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## “Walking Together Towards Freedom.” Patients’ Lived Experiences of Participation in Outpatient Forensic Care

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### ABSTRACT

There is a general agreement regarding the significance of patient participation in care. In forensic psychiatric care, however, this appears to be troublesome because of the paradoxical nature of having responsibility; to give person-centered, recovery-oriented psychiatric care and to protect society from potentially dangerous individuals. The aim of this study was to describe patients’ lived experiences of participation in outpatient forensic psychiatric care. Data were collected by means of individual interviews with five patients. The phenomenological hermeneutical analysis shed light on patient participation as having two dimensions. The outer dimension focuses on participation as “doing” and as a means of developing the understanding and skills necessary for being discharged from forensic care, while the inner dimension is related to “being” and experiences of acceptance and inclusion in communion with other people. This emphasises the importance of supporting patients’ experiences of being involved in everyday life together with others, even in periods when patients’ possibilities to affect decisions regarding their care are limited.

### Introduction

In Sweden, forensic psychiatric care is considered as an alternative sanction to prison for people who, due to severe mental illness, are not considered as being able to take responsibility for their criminal and violent actions. The care is involuntary, and partially regulated by coercive laws. However, as the Swedish Patient Act (SFS, 2014:821) should also be applied, patients are supposed to be as involved in decision making about their own care as possible (SFS, 1991:1129). This paradoxical situation, which even though the jurisdiction varies, appears also in other countries, calls for knowledge and understanding about the meaning of patient participation in forensic psychiatric care. In Swedish forensic psychiatric outpatient care, the psychiatric nurse is the patient’s primary care contact. The nurse can also act as a link between the patient, psychiatrist, and other professionals that the patient might be in contact with. Simultaneously, the psychiatric nurse has a coordinating function and is responsible for ensuring that the patient’s support needs in the form of resources from outside the health care system, such as housing and support in daily living, are met.

### Background

The importance of patient participation has been advocated in health care for decades, and it is a vital aspect of

person-centered and recovery-oriented psychiatric care (Hummelvoll et al., 2015). Patient participation can contribute to increased patient satisfaction (Dwamena et al., 2012), quality of care and safety (Schröder et al., 2006), increased motivation and adherence (Neech et al., 2018), as well as to patients’ recovery (Chester et al., 2016). By helping patients explore and develop their resources and strengths, their view of themselves as capable people can be strengthened (Biringer et al., 2016; Jacob et al., 2015).

Despite general agreement regarding the significance of patient participation in care, this appears as troublesome. This is because the care is not only a matter of supporting recovery, but about protecting individuals and society from the risks associated with patients’ psychiatric problems, and because patients need to adjust to different restrictions for a long time, often several years (Swedish National Forensic Psychiatric Register, 2020). Long periods of hospitalisation can give rise to feelings of meaninglessness and decrease patients’ motivation as well as their autonomy and self-efficacy. Patients describe forensic care as predetermined, predominantly monotonous, and not adapted to them as persons, as their perceived needs are often opposed or ignored by professionals. This gives rise to a struggle between adjustment and resistance to uphold one’s integrity (Hörberg et al., 2012; Marklund et al., 2020). When social identity is affected, relationships with family and friends can be disturbed and self-stigmatization can also remain

after discharge (Livingston et al., 2011; Mezey et al., 2016). Therefore, to ensure person-centeredness and high quality, it is important to encourage patients to develop skills that can facilitate social inclusion after discharge, as well as supporting patients' experiences of being accepted and accounted for (Fitzgerald, 2011; Hutchinson, 2008; Mezzina et al., 2006; Selvin et al., 2019).

Nurses are thus responsible for enabling patient participation as a means of strengthening the patients' ability to identify and express problems related to their ill health, to explore the impact those problems have on their lives, and build on and develop personal resources to address those problems. However, the nature of the context is perceived as an obstacle for this (Magnusson et al., 2020; Olsson & Schön, 2016; Söderberg et al., 2020). Nurses strive to balance between restrictive activities to uphold security, and caring ideals. This is not only reflected in professionals' experiences of their working-situation and a possible source of stress (Gustafsson et al., 2013; Jacob et al., 2009; Jacob & Holmes, 2011), but in nurse-patient interactions and documentation in a way that could have negative consequences for care (Hörberg, 2008; Martin et al., 2020).

