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In the Facets of Powerlessness: Agency as an Essential Aspect of the Self

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Portfolio for Professional Doctorate in Counselling Psychology (DPsych)

City University London

Department of Psychology

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Anna Wachowska

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SECTION A: PREFACE

1. Overview

The preface will introduce and provide a general review of the main components of the doctoral thesis portfolio. The current portfolio presents several pieces of work that are combined under the overarching topic-based theme of ***powerlessness***. The portfolio comprises of four main sections. Section A includes the preface, which presents a broad overview of the portfolio itself, briefly explores the relevance of the powerlessness concept and provides an illustration of how each component of the portfolio is linked with its central theme. Section B consists of an exploratory empirical research study that focuses on the experiences of former patients that were treated involuntarily in a psychiatric ward during psychotic distress. In Section C, the case study presents a reflexive exploration of the clinical journey, portraying certain parameters of entrapment from a client's perspective. Lastly, Section D includes the publishable paper that broaches the issue of powerlessness in the context of affect-regulation difficulties and in relation to the literature review, with an aim to consider its implications for clinical practice.

2. Thematic Connection of the Portfolio: The Issue of Powerlessness

Various manifestations of distress encountered by clinicians and allied professionals in a therapeutic context, as well as in ambulatory and in-patient settings can be conceptualised as a result of imbalances and abuse of power in relationships. Such occurrences are characterised by eliciting a sense of powerlessness and helplessness (Mack, 1994; Lord and Hutchison, 1993). A wide range of social and physical risk factors like socio-economical disadvantages, low self-esteem, high demands, chronic stress, limited resources and lack of support, may give rise to the feelings of powerlessness (Albee, 1981; Strandmark, 2004). Thus, powerlessness can involve a perceived lack of internal and personal, as well as external control over certain situations (Johnson, 1967). Buddhist, as well as psychoanalytic perspectives, in particular, draw attention to power and agency constituting an essential aspect of the self (Mack, 1994). It is also important to note that the word *agency* itself places emphasis on the role that institutions play in governing the lives from outside of the self (Mack, 1994). The concept of power is, therefore, pivotal in our lives as it exists within the activities of people and within a network of relationships (Foucault, 1965, 1977, 1980a, 1980b, 1980c, 1983; Deleuze, 1988). In contrast to an individualised

perspective of the origin of personal distress, the relevance of toxic external social influences and economic inequalities has also been highlighted, which may profoundly alter identity and sense of efficacy of the most vulnerable individuals (Mirowsky and Ross, 1991; Bruce et al., 1992; Prilleltensky et al., 2000; Wilkinson, 1995, 2005). In this respect, lack of control may not always be a matter of mere subjectivity, but a reality that may prevent individuals from altering their situation, including the scope of social or material determinants in which they are embedded (Franzblau and Moore, 2001; Smail, 2001; Wilkinson, 1996).

However, it seems that the perspective on powerlessness has been poorly investigated (Aujoulat et al., 2006). The sense of possessing some form and degree of personal power inculcates a feeling that one, to some extent, is an author of one's life (Mack, 1994). More importantly, it is postulated that powerless states can pose a threat by fragmenting the sense of self and evoking fear centred on its dissolution, annihilation or even death (Mack, 1994). This powerful link has been demonstrated in different ways in each component of this portfolio.

The following section consists of a concise summary of each of the portfolio's components and their objectives. The preface ends with a reflection on the personal journey undertaken throughout the training of the researcher and the learning that has followed.

2.1 Research Thesis

Section B consists of an original piece of research that constitutes the chief component of this portfolio. The study is aimed to explore the in-depth lived experience of former patients, treated involuntary on a psychiatric in-patient ward, as a result of psychotic distress and the impact such an experience had on their well-being and recovery process. The project utilised semi-structured interviews to gather the data, which has been analysed from a homogenous sample of six individuals, who were detained under Mental Health Act (1983 and 2007). Individual accounts were analysed using the qualitative methodology of Interpretative Phenomenological Analysis (IPA); emergent themes from narratives were subsequently explored, and findings and implications were discussed in the light of existing literature.

