or fleeing to save oneself (III). Being afraid means facing difficulties to see the meaning of the encounter and, consequently, making it problematic to maintain commitment to the patient’s well-being (Carlsson, 2003). Having the courage to remain caring in the situation (I) may provide a change and inspire to compassion and attribute meaning to the patient’s life (Vincze et al., 2015). That a caring approach is directed by the courage and strength to be open and letting the patient get close (Rydenlund et al., 2019). In the findings, carers describe fear as being intertwined with a sense of uncertainty and a lack of confidence of not knowing how to respond to undistinguishable expressions of suffering (I), as fear is intertwined reacting to not only the patients’ vulnerability, but also to their own (II, IV). According to Jacob and Holmes (2011), fear for carers could mean having difficulties normalising patients, i.e., to see them as a person. Canales (2000) argues that when facing this difficulty, where positive and negative representations of the patient
collide, carers find themselves in a dual process of either being inclusive (identifying themselves with patients) or being excluding (differentiating themselves from patients). In my results, the negative representation of the patient is based not only on the assessment of the patient’s immediate danger but also on the crime they have committed (I, IV). Canales (2000) believes that the crime committed affects the carers and forms a basis for fear and antipathy aimed towards the patient. In addition, the findings suggest that the patient is seen as a potential risk, a risk that the carer must find strategies against to ensure that safety is maintained (III). Finding the courage to stay with the patient and not fleeing the situation means having a sense of confidence (III) and reflecting upon fear and one’s own fragility as both a weakness and resource, which requires talking about fear with another carer (IV). Courage is manifested as one’s capability and motivation to help patients face their own vulnerability and suffering (Thorup et al., 2012). As carers in this thesis portray, for some during the interviews, it was the first time they verbally expressed fear related to encountering patients (IV). The findings (III, IV) are in line with Thorup et al. (2012) who suggest that courage is intertwined with self-perceived vulnerability and suffering and is of ethical importance for carers’ ability when becoming engaged and committed to patients. This means not only having courage to bear witness to patient’s expressions of suffering and helping them, but also finding the
courage to trust oneself by addressing own sore points and maturing as a carer and a person.

**Being Genuine or Pretending**

In my findings, embarking on the role of a carer in FPC and dealing with the complexity of encountering patients is intertwined with expectations of oneself as a person and being a professional and role model for patients and other carers (III). Caring in FPC, as described in prior research and in this thesis, is complex, as it means being in the tension between maintaining safety and promoting a therapeutic and patient-centred approach (Green et al., 2018) and building an alliance founded on empathy, genuineness, and compassion (Möllerhøj & Os Stölan, 2018). Encounters in FPC means for the carers to come to terms with the contradictory tasks of caring and guarding (II), where the encounter is most often characterised by an overriding meaning of control of the patient, situation, other carers and oneself (II, III). Carers’ narratives depict encounters that vary to a great extent, but despite the various and numerous encounters, it was of meaning to carefully control responses, which created an awareness of striving to present a frontage of calm and comfort (II). In my findings, carers often found themselves in situations where they were presenting a front or façade as a way of dealing with contractionary emotions, a self-protective strategy (I). A strategy that was intertwined with carers becoming aware of their dependency to
other carers, as they found themselves conforming to others and being perceptive to the ever-changing dynamics in the ward (III). How to approach the patients in the encounters is interwoven with perceptions of oneself and rooted in trust and confidence of being accepted by others despite shortcomings and frailty (IV). The findings imply that time and experience are of importance when finding one’s place, understanding oneself and knowing how to act in the encounter. There existed an awareness in carers, that when this understanding and sense of security was lacking, they gained a feeling of trust and safety by belonging to others, meaning that they found themselves playing a role and presenting a I that was described as foreign for themselves (IV). This thesis suggests that disguising vulnerability was intertwined with a role based upon the regulations and rules that constitute FPC at the expense of being true to oneself (IV). The notion of control as both a clinical obligation and a way of presenting oneself was an important aspect of encounters in nursing practice in FPC. Because it is a closed environment and carers are responsible for providing security, they are forced to intervene in encounters no matter how they feel. Carers often must ignore ‘a flight response’ and engage with individuals who may be considered as threatening, thereby having to control internal emotions as well as controlling threatening situations (III). These notions of self-control, i.e., by presenting oneself as being calm and controlled, carers reject and disguise their own sense of the threatening situation in favour of
a professional person or front (Jacob et al., 2009). In contrary, the findings also suggest that having an open mind and being open to the others otherness (I) assisted carers in displacing trust in the relationship with the patient, building an alliance, allowing the patient to see past the role and become authentic and genuine (IV). Thus, the encounter had meaning for building an alliance and becoming a pivotal place where carers could deal with the space in-between being genuine or pretending. Thus, a stronger bond could be formed due to carers being attentive to both one’s own as well as the patient’s vulnerability (IV). Meaning, displacing trust and comfort in oneself and being accepted for who you are instead of a sense of belonging as someone else (IV). My findings agree with Rytterström et al. (2020) who explain that opening up to others may be a risk, as it also means jeopardising harm. Instead of protecting vulnerability and what is perceived as personal and private (Buchanan, 2015), encounters mean for carers, nevertheless, being authentic and genuine in the eyes of patients, thus being the same to oneself by inevitably addressing own vulnerabilities (Angel et al., 2020).
Composition of Carer–Patient Encounters with Patients with Mental Illness in FPC as Experienced by Carers

