Interprofessional learning through discussions of troubled sex/gender in mental health care: a case study

Tuija Viking, Maria Skyvell Nilsson and Inga Wernersson

Abstract

Purpose – *This study aims to investigate how aspects of the sex/gender were scrutinized in a team's production of clinical guidelines for psychiatric compulsory care and what the implications were for the final guidelines and for interprofessional learning.*

Design/methodology/approach – *The study is a case study, where interviews were conducted and a narrative analysis was used.*

Findings – *The results reflected how sex/gender arose in a discussion about gender differences when using restraining belts. Furthermore, discussions are presented where profession-specific experiences and knowledge about sex/gender appeared to stimulate interprofessional learning. However, the team's learning about the complexity of sex/gender resulted in guidelines that emphasized aspects of power and focused on the individual patient. Thus, discussions leading to analysis and learning related to gender paradoxically produced guidelines that were gender-neutral.*

Originality/value – *The study highlights the potential interprofessional learning in discussions of sex/gender and its complex relation in medicine.*

Keywords *Case study, Interprofessional learning, Interprofessional teamwork, Professional differences, Sex/gender, Textual mediation*

Paper type *Case study*

Tuija Viking is based at the University West, Trollhättan, Sweden.
Maria Skyvell Nilsson is based at the Department of Health Sciences, University West, Trollhättan, Sweden.
Inga Wernersson was based at the Department of Social and Behavioural Studies, University West, Trollhättan, Sweden.

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Introduction

This study concerns learning in an interprofessional team which had to address sex/gender issues that arose when developing clinical guidelines for compulsory psychiatric care. In the study, "gender" refers to a socially constructed order using biological sex as a basis for categorization. The concept of "sex/gender" is used here to stress the entanglement of biological body with social construction of gender. The aim is to investigate how aspects of the biological (sex) and social (gender) were scrutinized in the production of guidelines and what the implications were for the final guidelines and interprofessional learning (IPL). This is "the learning arising from the interaction between members (or students) of two or more professions" (Freeth *et al.*, 2005, p. xv). IPL is often expected in teamwork where gender-related issues can also be actualized.

The concept of gender was introduced in the field of medicine under the "premises that biological differences of the sexes are interpreted differently in different societies, meaning what is perceived as masculine and feminine varies socially and culturally" (Hammarström, 2001, p. 1222). Gothlin (1999) emphasized that gender studies make visible the contexts where not only femininity but also masculinity are problematized by focusing on how sex/gender "is constituted, symbolised, conveyed, and (how it) structures relations, institutions, identities, texts etc" (p. 14).

Hammarström (2001) emphasized that biological sex, as defined by differences concerning, for instance, hormone systems and reproduction, has been (and is) the focal point of medicine. The philosopher Lehtinen (2004) has reminded us of the close interconnectedness between sex and gender in the field of medicine. In medicine, health-care professionals have expert knowledge of the biological body. Consequently, it is the physical body that is treated by professionals who are responsible for its care. In the field of medicine, the biological aspects of men's and women's health should also be considered when socially constructed gender is observed (Smirthwaite, 2010; Vetenskapsrådet, 2003).

Research has addressed stereotypes, attitudes and their consequences for learning in professional education. Some examples include nursing and medical students who after interprofessional education (IPE) maintain professional stereotypes (Carpenter, 1995) and how nursing and medical students' stereotypical conceptions limit dedication in IPE (Sollami *et al*., 2015). Gender has also been described as contributing to the maintenance of the hierarchical order of professions in IPL (Bell *et al*., 2014). Other studies have addressed the development of identity and how gendered processes impacted teamwork and learning (Lindh Falk *et al*., 2015).

However, the implications for IPL within the field of medicine when a team discusses sex/gender in their work have not been studied. This study contributes such knowledge.

A sociocultural approach

This study applies a sociocultural approach (Säljö, 2014; Wertsch, 1997) that focuses on the learning that emerges in the interaction between members of a team of experts. In IPL, it is assumed that interaction between different professions, with their distinct responsibilities, perspectives, knowledge and values, adds to the value of the expected learning across professional borders. Therefore, it is expected that representatives from different professions performing collaborative group work will clearly express the roles, knowledge and values of their respective professions (Hean *et al*., 2009).