The project, in essence, is therefore concerned with the experience of coercion. Powerlessness, as defined by Freire (1973, cited in Kieffer, 1984) seems to strongly reflect the participants' accounts in this study by pointing to the role of environment on the object, as opposed to a subject that acts in and on the environment. The study

also captures distressing experiences related to the loss of social and personal identities, representing yet another dimension of powerlessness.

2.2 Professional Practice – Case Study

The case study in Section C focuses on the therapeutic alliance between the therapist and the client, across the nine sessions of psychodynamic therapy. The psychodynamic approach falls largely under the comprehensive subjectivist paradigm, based on hermeneutic philosophy and *methaporism* - an epistemological worldview underlying constructivist therapy (Alderson, 2004). However, the case study also represents a scientist-practitioner's attempt to integrate theory and research into practice; such is demonstrated by drawing on psychodynamic theories of child development that tend to adopt a realist and positivist epistemology. The case study is, in essence, an illustration of how both the client and the therapist embark on an uncharted journey that often requires them to struggle, bear fear and pain, and confront helplessness. Thus, the case study describes the client's journey towards finding herself by overcoming a state of powerlessness, which seems rooted in the client's inner conflicts and constraints. The client's problems are formulated within a psychodynamic model with the aim of identifying the core pain. A range of therapeutic interventions is contemplated and subsequently developed. Finally, the therapeutic work is critically and reflectively evaluated.

2.3 Publishable Paper: Theoretical Article with Implications for Clinical Practice

Section D constitutes the publishable paper and presents a critical review of some relevant theories, as well as research on *affect* and its relevance to human functioning and change. The objective of the paper is to promote therapeutic integration and adaptability by exploring the potential improvement of psychotherapeutic practice, and making the skill of emotion-regulation a target intervention. It has been highlighted that science has often overlooked emotions and their connection to rationality, as well as discarded the possibility that emotions are the source of a person's true being (Damasio, 2006). Since early life experiences can shape the emotional structuring, the section draws attention to the 'affect-regulation difficulties' that may manifest themselves as a reversible neuropsychological breakdown, and even a failure in the development of the function of the self (Schore, 1994; 2000; 2003; 2005; Schore and Schore, 2008). Since affect has been defined as a neurophysiological state with a non-conscious experience of intensity, acquired ruptures in this domain may denote positions characterised by a lack of control

(Grotstein, 1986; Gross and Munoz, 1995; Cozolino, 2010). The article outlines an integration of findings, predominantly from research on cognitive science and neuropsychology, as informed and inspired by psychoanalytic theory and developmental psychology. It has been noted that Bowlby's (1969, 1973, 1980) pioneering work on attachment constitutes, in essence, a theory of powerlessness. In other words, to broach the issue of affect-regulation deficits is to embrace the psychology of powerlessness (Grotstein, 1986). The paper will be submitted for publication to the *Counselling Psychology Review* (see Appendix 12 for Journal's Submission Guidelines for Authors).

3. Personal Journey

On many levels, this portfolio represents a journey that I have travelled throughout my counselling psychology training. There is a fine line, if any at all, between personal and professional development, as both are undoubtedly intertwined within this project. Therefore, for me, this journey symbolises transformation, discovery and a rather profound learning experience.

First of all, my motivation to conduct this research thesis stems from my experience of working in a psychiatric ward and the struggle I faced, as a result of being caught in what I perceived to be a dysfunctional system that I had no power to influence. This research is, therefore, essentially born from a keen interest in working with marginalised populations and the issue of power dynamics, in general. In fact, this project further fuelled my fascination towards the issue of power and powerlessness. Such is also evident by my growing commitment towards the phenomenon of psychosis, as I hope to make some contributions in combating stigma and pathologising practices, by advocating for a paradigm change within the dominant biomedical model.

Furthermore, the theme of powerlessness seemed to have consistently bubbled through both my professional, as well as personal life spheres and induced some poignant reflections on the subject. It also transcended in many ways during the process of producing this portfolio. For instance, during the data analysis stage, I struggled to contain what seemed like uncontainable or understand what appeared as incomprehensible. As an inevitable part of the existing parallel processes, I also had to 'sit' with the powerlessness, which participants vividly described in their accounts. This powerlessness became more apparent as I immersed myself in writing the 'Results' chapter. I was confronted by constraints related to the word limit, which I battled for a long time. I must reveal that I could not help feeling that I would not be

able to do justice to the accounts of individual experiences, which could be left unheard. My emotional attachment to the project and its significance was so strong that I had to work through my resistance and process my emotions, including anger, which eventually allowed me to accept the 'unacceptable'.