The theoretical perspective that emerged in the thesis is based on the independent and distance-free access to the world and the context in which man is embedded (Dk: sansing) (Lögstrup, 1997). The thesis shows that the encounter with the forensic psychiatric patient can and should be seen as permeated by communication, where the carer is the key person in the creation of a caring relationship by a strive of sharing the patient’s lifeworld (Martinsen, 2012b). The thesis illustrates how carers in encounters must manage the duality that exists in FPC and the space in-between their lifeworld that occurs in the impressions of the encounter. The sub-studies describe how the patient’s expression affects the carer’s impression, and thus helps us not only to understand what the carer is affected by in the encounter but also what is expressed in the awareness of the impression that the encounter gives. This provides an understanding of the meaning of the encounter through the eyes of the person behind the keychain. This thesis elucidates that the encounter contains several existential phenomena that belong to the basic conditions of life.

Furthermore, it appears that the carer’s experience of the encounter is affected by the tone of the impression. Heidegger (2010) explains the tone as something that opens the world and helps to be in harmony with it. Heidegger’s statement indicates that, in the
encounter, it is impossible to distinguish between the person's consciousness and the world he is surrounded by, as the tone is originated in the social and natural environment and not as something the person itself has created. This means that in the context in which my thesis was conducted, carers are structurally and contextually affected not only by the duality of FPC, but also by the culture that exists at the clinic and the ward.

The impression of the encounter seems to be crucial to the experience of, for example, vulnerability, as our relationship with others can increase or decrease the feeling of being vulnerable. Therefore, the encounter can also be seen as a relational phenomenon. The encounter with the patient means that the carer is affected by something that concerns him or her, which can be seen as an acknowledgment of the content of the impression that the patient's expression gives (Lögstrup, 1983a). The patient's expression is sometimes met by resistance, as initially there is always a desire to reshape the impression and intervene based on one's own assumptions (Lögstrup, 1983b). To understand the impression, a distance is required, a distance that is not about getting out of the encounter and looking at it from the outside, but creating a distance to one's naturalistic intention. If carers are emotionally present, sensing opens up for understanding the impression (Lögstrup, 1983a).

Lögstrup (1983b) believes that all living life has a resistance to being invaded, violated and revealing what he refers to as our
untouchable zones. Without openness and insight about the untouchable zone, they will become a limit that hinders the encounter. It is only when the carer, through understanding and interpretation, senses what he has in common with the patient and can recognise oneself, despite differences, the carer can ‘lower the guard’ and show one’s true self and enter a ‘room of awareness’ (Devik et al., 2013). Encountering others with the aim of letting the other raise their voice and telling their stories require that one must be open to the other and let them make an impression to potentially develop as a person, and not act upon own perceptions and experiences, according to Barker and Buchanan (2005) and Brookes (2005). Lögstrup (1983b) shares this reasoning in what he believes is phenomena that appear in the impression of expressions. As these phenomena can only be understood through openness and presence, they give us an insight that the impression is something we only can follow, not control.

In conclusion, the duality of FPC and the space in-between that arises in the impressions of encounters means that the carer is forced to be confronted with existential phenomena that constitutes one’s lifeworld. These impressions of the encounter mean facing own fragility and what is perceived as personal or private. Vulnerability can be a burden if not addressed and, instead, protected at all costs, or a possibility for change by being authentic and true to oneself (Lögstrup, 1997). For carers, this has meaning as it depicts the dilemma of navigating between the rules and norms that stipulate FPC and the
lifeworld of the patient, other carers and themselves. By being active in the space in-between and reflecting upon openness, the carer moves between this duality that exist in the continuum that the opposite phenomena contain. The space in-between contradictory impressions may become a place where the carer may unravel one's own lifeworld, and the space in-between may become a place where one may grow as a person. This is obtained by an openness and consciousness to the impression by active self-reflection to convey its meaning (Lögstrup, 1997).