In interprofessional teamwork, learning can emerge in personal encounters but may also occur when the team absorbs information together, such as from visual media or texts (Mäkitalo, 2012).

Method

Context

The Compulsory Mental Care Act (1991:1128) (LPT) is a law that regulates and presents the legal justifications for psychiatric compulsory care in Sweden. Section 3 states that compulsory care may only occur when the person is suffering from a serious mental disorder; there is an unequivocal need for continuous, inpatient hospital treatment; and the person is opposed to the care or it can be assumed that care cannot be given with the patient's consent.

LPT Section 19 (1991:1128) states that in the case of immediate danger of a patient harming themselves or another, it is allowed that the patient be temporarily restrained by belts or a similar device. When sex/gender was actualized in the context of the current study, the initial discussion concerning sex differences was related to belting frequency.

Mission and the team

The team was appointed by the Swedish Psychiatric Association (SPF) to create guidelines for compulsory psychiatric care, and the LPT was an indicative document. When the final draft of the guidelines was published (Document 38bb), it was described as "an attempt to

formulate a best practice for psychiatric compulsory care from ethical deliberations and current knowledge, based on scientific research".

The team consisted of 10 members and is presented in Table 1 below. The team's sex/gender make-up was male-dominated.

The team's work with the guidelines for psychiatric compulsory care was carried out from 2010 through 2013.

Gathering of data

In December 2012, the team was asked if it would be interested in participating in a study focusing on its work and learning. The team accepted the invitation to participate in the study. In 2013, the researchers received the working materials (when the guidelines were finished). Data, a part of which is used for the analysis presented here, consisted in total of minutes from 18 meetings, 358 email communications, 109 documents and 11 media reports. At the same time, all members except one agreed to individual interviews.

Individual interviews with the members were conducted from October through December 2013. The time and place were chosen by each informant, and each interview lasted one to two hours. The overarching purpose of the interviews was to discover each individual participant's experiences of and thoughts about the work with the guidelines, with a focus on IPL.

Interviews were recorded and transcribed verbatim.

Ethical discussion

One ethical dilemma was that it was not possible to protect the team's anonymity or ensure confidentiality, since their project was publicly known. Therefore, the interviewed persons had the opportunity to state their view regarding this matter. The lack of anonymity did not affect the members' willingness to participate in the study. The Swedish Research Council's ethical principles for scientific research were followed (Vetenskapsrådet, 2002) since the demands for informed consent and use of information were fulfilled.

Case study

All material from the team's work related to sex/gender has been used and analysed in its entirety. This is consistent with Yin's (1994) description of a case study as a process of describing a phenomenon that can be difficult to separate from its context. The case consisted of the team's work with the guidelines for compulsory care, and in this article, we specifically analysed how sex/gender was discussed and treated. Data for the analysis

Table 1 Members' profession and sex

Profession	*Sex*
Physician 1	Female
Scientist	Male
Physician 2	Male
Coordinator of Ethics	Male
Nurse 1	Male
Occupational therapist	Female
Physician 3	Male
Physician 4	Male
Physician 5	Male
Nurse 2	Female

regarding sex/gender consisted of minutes from five meetings, four email communications (mailings from any of the members to the entire team and/or to the team and the chair for the SPF [the principal]), 12 documents (the finished guidelines, public reports on psychiatric compulsory care, scientific reports on sex and gender, scientific articles on belt restraining of young women in compulsory care) [written by members], a debate article [written by a member] and a scientific report on gender in psychiatric compulsory care [written by a member]), two media reports (media coverage regarding belt restraining of young women that were discussed during work meeting), one observation (of a seminar where the guidelines were presented) and nine individual interviews.

Processing the material

An initial description of the team's discussion on sex/gender was created. This phase aimed to form an overarching picture of how sex/gender was brought up and how the discussion played out.

The second phase consisted of analysis of the individual interviews that took place after the team's work was finished. A narrative analysis was conducted. The interviews were analysed as narratives in which statements were interpreted from the text as a whole (i.e. not by categorizing separate words or expressions) (Riessman, 2005, 2008).