Research highlights that the prevailing culture influences both safety behaviours and outcomes for patients as well as professionals (Kuosmanen et al., 2021; Livingston et al., 2012). In line with Hörberg (2008), the forensic culture could be understood as focussing on either caring in the meaning of supporting patients' personal growth and recovery, or adopting a more objectifying perspective focussing on correction and adaption to societal norms. The latter is also associated with the distribution of power and a maintained gender order where masculinity and protection of society is given propriety over person-centered care (Kumpula, 2020). This can also contribute to conflicts and stress among professionals (Gustafsson et al., 2013; Jacob et al., 2009; Jacob & Holmes, 2011).

A predominant focus on correction and security issues might also explain why nurses tend to assess the quality of care higher than patients (Lundqvist & Schröder, 2015; Rask & Brunt, 2006). Experiences of being ignored or subject to dismissive behaviours from professionals, the care as a punishment, or the threat of becoming even more restricted if one does not follow the rules might then be part of everyday life for patients (Askola et al., 2018; Hörberg et al., 2012). Not being able to influence one's own care is perceived as a factor that impairs the experience of care significantly. Not feeling involved and involved in decisions that greatly affect one's life causes suffering, and can contribute to a lost confidence in care, as well as cause patients to lose direction in their recovery process (Marklund et al., 2020; Pollak et al., 2018; Selvin et al., 2016).

This does not mean that patient participation is impossible, but that it is dependent on trustful caring relationships and communication (Bäck-Pettersson et al., 2014; Selvin et al., 2016). Patients can experience glimpses of light when the staff are themselves, acknowledge the patient's lifeworld and provide emotional support (Hörberg, 2018; Hörberg & Dahlberg, 2015). This also contributes to motivation,

experiences of meaningfulness and hope for the future (Marklund et al., 2020; Pollak et al., 2018).

Thus, if forensic psychiatric care is to be regarded as person-centered and recovery-oriented, then it needs to account for patients' perspectives, and patients must be actively involved as resourceful persons. Despite this, previous research shows that it is unusual for patients in forensic psychiatric care to feel involved. However, even though outpatient settings were represented (Selvin et al., 2016) most of the studies we found depicted closed inpatient settings. Studies from outpatient settings are mainly quantitative studies focussing on outpatient commitments (Segal et al., 2019), shared decision making and risk management (van den Brink et al., 2015) or psychoeducation (Banerjee et al., 2006). This gives rise to questions about how participation by patients in open forensic psychiatry, who live outside the forensic clinic but whose care is still involuntary is experienced. Hence, the aim of this study is to describe patients' lived experiences of participation in outpatient forensic psychiatric care.

## Materials and methods

The study is conductive within an interpretive tradition. The inclusion criterion was at least one year experience of open forensic care. Patients with ongoing substance abuse, cognitive impairments and/or difficulties understanding or expressing themselves in Swedish were excluded. Written information was given to patients that met the criteria when visiting the outpatient facility. If interested, the patients contacted the first author and a time for an interview was settled. Five patients, one female and four males with an age range between 27 and 63 years, volunteered. Inspired by Brinkmann and Kvale (2014), as well as Thomas (2021) the interviewer strove to assume a not-knowing position while encouraging the interviewees to elaborate on their experiences of participation in open forensic care.

The verbatim transcribed interviews were analysed by means of a phenomenological hermeneutic method developed by Lindseth and Norberg (2004). The method is based on Ricoeur's description of interpretation as a hermeneutic movement between the whole and the part, and understanding and explanation of the text. The first of three methodological steps requires a phenomenological openness and receptivity to what the text conveys. This was formulated as a naïve understanding of the whole. In the following explanatory step, the thematic structural analysis, the text was divided into meaning units, condensed, and abstracted into subthemes, themes, and a main theme. This revealed re-occurring patterns in the texts and shed light on different nuances in patients' experiences. Finally, the findings from the previous steps were related to each other, and reflected on in relation to theory and research focussing on person-centered and recovery-oriented psychiatric care. Based on this reflection, a comprehensive understanding, expressing the

**Table 1.** Overview of findings.

Main theme: Walking together towards freedom	
Themes	Subthemes
Participating on others' terms	Submitting to the system Adjusting to other peoples' decisions Failing to obtain necessary support Trying to negotiate
Setting the course together	Co-creating a trustful alliance Becoming active and taking on responsibility
Being included in an everyday communion	Feeling appreciated as a person Becoming anchored in a social context
Growing towards one's personal goals	Acknowledging resources and vulnerability Having patience while remaining aware of one's personal progress

meaning of the lived experiences of participation in forensic care, was formulated.