If the carer can do this through openness and compliance, there is a possibility that the meeting can become a place that promotes personal growth for the carer, that provides space and encourages the sovereign utterances of life. In turn, this enriches nursing, because carers can to a greater extent understand both themselves and patients' expressions of suffering. Person-centred care is then made possible, based on the patient's lifeworld, as it should be.
Limitations

The following section elaborates on reflections of the limitations and methodological considerations regarding this thesis. To do so, questions arise regarding how science and evidence is perceived. The common criteria for discussing evidence are usually linked to a positivistic approach, which presupposes that the world is there for researchers, given and unchanged at a distance, an approach that is arguably not suitable for research linked to human existence (Dahlberg & Dahlberg, 2019b). Another common approach, often used with qualitative research, is to discuss evidence based on the reasoning of trustworthiness (Lincoln & Guba, 1985), a reasoning that is founded upon a naturalistic inquiry, which can therefore be considered inappropriate and not suitable for research based on ontological and epistemological values linked to phenomenology and hermeneutics (Dahlberg et al., 2008). When discussing findings related to existential meaning, acknowledging ontological and epistemological assumptions and being faithful to phenomenology and hermeneutics is preferable, when finding answers to research questions (Dahlberg & Dahlberg, 2020), such as complex existential matters and lived experience (Dahlberg, 2018). Hence, the following reasoning about limitations, considerations and strengths regarding the methodological procedure in this thesis and its sub-studies is based on Dahlberg et al. (2008) criteria for claiming evidence and
reintroducing the traditional concepts, namely objectivity, validity, reliability and generalisation, problematising them from a phenomenological point of view and hermeneutic approach. Matters of these traditional concepts was an ongoing process throughout the research process, from the very beginning of the research plan to the end when reflecting upon the research and writing this thesis. This section will discuss this thesis as a whole to better understand the methodological reasoning of the various studies (I, II, III, IV); the reader is encouraged and referred to the said part studies.

**Achieving Objectivity by Bridling**

Scientific research differs from other activities as it sets out to see the ‘otherness’ of a phenomenon, revealing aspects that we did not know or sides of a phenomenon that surprise us (Gadamer, 2004). This is only achieved if one reevaluates the idea and notion of objectivity from a phenomenological standpoint that differs from logical empirism (Giorgi, 1989). Hence, objectivity should be perceived as the researcher’s honesty and openness and one’s consciousness of being a part of a context, paradigm and relation to our own existence (Husserl, 1970). For researchers, this means to problematise one’s non-reflective naturalistic intentions and attitude, striving towards a phenomenological approach by bridling, questioning our prejudices, fore meanings and openness towards the phenomenon we are researching (Dahlberg & Dahlberg, 2019). The first author’s familiarity
and previous knowledge regarding forensic psychiatric care could be seen as both a weakness and strength. It could be perceived as a weakness as this experience constitutes my preunderstanding of the field I intended to investigate in this thesis, hindering openness and consequently objectivity. This prior knowledge and preunderstandings constitute one’s naturalistic attitude and may influence the descriptions and interpretations of the collected data. Being known in a forensic context may have been an asset as it may have enabled the participants to speak honestly with trust and without hesitance and fear of revealing their shortcomings. In another sense, it may also have been a disadvantage during the interviews, as it may have hindered participants from revealing weaknesses. Being known to some of the participants could mean gaining insight and admission to delicate information. It could also mean that I, the first author who conducted the interviews, became insensitive to obvious conditions since they seemed so; thus, one’s preunderstandings obstruct the interviews as I may have missed hidden messages in the participants narratives. To ensure objectivity during the interviews, open-ended questions with follow-up questions was used to encourage the participants to tell their own story, which, according to Dahlberg and Dahlberg (2019), is preferable. During the process of analysis of data in the numerous studies and the writing of this thesis, the aim has been to problematise and bridle my preunderstanding, depart from my naturalistic approach and strive for a more phenomenological
approach. In this way, the risk that I would be guided by my own prejudices and preconceived opinions about what I intended to study was minimised. My familiarity with the studied context meant being faced with the challenge of becoming aware of my own prejudices and preconceptions through self-reflection and discussions with co-authors which, in retrospect, was of essence to challenge the naturalistic intentions. In this sense, the co-authors’ different backgrounds and prior knowledge was an asset in the numerous discussions. Having preunderstandings and prior knowledge can also be seen as a strength, as being familiar with the context in which the data was collected and being familiar with the subject also meant a unique ability to unravel and truly understand the meaning of the participants stories. The thesis comprises of four studies to gain an understanding to the overall aim, using three different methods which, according to Patton (2015), encompass methodological triangulation. The fact that data in the various studies was analysed and discussed by all authors and reflected upon by different theories can also be perceived as a necessary form of triangulation to ensure objectivity.
Reflections Concerning Validity and Reliability