In the third phase, the results were further evolved through consideration of the information that appeared in the individual interviews, after being compared with the initial description of the team's discussion of sex/gender. After several readings of the interviews, four themes emerged that can be viewed as steps in the team's sex/gender discussions:

1. The team noticed a statistically significant difference between the sexes and the lack of purposeful treatments. The related theme is different opinions of why the difference between the sexes regarding use of restraining belts is a problem.
2. The team discussed the difference between the sexes and possible gender-related causes. The related theme is different knowledge and experiences of the causes for difference between the sexes regarding use of restraining belts.
3. The team discussed the difference between the sexes relating to behaviours and the need for a power perspective. The related theme is different opinions of power and gender.
4. The decision was made to maintain a neutral perspective on power and the individual. The related theme is different perceptions on gender and focus on the individual.

Results

The four steps in the team's discussion of sex/gender are presented below. The results are illustrated through a selection of quotes. Some quotes were edited for clarity.

Step 1. A statistically significant difference between the sexes: a lack of best practice

In the first step, the team reacted when they observed the difference between the sexes regarding the use of restraining belts and a discussion began about praxis in the treatment for some young women. The psychiatric problem of self-destructive behaviour served as the starting point. The obvious differences in use of coercive measures made the team seriously consider a gender perspective, which is documented in the minutes:

> Gender. Is this something we should include? Coercive measures are more common among young women. The researcher pointed out that there is a Swedish National Board of Institutional Care (SiS) report [1] covering this topic [gender]. We should include it. (Minutes 13a)

That there was an extended discussion on sex/gender in relation to self-destructive behaviour was confirmed in the interviews. Physician 1 highlighted that the increasing number of self-destructive patients must be taken very seriously:

> And that group [young women] has increased since [. . .] with self-destructive behaviour, but also young men. And it is young women under the age of 35; it is the younger ones so to speak [who get restrained more often]. And this is a completely new phenomenon [that so many have self-destructive behaviour]. And I think this is very serious indeed. It is like this, this is something you really have to take seriously. (Interview 1.1)

The message in the next quote is that this member believed there was a lack of knowledge about how to treat women with self-destructive behaviour. According to Physician 2, these patients required treatment from health care personnel with special knowledge about this kind of problem, but he also indicated that there was no agreement on the best course of action when he stated, "and a problem area is the care, the compulsory care of young, self-destructive women. But it isn't easy [. . .] you can say that there really is no best practice" (Interview 3.12).

The lack of a best practice was also noted in several interviews. According to Physician 4, the problem was that care did not include an adequate method of treatment for self-destructive girls, thus placing them under compulsory care. He stated, "Something the health service has not been good at is helping certain girls. And that has to do with knowledge, with methods of treatment rather, than to do with compulsory care" (Interview 8.12).

Physician 2 talked about how restraining belts became praxis in the treatment of women hurting themselves. Consequently, dealing with self-destructive women was seen as a problem of clinical praxis:

> It is terrible [. . .] And it doesn't have to do so much with guidelines [the team's work]; it has to do with clinical praxis. It is the case that we have a group of patients we have great difficulties handling. And that is young women with self-destructive behaviour [. . .] they are, very many, and they are off and on hospitalised and sometimes it becomes very miserable and then they are put in restraining belts very often. Sometimes they get compulsory care. (Interview 3.2)

Physician 4 suggested that the health service does not purposefully treat women differently from men, but rather, the difference is a consequence of those young girls or women exposing themselves to danger. His standpoint was that the problem should be seen from a larger perspective, beyond sex/gender. Self-destructive behaviour is a dangerous condition where drastic measures are used to save lives:

> I think more that compulsory care is necessary when such a situation arises, the patient's life being in danger and their wellbeing, and so on. And that really has nothing to do with gender. (Interview 8.9)

In addition, Physician 4 spoke in the interview about how the team's discussions about putting these women in restraining belts largely concerned the lack of adequate means of treatment. He stated, "Yes, we discussed it quite a lot, but we discussed just the methods of psychiatry and the great lack of knowledge about what helps" (Interview 8.15).

Physician 3 stated that the discussion in the media about young women with self-destructive behaviour made clear that restraining belts should not be considered an acceptable method of treatment. It was made evident that restraining belts should only be regarded as a coercive measure and not considered or used as a method of treatment. He noted "that it is something good that came from it being exposed [. . .] restraining and sequestering like some kind of method of treatment, it is a coercive measure" (Interview 7.5). This quote exemplifies how in the discussion aspects of treatment were immediately problematized. In this stage of the discussion, the team also concluded that the statistical

differences between the sexes regarding use of restraints were not really about sex/gender but instead about the lack of adequate treatment. By putting the lack of functional treatment in the foreground, the sex/gender dimension was reduced.