### **Ethical considerations**

As participants were subjected to involuntary care, it was important to ensure that participation in the study was voluntary and that they could withdraw at any point. In line with Holloway and Freshwater (2007) thoughts about vulnerable storytelling, it was considered important to be sensitive as to how the participants' narratives unfolded, and to offer a break if participants seemed emotionally affected during the interview. However, participants expressed that they appreciated telling their stories, and none of them withdrew. Confidentiality was assured in relation to the handling and storage of data, as well as in the presentation of findings where the names are fricatives and gender and age excluded to avoid participants being identified. In addition, the researchers carefully reflected on ethical issues associated with small, connected samples as described by Damianakis and Woodford (2012). The study was approved by an ethical board at the university.

### **Results**

The results are structured in line with the initial steps in the interpretive process, i.e., the naïve understanding and the thematic structural analysis. The third step, the comprehensive understanding, is integrated in the discussion.

#### **Naïve understanding**

Participation in open forensic psychiatric care is experienced as challenging, as the care is not provided on a voluntary basis. Hence, patients experience that possibilities to influence their care are restricted by rules and legislation. Professionals who focus on the rules, and who position themselves as the experts, reduce patients' experiences of being able to affect their care and manage challenges in the life outside the institution. Yet, it is possible to influence one's own care in the desired direction if health care professionals are engaged and provide the support needed for managing one's health as well as life in general. Being met with respect and being able to affect the nursing care plan is experienced as contributing to personal recovery as well as transformation from forensic to voluntary care.

#### **Thematic structural analysis**

The thematic structural analysis resulted in a main theme, four themes and ten subthemes (Table 1). In the following text, themes are presented as headings, and sub-themes marked with **bold italics** in the text. Quotations are used to support the analysis, and participants given fictive names to safeguard confidentiality.

The main theme could be described as patient participation in open forensic psychiatric care being an experience of *walking together towards freedom*. In focus are experiences of the path towards recovery, which has an outer dimension described in terms of discharge, and an inner dimension which constitutes experiences of personal freedom. The following description of themes and subthemes sheds light on different aspects of this experience, which will be further elaborated on when describing the comprehensive understanding.

#### **To participate on the terms of others**

As forensic care is involuntary, patients sometimes experience that when the professionals say that they should take part in planning, this is more an order than an opportunity. Care planning is something stipulated by authorities. Accordingly, participation is perceived as **submitting to the system**. Even though the care is given in outpatient settings, there are restrictions. The legal framework is experienced as limiting one's possibility to influence one's own life.

It's kind of a captivity, you are trapped by the forensic system. (In outpatient care) you are free yet imprisoned, forced to carry around that heavy responsibility (for managing a proper life outside the walls of the forensic clinic). That weighs on your shoulders every day as soon as you get up. But you still do everything you can, every day (...) I cannot do exactly what I want, I cannot go exactly where I want, there is this limit. As I said, the border of the county is the invisible wall right now, but that wall will move and expand to the whole world when the day comes, and I will be completely free from care. (Sara)

During such circumstances discharge and freedom are understood as getting away from something unwanted, rather than as approaching something desirable. Hence, participation becomes a matter of **adjusting to other peoples' decisions** as that is considered as a necessity for an upcoming discharge from forensic care. This means that the plan is dictated by professionals, and patients are informed about what is expected from them.

What I feel is awkward, and if something happens, the discussion about it does not take place here (in the outpatient facility). I must go back to inpatient care, then you discuss the matter there ... Do you understand? If I make a mistake, if someone complains about something I have not done, then I must go back to inpatient care ... They do not ask me here on the spot what happened, and why it failed. The doctor decides to take me back, even if I haven't done anything wrong. I must go back and restart a process to get out of there, and it can take some weeks ... 2–3 weeks to get back.... (Niko)

Living with an implicit threat of being sent back to the forensic psychiatric inpatient care in the event of a deviation from the care plan, is understood as restricting the patient's ability to grow as person, and to develop in a direction in life that they would prefer themselves. Feeling forced to adapt to other people's decisions concerning one's own nursing process and future can be experienced both as offensive and as being denied the possibilities of participation. This is associated with experiences of *failing to obtain necessary support* to fulfil one's needs and wishes. This can be associated with experiences of not being able to make oneself seen and heard, and thus unable to influence any decisions about the care given.