Furthermore, both the publishable paper and the case study were produced during the most professionally challenging and fruitful period of my training. This period was filled with questioning and constant self-evaluations, which resulted in a significant change in my ever-evolving self and undoubtedly helped me shape myself as a clinician, especially within scientist-practitioner affirmations (by emphasising binding theatrical knowledge). However, paradoxically, as a practitioner-scientist, I also learned to value the felt sense and intuition; as well as obtain learning and substantiate theory directly from experience. After all, it has been pointed out that counselling psychology is a pluralistic-orientated branch of psychology, which embraces the multiplicity of viewpoints and possibilities (Kasket, 2012). The publishable paper represents, what I perceive to be, a crucial developmental milestone in my journey as a trainee counselling psychologist. It helped create a solid critical reflective forum that ultimately enabled me to construct (and continue developing) my professional identity. It created a therapeutic epistemic orientation, which built a foundation upon which I stand; particularly as related to how I grew to conceptualise distress and therefore *change*. Thus, by focusing on the historically underexplored area in the publishable paper, I hope to make a valuable contribution to the field and demonstrate my commitment to the importance of producing long-lasting changes by addressing a root cause effectively. The thesis itself aims to increase the awareness among practitioners of the issues faced by the patients, who are treated involuntarily in an in-patient ward, taking into account the impact such experiences may have on their lives.

Finally, at some point during the completion of this research thesis, I was confronted with some major upheavals in the personal domain and was compelled to manage my own powerlessness as well. Such an experience highlighted the relevance of satiating my needs and the issue of not only professional, but personal identity also came to the surface. I believe such adversity, when placed within the context of my professional path, has led to the culmination of the process of self-discovery, not only as a professional but also as an individual. Perhaps, this may allow a more potent transition from a trainee to a fully qualified counselling psychologist.

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SECTION B: Doctoral Research

To be heard: Qualitative exploration of individuals' experiences, views and meaning of psychiatric in-patient treatment under section and its impact on the recovery process

Anna Wachowska

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Supervised by Dr Soren Nils Petter

Abstract

Though in-patient psychiatric treatment remains an integral part of the mental health services, research that focuses on the exploration of patients' experience remains scarce. Existing investigations mostly rely on quantitative methods that seem to produce inconclusive results or raise methodological concerns. The current qualitative research aims to explore how individuals' experience and view their treatment in a closed psychiatric ward under section. The goal is to extract the meaning of such experiences and broaden the understanding of the impact it has on the individuals' well-being and recovery process. Data was gathered from six former patients who had experienced psychosis at the time of their involuntary commitment onto a psychiatric in-patient ward. Semi-structured interviews were conducted, and an interpretative phenomenological analysis (IPA) was employed to investigate the data. The findings comprise of four superordinate themes: *A struggle for recognition; Terrifyingly out of control - striving for a sense of agency; Transformation and loss;* and *The comforting and sanguine.* The results suggest that involuntary hospitalisation to an in-patient ward not only provides a limited opportunity for recovery but can also be very distressing for the patient. The findings are aligned with the existing conceptualisations of involuntary treatment, potentially constituting a traumatic experience with debilitating impact upon individuals' sense of self. The study also highlights the importance of the relationship with the ward staff, which seems pivotal in directly shaping patients' perceptions and recovery. Involuntary detention to a psychiatric in-patient ward, however, is a complex process that may be influenced by various contextual factors, potentially triggering a wide range of responses. Thus, contradictory nature of the phenomenon is also unravelled; although individuals share stories of great losses, some significant potential gains have also been identified retrospectively. Findings, in relation to the existing literature, are discussed, and the limitations of the study are identified. Finally, the recommendations for practice and prospective future research are also analysed.