Step 2. Possible gender-related causes

In the second step, discussions emerged about possible gender-related causes for why young women with self-destructive behaviour were being restrained with belts. Different knowledge and experiences of the causes are presented below.

In the interviews, members suggested possible causes for the gender difference in restraining belt use. Physician 5 explained that differences in types of personality disorders statistically overrepresented in women led to belting. He stated, "Yes, it is enough to look at these personality types. So, if one looks at personality disorders you find that narcissistic and paranoid traits are overrepresented among men, whilst histrionic and borderline traits are overrepresented among women" (Interview 9.9).

The Coordinator of Ethics suggested that the statistics showing that women with certain personality disorders are put into restraining belts more often are notable:

> On the other hand, when one looks at national compilations about restraining belts, it is at least remarkable that young women with self-destructive behaviour and/or personality disorders, stand for such a significant part of cases [when] restraining belts are used. (Interview 6.5)

He went on to describe that he had imagined it being big, strong men who were put in restraining belts to protect professionals from violence:

> I would have guessed that [. . .] in the name of reason it would have been big, strong, drunk psychotic men that are put in restraining belts in order not to hurt someone else, because you'll have to in order not to be beaten to death. And then it appears that it was this group instead. (Interview 6.19)

The Scientist also saw the statistics as startling and noted that the causes needed to be investigated and amended:

> I believe that even if you can't be exactly sure that those numbers are correct in every detail, it is still so remarkable, those columns, that you have to take it seriously and see if you can find out the causes. See if you can do anything about it, I think. (Interview 2.4)

The Coordinator of Ethics suggested that the use of restraining belts on young women might be applied on arbitrary grounds and expressed moral difficulties that could cause future guilt among professionals:

> If one is to be able to look oneself in the mirror 10 years from now, and say that one worked in psychiatric compulsory care [. . .] then I would wonder why these girls were put in restraining belts. Didn't we have any other measures? [. . .] How can we solve these things? (Interview 6.7)

Other concerns about sex/gender in the use of restraining belts emerged. For example, a concern arose that individual characteristics required more attention. The Coordinator of Ethics stated that young men with self-destructive behaviours faced the risk of being neglected since they displayed other symptoms. His opinion was that the problems surrounding self-destructive behaviour are gendered:

> So, if one sees a boy with a scratch, or a cut on his arm, you think he made daddy mad. [If] it [is] a young girl, one thinks directly of self-destructive behaviour. That is to say, this is largely related to gender by and large. (Interview 6.12)

Another member, Physician 2, used the concept of gender roles and put forth the tendency of young women to have a "role of self-destruction", meaning that self-destructive behaviour in young women is largely expected and approached from the structural category of

"women". Such a categorization risked overlooking young self-destructive men since they show different symptoms that are expressions for a different (gender) role.

One member proposed that if personnel increased their understanding of what is gender-specific in self-destructive women and how to handle it, the use of restraining belts on women would decrease:

> Because it is once again, if we can understand and deal with these affect instabilities and handle them in a different way than by coercion, then we won't have to use coercion. But one must focus on the issue; this we have to learn more about. This we have to think about. (Interview 9.11)

In this step, the discussion has illustrated how the members were puzzled and worried about the sex/gender-related patterns in the use of restraining belts, discussed explanations and the need for more knowledge and better treatments.

Step 3. A power perspective is put forward

In the third step, the team discussed sex/gender differences in relation to behaviour and the need to highlight a power perspective in the guidelines. In these discussions, different opinions about power as well as sex/gender were presented. Initially, a problematic balance of power between personnel and young self-destructive women was discussed. Attention was focused on how these women's self-destructive behaviour provoked and influenced the actions of personnel. Thereby, a power dynamic, between staff and patients, was revealed and problematized. In total, the analysis showed that the team decided that a perspective on power should be included in the guidelines.