If you are my doctor and I tell you; this injection does not help me, you must change! The doctor is not listening! And the nurse... the nurse says that the doctor is informed, but... She does not want ... She does not even know me.... (Charlie)

Experiences of being excluded from decisions, as well as thoughts of maltreatment or a sense of being subjected to forensic care too long and not being able to see an end of it can contribute to feelings of helplessness, hopelessness, and resignation. However, patients also try to cope with this by *trying to negotiate*. The negotiation is characterised by a giving and taking between the patients and the professionals. In other words, care is not unconditional and can be challenging due to the person's desire to, on the one hand, get the most out of their care, but on the other hand not dare to ask for too much. Making reasonable demands and not having too high expectations in a negotiation becomes a means to get one's wishes and needs met.

Negotiation is a part of it, to get something out of your care. You must negotiate things, you must ask, ask questions too, in a good way. What do you want from me? What can I do within my freedom? What kind of freedom do I have? What does my freedom look like? Do you think we can add ... what can be reasonable as well? (Sara)

Negotiations can be facilitated if the patient complies with the health care staff's opinions and suggestions, even if they are against their own will. By accepting professionals' terms, patients can avoid complicating relationships to the care-givers they are dependent on. Hence, even though the person fails in negotiating his or her goal; discharge and freedom, negotiation is experienced as adding value and

meaning, as it allows for minor influence, and conflicts with the professionals, who are understood as important others, can be avoided.

### *Setting the course together*

Professionals thus play an important role, for good and for worse. The theme setting the course together is related to experiences of mutuality in relation to goalsetting and the trajectory towards recovery. Hence, *co-creating a trustful alliance* is pivotal. The alliance develops based on encounters where patients experience it as just as important that the professionals have trust in the person, as it is for them to be able to trust those who are supposed to support them on their course towards recovery.

You help and build alliances together, then you can give them directions about what to do and what we should agree on, stuff like that. This makes it easier for them and for me (to reach the goal). You must be involved and plan it together. (Niko)

When feeling trusted and listened to, and that one's proposals are taken seriously, the alliance is strengthened. By creating an alliance, the responsibility for taking out and following the desired direction rests jointly on patients and professionals. The mutual trust enables patients that experience themselves as doubtful about their next step to acknowledge suggestions from the professionals as helpful and given out of concern. Likewise, experiences of being trusted support patients in *becoming active and taking on responsibility*. This means that the patients are enabled to affect the course, not only of the nursing care plan, but also their future.

To be discharged, it is the great golden goal that everyone wants you to achieve and that you yourself want to achieve. To get there, no matter where you are anywhere, whatever part of the care you are in, you always have the chance to influence, the chance to say; this is what I want with my care. (Sara)

Thus, becoming active and taking responsibility is also a matter of being able to identify one's own needs, to describe problems and seek solutions, and to resolve them in co-operation with others. Such experiences are not only about identifying goals, and what steps to take towards them. They also support the person to "stay on the track" towards a desired future, not only by providing a plan to follow, but by building confidence in one's own ability to handle life.

### *Being included in an everyday communion*

Participation also means being part of a context, and included in an everyday communion. Hence, this aspect of participation is mainly and primarily related to a sense of togetherness with others. This involves *feeling appreciated as a person*, and evolves from everyday social interaction with professionals. This sense of community is perceived as facilitating the way forward, contributing to self-esteem, worth and enablement.



It feels great. Then I prove that I can handle it. To go forward.  
(Sam)

Experiences of one's progress as visible and acknowledged by others also contribute to feelings of moving forward, and having a place in society. Such encounters are experienced as stretching beyond structured meetings with focus on nursing care plans, medications, and psychiatric symptoms. Rather, it is a matter of two persons meeting on equal terms in a way that supports patients experiencing that they can contribute with something, and that the professionals value them for who they are, rather than the professionals being preoccupied with assessing their mental health status.

Every week he (the nurse from the outpatient care) usually comes, then we drink coffee and joke and talk a little and so ... I'm happy. (Charlie)

Such encounters bring about experiences of **becoming anchored in a social context**. This is understood as a sense of being part of something that exceeds the formal, nurse-patient relationship, namely a context of human connectedness where loneliness is diminished. As patients might have spent many years in institutions, and lost contact with family and friends, the relationships with caring professionals become important.

I feel great when I come here (to the outpatient facility) and visit, they mean everything to me. They have helped me a lot, stood up for me. (Alex)

Having someone to confide in, feeling welcomed and forming emotional bonds to professionals as well as fellow patients is thus described as important for re-entering society. Thus, from a patient perspective, participation cannot be reduced to shared decision-making when planning care. Rather, it is a matter of being supported to be actively involved in making and fulfilling plans for life, as well as having someone alongside when encountering challenges in life.