Chapter 1: Introduction and Literature Review

1.1 Overview

The current study focuses on the experience and impact of involuntary treatment in a psychiatric in-patient ward, from the perspective of former patients, undergoing psychotic episode at the time of their hospitalisation. This chapter, therefore, begins by offering a rationale for the present study by taking a critical perspective on the existing literature on the subject and will address the importance of qualitatively researching the phenomenon in question. Next, the aims of the study and its relevance to counselling psychology are discussed. Furthermore, the section ponders upon the ethical considerations, as well as other relevant issues related to the concept of trust and insight, which are embedded in the implementation of such coercive treatments. Causal factors for psychosis are also outlined, as it is deemed important to place the researched phenomenon in the wider context, by providing the main theoretical and empirical explanations for the psychotic distress that so frequently result in an involuntary commitment to an in-patient ward. In this respect, views concerning the subjective experience of psychosis are also included. The chapter also touches upon the empirical evidence, evaluating the available treatments for psychosis. The final part of the introduction offers an evaluation of relevant qualitative studies and reflections concerning the patient experience of involuntary commitment and its implications.

1.2 Rationale for the Present Study

Despite the implementation of community care and the emphasis that has been placed on the processes associated with de-institutionalisation, an in-patient psychiatric treatment remains an integral part of mental health services (Quirk and Lelliott, 2001). The fact that psychiatric treatment is often implemented against patients' will have become a source of controversy in relation to ethical justifications, as well as the best practices concerning such coercive interventions (Høyer, 2000).

Initially, the concept of seeking the views of users of mental health services was met with some reluctance, and debate was raised about whether patients, who are seen as 'mentally disordered', are capable of making valid and insightful comments about their treatment (Crawford and Kessel, 1999). Such arguments, as Bentall states (2009), do not adhere to recovery-based model and autonomy enhancing services. What is more, there has been a growing body of evidence demonstrating that severity of

'mental illness' does not necessarily undermine the ability to convey views or provide valid and useful information (Awad et al. 1995). Thus, in general, patient experience has been increasingly recognised as an indicator in its own right that evaluates the quality of care and helps identify its limitations. It also forms an important element in policy and service development processes (Department of Health, 1998; Prabhakar et al., 2012; Gilburt, Rose and Slade, 2008; Stenhouse, 2011).

Nevertheless, research indicates that the dominant paradigm in psychiatry still demonstrates great resistance to seeing patients in severe distress (i.e. those experiencing psychosis) as experts and to their involvement as partners in helping to facilitate the treatment process or set a research agenda. This may be evident from the dominance of clinical neuroscience in the psychiatric and allied journals (Faulkner et al., 2002; Bental, 2009). It is often assumed that patients who are acutely unwell may not be able to recognise the need for their treatment and safety (Katsakou and Priebe, 2006; O' Donogue et al., 2010). Findings also seem to suggest that mental health professionals hold a more negative attitude than the public, towards individuals diagnosed with 'mental illness'. Hence, psychiatrists themselves may be perpetuating many concepts that underlie biased and stigmatising attitudes towards psychotic conditions (Walter, 1998; Sartorious, 2002; Rao et al. 2009). Individuals suffering from psychosis are also most likely to report feelings and experiences of stigma and may be the most affected by them (Dinos and Stevens, 2004; Gray, 2002).

Consequently, some issues have been identified around the current knowledge of the patient experience of acute psychiatric wards. Most studies concerning patient satisfaction with psychiatric treatment have utilised questionnaires as a means of collecting data and these surveys, usually generate high levels of apparent patient satisfaction (Johansson and Eklund, 2003; Noble et al., 2001). Such seems puzzling in the light of high rates of non-compliance with psychiatric treatment continuing to pose a major problem (Warner et al. 1994; Day et al., 2005; Webb et al., 1999). It has also been postulated that the use of these questionnaires raises questions on the reliability and validity; they have been criticised for lacking a clear definition, as it remains uncertain as to what the different questionnaires measure (Webb et al., 1999). Such methods have also been characterised by reductionist approach - reliance on closed questions and over simplicity that tends to underestimate and disregard factors related to the dissatisfaction of many patients, therefore possibly discouraging the expression of critical views and negative experiences (Crawford and Kessel, 1999). The relationship between satisfaction levels and treatment outcomes also appears to be weak (Ridley and Hunter, 2013). Hence, there appears to be a general lack of significant patient input in defining the outcome measures (Gilburt et al., 2008; Ridley and Hunter, 2013). As far as quantitative studies are concerned, it seems that findings support the idea that the patients are overall satisfied with their involuntary in-patient