The interviews also revealed that the members shared their experiences regarding how personnel can treat self-destructive women. Physician 2 stated that in the general treatment of these women, a gender perspective is needed:

> And there is also a gender perspective. Maybe one can't express it in terms of oppression, but one could still, I think, express it in terms of general treatment, that one gets treated, one gets treated in a certain way if one is a young woman with self-destructive behaviour [. . .] and that [. . .] such could be brought forth. (Interview 3.16)

The physician suggested here that personnel erroneously used their power in the treatment of young women with self-destructive behaviour.

In a media report, the importance of emphasizing aspects of power in relation to the problem was highlighted. Physician 2 informed the team about this via email:

> It is storming a bit extra in connection with the media reports about the case [of] Nora 'The restrained girl' [. . .] It certainly has bearing on our work – a young girl whisked in and out with different kinds of coercion, LVU, LPT, LRV [2] and frequent compulsory measures. The systematic errors made by [the] municipality, police and health service have had great consequences not just for her. My thoughts go more to the errors of the system than individual doctors and others who have failed. Maybe we should have a section on power and the use of power, something we don't learn much about in the training. To exercise power without turning into a 'power person'. (Email 163a)

The report described above was especially relevant to the team in their development of guidelines for compulsory care. In that work, the media element and the reflections that followed led to a development of meaning and knowledge that provided insight in the importance of power.

Power in relations between personnel and women with self-destructive behaviour was addressed in different ways by the members. Physician 2 committed to the issue by writing a debate article that focused on the exercise of power by professionals in compulsory care. The article problematized how physicians may enter stressful situations where it is difficult to have a professional approach encountering self-destructive women and is excerpted below.

> The case of Nora is mostly about shortcomings in the exercise of power [. . .] The problems regarding how we as human beings deals with power and how we are influenced by holding power over other human beings would benefit from being clarified, mapped out, and analysed. Of course, the design of laws and regulations is important. But it is equally important that we as human beings are capable of dealing with the traps and difficulties that the daily exercise of power of other human beings brings [. . .] (Document 30a)

The quote above seems to indicate that self-destructive women challenge personnel, leading to medically questionable use of restraining belts. The article described above can be seen as an example of an expert in the team also producing texts reflecting more deeply on the problem from a power perspective. This illustrates possible learning while discussing the content of the article and the aspects of power in compulsory care as related to working with the guidelines. Such reactions among personnel are also described in the interviews. Physician 5 shared the opinion that self-destructive women's behaviour could be perceived as provocative by personnel:

> And I can imagine that since young self-destructive women are an increasing group in compulsory care, that is caused by their [. . .] their personality provokes the personnel more. I don't think men provoke in the same way. They [young women] simply become stark raving mad and perhaps you must use compulsory care. But this grey area brings with it that one readily uses the belts on these women. (Interview 9.4)

The physician meant that personnel had greater difficulties approaching self-destructive women because of their (often) affect unstable behaviour. In this context, he also presented his opinion on the importance of the tradition that personnel more often use restraining belts on women because of inadequacies in knowledge and praxis:

> And it is the case that we traditionally have learned to handle the paranoid or narcissistic trait better, so we can more easily accommodate for them, than we have the acting out of affect instable traits, those we can't stand. And then we strike using our coercive measures. (Interview 9.10)

The members seemed to think that personnel need knowledge about how power can be related to their own reactions to an expression of mental illness. The text in the guidelines therefore came to include a power perspective to raise awareness among personnel about the risk of overusing their position of power.

Although the team's formulations on the relations of dependence between patient and personnel emerged as gender-neutral, their discussions began with examples specifically illustrating the treatment of a female group of patients. The final formulation aimed to develop an increased awareness among personnel regarding the exercise of power when using coercion. The use of coercion interconnected with power was expressed in different ways due to patients' sex or gendered images. Young female patients were put in belts because it was possible to do so, while belts were used less frequently on men, as they could be handled better through other means. Thereby, the discussions highlighted a gender-mediated use of power.

An assumption that the personnel's actions were related to sex/gender-specific diagnoses and patient behaviour, rather than gender as such, led to a view of the gender perspective as irrelevant in the guidelines. This is despite indications of how a power dynamic between staff and patients may lead to women being restrained more often than men. However, a greater focus on the relations of power between personnel and patients resulted from the discussion of sex/gender and was believed to contribute to more equal health care.