### **Growing towards one's goals**

Participating in nursing care planning is not only a matter of being able to influence the care one receives. It is also experienced as being able to be more active and engaged in one's personal life, and thus also to approach one's personal goals. Even though personal goals differ, they are linked to a vision of being capable and free to live life according to personal values. From the patients' perspective, discharge becomes a marker for the transition from a life restricted by others, to a more independent life. This does not mean that the person believes that he/she will not need support from health care staff, but that the support will be on their own terms. A prerequisite for this growth is **acknowledging resources and vulnerability**. Exploring and using one's resources in collaboration with professionals enables an increased awareness of oneself as capable of managing different challenges in life. One profound

challenge might be to acknowledge one's vulnerability, and to trust others as helpful and concerned about one's well-being. Participation, or rather involvement, is not only a matter of patients becoming involved in nursing care planning. First and foremost, it is about patients being open for receiving support in life from professionals.

Then in the end everything is about me ... They (the care staff) help me and are here and support me, but I must manage myself too... Be stable, live by yourself.... (Alex)

By acknowledging one's vulnerability and using personal resources when encountering challenges, the person can be active together with professionals in a way that transforms the nursing process to a human growth process, where the person's ability to manage a life in freedom is promoted.

However, such personal growth can be challenging and tiring at the same time. After months and years in a locked clinic, surrounded by high security and strictly regulated, the person is now "outside the wall, but still in the system." Discharge and freedom do not appear from one day to another, and plans initiated during hospitalisations are now further developed. Hence, **having patience while remaining aware of one's personal progress** is important.

I have done it for 20 years ... I have always planned together with my nursing team, (...) we build a plan, I am always involved, most of the plans come from me! I create a plan, and go to them, talk to them, and say what do you think about this and that? And they say: Yes, we can try ... This is how to progress, one step at the time. (Niko)

When the professionals listen and adjust the care plan to the person's wishes, it is experienced as progress, and as coming closer to one's goals. This builds confidence in one's own ability and motivation to strive together with the professionals. However, the slow pace can create frustration. To remain motivated, it is experienced as important that the professionals do not only listen and contribute with their knowledge and support in relation to mental health problems, they also need to acknowledge and remind patients about how far they have come. This can enable patients to endure the "long way back" instead of "rushing ahead into problematic situations." Patients also describe the importance of remaining hopeful instead of being bitter or reluctant towards care when things do not proceed in the direction or pace one had hoped. This requires resourcefulness, and when these resources and the progress are acknowledged by both self and others, the goal is experienced as achievable. By using their resources, taking on a leading role, and actively striving towards their goals together with professionals, patients become involved and proactive not only in their own nursing process, but in relation to their personal lives. Being able to identify what needs to be done and building your own future plan supports self-confidence and self-esteem, feelings of being important and being able to transform one's life in a valued direction.

## Comprehensive understanding and discussion

In line with the Tidal Model, severe mental illness, can be understood as problems in life (Barker & Buchanan-Barker, 2005). For patients subjected to forensic care, these problems manifest themselves in difficulties with social interaction and quite frequently there is also a problem with impulse control and violent behaviour (Askola et al., 2018). As these problems are considered as causing criminal actions, patient freedom becomes restricted, often for a long time. Even when discharged from inpatient care, patients' lives are still restricted and regulated for months and even years. Hence, it is not surprising that participants perceive of outpatient care as a slow process, where the individual, step-by-step, approaches the goal, freedom. The main theme "walking together towards freedom" describes the phenomenon of participation in open forensic psychiatric care as having two dimensions. In the outer dimension, participation is understood as a joint walk towards freedom, which is related to discharge from forensic and involuntary care. In this dimension participation relies on negotiations and adjustment to other people's norms, and step by step freedom increases. Sometimes this is needed, and prepares the patient for increased autonomy later, and the nurse role tends to alter between training and coaching. This could be compared with a more everyday meaning of patient participation associated with shared decision-making and planning of the content of care (Dahlqvist Jönsson et al., 2015; Jørgensen & Rendtorff, 2018). The process is facilitated if the nurse-patient relationship is trustful, and the patient is supported to be active and take responsibility.