treatment (e.g. Adams and Hafner, 1991 or Toews et al., 1986). Nevertheless, recent reviews indicate that quantitative research, as a whole, tends to generate mixed results. For instance, the study by Rooney and colleagues (1996) revealed that majority of patients who were subjected to a compulsory treatment were more optimistic towards their hospitalisation after discharge, but were not so positive six months later, as compared to the voluntary patients. Swarts et al. (2003) found that patients who had a history of multiple involuntary hospitalisations in the past were more reluctant to seek help afterwards, out of the fear of receiving coercive interventions. On the other hand, Rain et al. (2003) reported that no association was identified between the perceived coercion at the time of admission to a hospital and adherence to the treatment after discharge. Another quantitative literature review conducted in 2006 by Katsakou and Priebe, suggested that on an average, involuntary admitted patients demonstrated clinical improvement and in retrospection, perceived their hospitalisation from a rather positive lens. On the other hand, there seems to be a substantial proportion of individuals who felt their treatment was not beneficial and who also continued to uphold such a view. Thus, it appears that little is known about the factors that are responsible for both negative and positive perceptions, as the quantitative studies on the subject seem largely inconclusive (Priebe et al., 2009; Katsakou and Priebe, 2006; Katsakou, 2012).

All in all, qualitative research that focuses on exploring patients' experience of acute psychiatric care seems to be limited, and existing investigations mostly relied on quantitative methods (Aranda and Street, 2001; Ridley and Hunter, 2013; Greenwood et al., 1999). Moreover, it seems that there is a contrast between the high level of a general satisfaction reported consistently in studies (based on brief rating scales) and existing qualitative studies on a group of patients and many descriptions given by individuals (Gask, 1997). For instance, Lovell (1995) reported conflicting findings, as the satisfaction scale results seemed far more positive when compared to the interviews, where significant areas of patients' dissatisfaction emerged. Thus, qualitative research on the subject allows an individual to explore in-depth the involuntary in-patient hospitalisation experience and enables such variability to resurface (Smith et al., 1999). Furthermore, as Clyne et al. (2007) suggested, it is pertinent for professionals to familiarise themselves with lay knowledge and perspectives on compulsory treatments, in order to achieve the objectives of concordance and better outcomes.

Furthermore, an involuntary psychiatric treatment is in essence characterised by its distinct legal status (Craw and Compton, 2006) and therefore may constitute a unique experience that is likely to differ from voluntary admissions, in relation to various factors like patients' perceptions (Hoge et al., 1997; Gilburt et al., 2008) or outcomes (Kallert et al., 2008). On the other hand, studies that focus on the perception of coercion seem to indicate that legal status may only be a blunt index among other

influences that are associated with such experiences (Poythress et al., 2002). However, it seems that the most existing qualitative research mainly focuses on the exploration of such specific measures (such as those linked to coercion or seclusion only), rather than on the overall experience (Katsakou and Priebe, 2007). Thus, it appears that the existing findings may be a poor representation of patients' perspectives, due to the apparent division in the opinions of users and professionals, in terms of relevant factors and themes (Gilburt et al., 2008; Ridley and Hunter, 2013). Additionally, many qualitative studies also include mixed samples of both voluntary and involuntary patients (Katsakou and Priebe, 2007). Hence, above mentioned issues certainly identify an important developmental potential for future research. Overall, little in-depth research on the subject has been conducted till date (Quirk and Lelliott, 2001; Ridley et al., 2013). Therefore, it seems that there is a need for studies that would not only seek to focus on overall patient experience directly but also aim to extract the meaning and explore the impact that an in-patient psychiatric treatment under section has on individuals (Gilburt et al., 2008; Ridley et al., 2013)

Consequently, the above goal has been set for the current research project and has been developed into the following research question:

Research Question:

- How individuals experience and understand their treatment in a closed ward under section and its outcomes?