Step 4. A diagnosis and gender-neutral law: an individual perspective

Step 4 illuminates the team's discussion about how sex/gender differences led to the decision to present in the guidelines a gender-neutral perspective on power and the individual. Aspects of sex/gender were perceived as difficult to incorporate in the guidelines which were based on LPT regulations. The legal text that governed the team's work was meant to be general and not highlight some specific diagnosis or group.

In the interviews, it becomes clear how the discussions about sex/gender led to the general characteristics of the guidelines. According to Physician 3, the team had written in more general terms on methods useful in de-escalating violence instead of focusing sex/gender differences in use of restraining belts. He stated, "Not specifically, it wound up more like in these [. . .] general aspects, de-escalation methods and such things" (Interview 7.9). Since the legal text addressed the use of restraining belts in more general terms, it was considered inappropriate to link the practice to specific diagnoses or groups.

As Physician 1 explained in the interview, the team's assignment was to start from the law, which formulates how compulsory care should be applied. The physician's opinion was that since the law does not solely or directly concern self-destructive behaviour, the focus of working with the guidelines was not to elucidate the use of restraining belts on self-destructive women. She stated, "And then we won't focus on it. Because this law isn't designed from the person with self-destructive behaviour" (Interview 1.21).

The Coordinator of Ethics also noted this:

> Maybe in some sense, I wonder, [if it] is least controversial to raise, if healthcare shall be equal regardless if one is a woman or a man, or regardless of expectations of a gender perspective. But it probably has to do with that, it is difficult and, like highlighting certain diagnoses and so on, even if research and other kinds of gathering [of] facts point out that certain groups are more vulnerable than others, it can easily be the case that all hell breaks loose if one either mentions certain diagnoses or certain groups in these kind of guidelines, I think. Either that that group feels singled out as problematic or that the groups who are not singled out wonder 'why haven't you mentioned us as well then? [. . .] We too want a better care'. So, I think that is one reason why this problematic part actually has not been addressed sufficiently. (Interview 6.21)

The quotes above testify to a fear of singling out certain diagnoses, groups or areas within psychiatric care in the guidelines. Against this background, a focus on the individual patient was emphasized. Just like other patients, the Occupational Therapist stressed that self-destructive women should be approached as individuals. As an occupational therapist, focusing on the patients' ability to function:

> Yes, I suppose I think just like I think with all patients, that one should show a great respect like you do with all patients, that you treat them from where the person is. (Interview 4.8)

> And I think one has to do this with all patients one meets regardless of problems, disabilities, or diagnosis. (Interview 4.9)

The Scientist also emphasized the importance of always treating patients from the perspective of the individual, for instance when monitoring patients:

> [. . .] that one includes the gender aspect when one designs that, the measure, individually, so to speak. So that one doesn't make it a rule to always have a person of the same sex monitoring these situations but finds out what is best for the patient in question. (Interview 2.14)

Physician 1 also noted that the team's discussions on sex/gender resulted in their understanding of the importance of the perspective of the individual when using coercive measures. She stated, "Yes, yes, it is obvious to think about the person in front of you, because it is always an individual decision. And that we also do assessment, and that [it] is of the individual" (Interview 1.30).

In the discussion, the problem of differences of gender in healthcare was transformed to a problem of approach, emphasizing the need to problematize power and focus on the individual patient. When the team produced texts about the need for increased awareness of the power aspects of using coercion, the focus shifted from gender (the categories men and women) to the individual patient.

Discussion

This study examined how aspects of the biological (sex) and social (gender) were scrutinized in the production of clinical guidelines and what the implications were for the final guidelines and IPL. The results showed how sex/gender arose in a discussion about gender differences when using restraining belts. Furthermore, discussions have been described where profession-specific experiences and knowledge on sex/gender appeared to stimulate IPL. However, the team's learning about the complexity of sex/gender resulted in guidelines that emphasize aspects of power and focus on the individual patient. Thus, discussions leading to analysis and learning related to gender paradoxically produced guidelines that are gender-neutral.

In the discussions, based on the more frequent use of restraining belts on women with self-destructive behaviour than on men, several textual tools were used in addition to oral language (cf. Mäkitalo, 2012). The texts included a legislative act and media reports as well as articles authored by members in the team.

It is assumed here that IPL took place in the exchange of profession-related interpretations of textual content.