However, sometimes patients also experienced a lack of support, and that it was rather other people's norms that guided goal setting in nursing plans. Hence, patients can experience participation as negotiations, where they participate on others' terms to please others and obtain a partial degree of freedom. Descriptions from inpatient settings where patients described themselves as vulnerable, neglected and exposed to professionals' power (Askola et al., 2018; Hörberg & Dahlberg, 2015; Marklund et al., 2020; Olsson et al., 2015), could be metaphorically described as being a hostage, where the ransom is paid by adjustments to others' expectations.

In contrast, a trustful caring relationship can provide the basis for shared decision making and a nursing care plan that is in line with patients' values and goals (Borg et al., 2009; Dahlqvist Jönsson et al., 2015; Eldh, 2019), as one sets the course together. This also sheds light on participation as having an inner dimension, where freedom is not only a goal but also an aspect of partnership and mutuality. The joint exploration of the patients' resources and vulnerability contributes to experiences of personal growth. From this perspective patients' participation is a matter of being in a reciprocal relationship with the nurse, where one feels accepted and where the nurses respect patients' goals even if they differ from their aspirations for the patient. It also means that the patient becomes anchored in a social context on an interpersonal level, not only based on social activities. Hence, rather than training or coaching the patient, the

nurse needs to focus on "bridging." The concept, described in the Tidal Model (Barker & Buchanan-Barker, 2005), sheds light on professionals' responsibility to establish a connection with the patient, and approach the world of the patient who is "on the other side." As described in previous research, this can indeed be challenging, as nurses need to give up their position and be open for the otherness of the patient (Hörberg, 2015, 2018; Jacob et al., 2009; Söderberg et al., 2020). In line with Rydenlund et al. (2019) such mutual, explorative caring conversations could be understood as an ethical expression of a caring ontology.

This double dimensionality also resembles the distinction between patient-centered and person-centered care as described by Håkansson Eklund et al. (2019). Both approaches rely on a concern for the patient, and an effort to involve the patient, but while the goal for patient-centered care is a functional life, person-centeredness is a matter of a meaningful life. Based on forensic care's responsibility to make sure that the patient will function outside the institution without being a risk to other people—or themselves—these aspects of patient-centeredness are motivated. Hence, shared decision making and a step-by-step plan for the route towards freedom are indeed motivated. However, to support recovery it is important that patients not only develop skills necessary to avoid new crimes and readmission. It is also important to develop a sense of being involved in community with others. The reciprocal relationship with nurses can thus become a model for other relationships and facilitate social inclusion after discharge. This is important both in relation to the person's wellbeing and for preventing relapse into criminality (Fitzgerald, 2011; Hutchinson, 2008; Mezzina et al., 2006; Pollak et al., 2018; Selvin et al., 2019).

## Conclusion

Participation in forensic psychiatric care is complex, and as described by Storm and Edwards (2013), it is important to reflect on the different meanings ascribed to the concept in different contexts, and by different people. Based on this study, patients perceive of participation as having an outer and an inner dimension. These could be understood in terms of "doing with" and "being with." Both dimensions contribute to reducing the influence of mental illness on life, and to experiences of freedom. This freedom is partly understood as being free from compulsory care, partly as regaining one's life and control over it. This is also in line with a view of recovery as reclaiming life (Barker & Buchanan-Barker, 2005). In other words, participation as both doing and being together with others will contribute new experiences that will be pivotal for patients to recapture their life.

It is also worth noticing, that even though participation in forensic care is restricted in relation to the outer dimension, nurses can support patients' experiences of being involved in communion with others in a way that can also provide the basis for collaboration and active participation in nursing care planning.

## Limitations and strengths

A possible limitation is that the study was performed on a single setting, as patients' experiences can vary among different contexts. The single setting also contributed to few participants. However, five participants is within the span (15+/-10) recommended for this kind of interview, where variation and quality of interviews rather than the number of participants is most important (Brinkmann & Kvale, 2014). The participants represented different genders, ages (27–63) and cultural back grounds, which contributed to varied descriptions of the phenomenon. The quality of data enabled a phenomenological hermeneutical analysis that revealed depth and nuances to the understanding of patients' lived experiences of participation in outpatient forensic psychiatric care. In line with the philosophical assumptions underlying the methodological approach, generalisation is not related to numbers, but to abstractions and the possibility for the reader to understand and act based on the renewed understanding (Ricoeur, 1991).

Another important consideration concerns the authors' preunderstandings of the subject. Even though none of us had experiences from outpatient forensic psychiatric care, we reflected on the possible influence theoretical understanding as well as clinical understanding from other contexts could have. The differences in our perspective enriched these reflections, and we constantly strove to find alternatives, not only during analysis but during interviews.

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