In qualitative research, validity is assessed in relation to how well we get to know and understand a phenomenon (Leininger, 1985). Validity refers to the findings of the research credibility which, in phenomenological and hermeneutic studies, demands that the results depict the meaning of the intended aim with the phenomena in focus and the usage of the right methods, data collection and analysis (Dahlberg & Dahlberg, 2019b).

In this sense, it is important to address the supplementary analysis of the data material in study II. The choice to reanalyse data that had already been collected from study I was based on the opportunity to establish a different understanding, which was seen as possible based on the assessment that additional information was available in the existing data material. In areas where already existing data is limited, complementary reanalysis (secondary supplementary analysis) of existing data can be used which, according to Heaton (2004), is to be regarded as a valuable method. However, this requires a deeper analysis of the data material, which is satisfied in this study through the choice of the hermeneutic method (II).

In secondary research, there is always the issue of ‘data fit’, as the data used was originally collected for another purpose. Nevertheless, qualitative data sets that are relatively unstructured tend to be rich and diversified, allowing us to determine which topics should be investigated further. Problems with ‘data fit’ are especially
relevant when data is missing, data is derived from a deductive standpoint, or when there is a divergence between the aims and methods of the two studies. This is less likely to be an issue in a supplementary secondary analysis where the focus of the second inquiry relates to matters which are, by definition, closely related to the original work. Reusing one’s own data is also an advantage, as the author is ‘familiar to own data’ (Heaton, 2004).

A purposive sampling strategy was chosen since, according to Polit and Beck (2020), it is an adequate way of recruiting participants over a limited period. The sample size in the studies was based on the concept of information power, as described by Malterud et al. (2015), which determines the appropriate number of participants needed in relation to the amount of information generated by the sample. The appropriate number depends on how narrow or broad the aim of the study is, the specificity of the participants’ experience of the phenomena and whether an established theory is applied. After applying Malterud et al.’s (2015) criteria, I arrived at an acceptable sample size in the various studies. All nursing staff were included and referred to as carers. This allowed us to gain as much insight into the studied phenomenon as possible, as encounters in forensic psychiatry are not exclusive to certain professions. On the contrary, forensic psychiatry is based on a team approach, where professionals work close to the patient with all members of the team.
It should be considered that the interviews (III, IV) were conducted by the first author digitally with video and audio recording via a video chat platform due to the COVID-19 pandemic. This meant challenges when interpreting body language; however, the use of video recordings made it possible to interpret facial expressions and understand the participants’ feelings and reactions. Another aspect regarding the use of digital aids is that face-to-face encounters would have been preferable as some may have felt uncomfortable using digital platforms.

A phenomenological attitude is crucial for the objectivity and validity of the research as well as transparency in the implementation of the research for assessing the reliability of the research (Dahlberg et al., 2008). The ambition along the research process has been to conduct it with emphasis on methodological and systematic accuracy, with transparency when describing and applying the matters of data collection, recruitment, analysis and ethical considerations. Meaning that it is well described and detailed, and that any philosophical belief regarding the qualitative inquiry in the research should also be described (Patton, 2015), allowing the reader to assess reliability and validity based on the descriptions. Throughout the conducting of this thesis and with the help of co-authors, I have constantly aimed to bridle my preconceived notions as this too, is a matter of validity. Openness, i.e., allowing the things themselves to present themselves in all their multiplicity is the very core of phenomenology and
hermeneutics (Dahlberg et al., 2008). Emphasising rigour with the use of quotes and the choice of words from the participants can be seen as an advantage to be as true to data as possible. Giving the reader access to basic data provides an opportunity to assess reasonableness in the interpretations made. It is also important to emphasise the amount and complexity of penetrating and understanding the true meaning and sometimes difficult-to-access text that surrounds the epistemological and ontological reasoning around phenomenological and hermeneutic philosophies. This challenge has been the basis for many reflections and discussions within the research team.