One explanation to the fact, that restraining belts are more often used on self-destructive women than on strong, angry men, was that it is not sex or gender *per se* that causes this difference but rather a lack of adequate treatment related to the type of personality disorders typical of women compared to those of men. One physician explained that women are perceived as provocative and more prone to harm themselves and that is why coercion is used.

The importance of power and its relation to gender is another explanation of the statistical difference in the use of restraints. This became clear in the discussions of ethics. The Coordinator of Ethics voiced moral objections to the use of coercion and was surprised that it was used on women even though men often are stronger. One physician stated that the staff¨s abuse of power was one reason for the gender difference.

The team also understood that complex relations between social and biological factors needed to be considered when explaining an overt sex difference. Whether nature (sex) or society (gender) was viewed as the "main actor" by the team was not clear in the available data. However, the team was clearly aware of social influences. Simultaneously, in all medical fields, the body is in the centre and a biological perspective must be included when dealing with social construction of gender (Lehtinen, 2004).

The assumption that the staff's use of power was connected to a specific sex/gender-related diagnosis and patient behaviour rather than gender itself led to a focus on problematic relations between patients and staff. To increase the staff's awareness of their own use of coercion, a reflection on power was included in the guidelines. Thus, the reasoning about gender made power visible. That sex differences are not fixed but part of a changeable gender structure was also stated. Self-destructiveness among young women could be viewed as part of a "gender role" in the social structure, and young self-destructive men could go unnoticed due to their different methods of self-expression.

The team reached the conviction that the best way to deal with gender in the guidelines was to stress an individual approach. The individual's functional capacity, which, for example, the Occupational Therapist brought up, rather than social belonging became important, and the aim for assessments in healthcare was always individually-based?.

While neither "sex" nor "gender" was mentioned in the final guidelines, this decision was based on a thorough analysis, or learning, of the nature of the problem. By discussing the problem when using, treating and producing texts, the members, consistent with the precepts of sociocultural theory, exchanged and reflected different professional interpretations of gender. The sex/gender aspects of psychiatric care became indirectly

negotiated, resulting in an emphasis on the individual person. This result indicates learning that also was limited by the members' expertise.

The results shed light on the value of expertise in gender, which in discussions of sex/gender can stimulate the IPL in the teamwork. Despite an ambition to provide mental healthcare knowledge-based guidelines, the power dynamic between staff and patients, which may end up in restraining women in belts more frequently, was not explicitly expressed, resulting in an exclusion of gender perspective. The decision to exclude gender and instead underline the power aspect among staff leads to other questions to consider. Was this decision related to the confirmed lack of adequate treatment for the targeted women; a male-dominated staff that tended to abuse their power by restraining (troubled) women; or the team (producing the guidelines) that was male dominated; or a combination of these factors? We choose not to discuss an interaction between power and sex/gender despite the indications of more power, i.e. staff and male, and indications of less power, i.e. patients and female. Although the findings indicate that more male personnel restrain more female patients, we cannot establish that this is the case. This study can only state that the team ended up highlighting the power perspective to increase the awareness of the risk of abusing power against patients and thereby reduce the use of restraints. To raise the quality of mental healthcare?, we suggest training that increases staff's knowledge of, for example, young self-destructive men who otherwise risk being neglected, and staff's own behaviour related to women with self-destructive behaviour. This should be a focus of further study: What are better treatment options in the case of young women with self-harming behaviours? Psychiatric teamwork benefits from including gender expertise that can support IPL.

Notes

1. The SiS is a government agency that delivers compulsory care to young people with psychosocial problems and to adults with substance abuse (Statens institutionsstyrelse, 2016).
2. The LVU is the Care of Young Persons (Special Provisions) Act (Sveriges Domstolar, 2010). The LRV is the Forensic Psychiatric Care Act.

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About the authors

Tuija Viking is a PhD candidate in education with specialization in work-integrated learning. Her research area is interprofessional learning in teamwork. Tuija Viking is the corresponding author and can be contacted at: tuija.viking@student.hv.se

Maria Skyvell Nilsson is a registered nurse and an associate professor in education with specialization in work-integrated learning. Her research area is work-integrated learning in a healthcare context.

Inga Wernersson was a senior professor in educational sciences. Her research dealt with the implications of gender in education, teaching and learning.