**Generalisation of the Findings**

The generality of the research regards its societal and scientifical value, a term that, in qualitative research, is often assessed and referred to as transferability, meaning to view the results and findings as either dependent or independent of its context (Dahlberg & Dahlberg, 2019). As research founded in phenomenology and hermeneutics is based on the lifeworld, meaning participants unique way of understanding a common shared reality, the findings generality is reliant on the variations of the depicted phenomenon (Dahlberg et al., 2008). In this sense, it should be seen as an advantage when demanded that the participants varied in age, experience, education, gender and the fact they worked in different wards, giving variations of the studied phenomena, as a heterogenous group (IV). In
other ways, it could also be seen as an advantage of a homogeneous sample, that the stories are based on an identical context. In narrative studies, where participants are asked to provide a narrative about a particular phenomenon, it is important that they have experience with the actual phenomenon. Hence, a homogenous sample was therefore deemed to be a suitable fit (Creswell & Poth, 2018) in study I, II and III. With the overall aim in focus through the research process and the intention of presenting the findings of the various sub studies and this thesis as the essential meaning of the overall aim, the conclusion should be applied in FPC in a Swedish context. However, as encounters with patients is not unique for FPC, it could be discussed if the generality of the findings could be seen in other contexts and FPC worldwide, as Hamel et al, (1993) states, ‘one can find the global in the local’. With detailed information on study participants, sampling and context, information enables the reader to judge whether the results can be transmitted to other similar contexts and areas. It is possible to interpret a text in different ways. My findings, therefore, constitute one of several possible interpretations (Ricoeur, 1976). The phenomenological perspective focuses on the person’s lifeworld and lived experience, and thus requires openness to the interviewee’s experiences (Lindseth & Norberg, 2004). The gateway to this lifeworld is provided through the individual’s narrative, with all its symbols and metaphors that must be interpreted using both explanation and understanding (Ricoeur, 1976). In line with the
hermeneutic tradition, issues of generality are a matter of rigour throughout the process, a process that aims to arrive at possible interpretations, not to reveal an absolute truth. Therefore, the intention has not been to generalise the findings; instead, the method of interpretation should follow the direction opened up by the text and be sensitive to the demands the text puts on the reader (Riceour, 1991) and should be seen as one argument in an ongoing discourse (Riceour, 1976). My interpretation represents what we have found to be the most useful way of understanding the phenomenon studied. Therefore, this study offers one perspective, which may constitute a basis for further reflection about the carer–patient encounter in general and in forensic psychiatry.

Suggestions for Further Research

This thesis has emphasised FPC as being directed by rules and regulations on one hand, and by the values of forensic nursing on the other – a duality that affects carers’ lived experience of encounters. However, this thesis in line with previous research (Hörberg, 2008; Rydenlund, 2012) which suggests that encounters remain the very ‘core’ of the care given. Hence, more knowledge on encounters is the foundation to further develop care. This research proposes important aspects of carer–patient encounters such as compassion, vulnerability, dealing with conflicting emotions and unravelling expressions of
suffering. This thesis concludes the need for carers to be guided by a strategy to create a permissive climate. Therefore, further research to unravel and gain insight to other phenomena that constitute the carer–patient encounter is needed that may have gone missing from this research. Knowledge that hopefully may form a foundation for an intervention study in the form of education for carers, promoting evidence-based practice as a common goal to further enrich FPC. Of course, the perspective of the patients’ lived experience is seen as an important and necessary aspect to fully comprehend the true meaning of the carer–patient encounter. As this thesis raises a voice for the carers, it also, in a sense, presents the complexity of encounters in FPC, proving the need for additional research to depict the patients’ narratives.
Clinical Implications for Forensic Nursing

This thesis accentuates the clinical importance of carers in FPC, thereby gaining insight into the meaning of encounters as it is the focal point of forensic nursing. Thus, it emphasises self-reflection and a self-compassionate approach to fully comprehend and manage expressions of suffering, finding courage and allowing these expressions to make an impression and to be emotionally touched. The findings of this thesis can be seen as a basis for discussion about one’s own feelings in the form of education when establishing a permissive and caring climate. As carers talking about their emotions, encourages the patients’ sense of participation, this strategy is of essence to empowering patients and achieving adherence. Addressing the carers’ emotions and being allowed to verbally discuss challenging encounters and shortcomings could be perceived as the road to a ‘place’ where the carers may grow as a person, thus understanding the patient’s perspective. Creating an awareness and being able to address own vulnerabilities as a carer may enable them to regulate oneself and emotions in demanding situations by challenging own understandings of oneself as a carer. This may further promote well-being of the staff and enable them to fulfil their purpose of promoting mental health of patients.
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