1.3 Study Aims and Relevance to Counselling Psychology

Current research project is developed and designed to explore, qualitatively and from counselling psychology vantage point, the lived experience of being in a closed psychiatric ward under section. Strawbridge and Woolfe (2010) assert that the counselling psychology has evolved from and inspired by the notions concerned with the subjective world of the *self* and *other*. Counselling psychology's philosophical underpinning is based on valuing the subjective, which leads to a call for methodological diversity and therefore a preference for idiographic over quantitative research (Nicolson, 1995; Morrow, 2007). It could be argued that placing counselling psychology as a profession, within both professional and intellectual context is overall a complex task (Strawbridge and Woolfe, 2010). This may be because, as Williams and Irving (1996) argue, counselling psychology can be viewed as having dichotomous and therefore, conflictual framework, as it is grounded not only in phenomenology, but also in logical empiricism. BPS's Division of Counselling Psychology Professional

Practice Guidelines (2006) places emphasis on not assuming '*the automatic superiority of any one way of experiencing, feeling, valuing and knowing*'. In fact, the non-assuming value base has helped to develop counselling psychology into a 'broad church' (Strawbridge and Woolfe, 2010) that seeks to embrace the complexity, ambiguity, conflict, contradiction and ambivalence that often human existence itself represents.

Thus, counselling psychologists work with individuals in various settings and across diverse mental health care provisions, including prison, acute admissions and psychiatric intensive care. Within the profession, there is a desire to recognise social and political contexts and to question the underlying assumptions of the status quo within the society, as well as to critically evaluate the dominant treatment interventions. It is therefore in the interest of counselling psychologists to understand the diagnosis and the medical and political context in which distress and its treatment are embedded. At the same time, they must emphatically embrace the first person accounts as valid on their own terms (Woolfe, 1996; Hopper, 2006). This research is, hence, essentially concerned with some key phenomenological constructs, such as subjectivity, meaning making, self and identity. To be more precise, its relevance to counselling psychology therefore relates to, but is not restricted to, the study of intra and interpersonal dynamics, the issue of power, the presence and influence of stigma, the experience of distress (in this case linked to psychotic phenomena), as well as the impact of treatment interventions on the recovery process. It is argued that mental health professionals are under obligation to evaluate and ponder upon practices that induce public concern; and overriding one's treatment decisions is one such practice (Gareth et al., 2009). Thus, the current study aims to provide further food for reflection for the existing debate and discussion of psychiatric involuntary in-patient treatment. Furthermore, it is highlighted that the use of coercion in a psychiatric in-patient care infrequently evokes conflicting feelings and moral dilemmas among professionals (Olofsson et al., 1998). In this respect, it may be of great significance for the personnel to enrich their knowledge of patient experience in order to provide a better quality of care (Avis, 1997).

However, it is suggested that it may not be enough to *talk the talk*. After all, key tasks of counselling psychologists entail not only competencies that relate to assessment, implementation of therapy or formulation, but also to the management of services and organisational development in general. The article of Hage and colleagues, 'Walking the Talk,' presented in *The Counselling Psychologist* in 2007, calls for a need within the profession to turn to community psychology, where the focus is on strengthening prevention and involvement in social action, as well as a desire to transform the world. In the light of the above context, it is anticipated that the wider implication of this study is to render and *promote* the views, experiences and

expertise of people in severe distress as *valid* and understanding the implications for informing treatment in an in-patient psychiatric setting. As such this constitutes a deeper purpose, a dedication and a message behind this project. The further contribution may result in identifying the components that could be measured to ensure the validity of patient satisfaction surveys and outcome studies. Such may perhaps provide an *inspiration* or *guidelines* towards the quality improvement of involuntary in-patient psychiatric care. Thus, knowledge from qualitative studies, such as this one can potentially inform treatment interventions, in order to improve patient experience as well as the outcomes. There is no denying that researcher's aspiration for this project is not only to yield interesting results but also to carry some impact upon how the world is perceived. However, a lack of impact does not necessarily invalidate the quality of the research, as there is an inherent value in any enhancement of the existing knowledge after all. It is, therefore, pertinent that the results are credible and meaningful. In other words, this study aims to enhance knowledge on the subject and fill the previously recognised gaps in existing research.

Finally, despite the fact that the distress is so widespread, some of its more severe forms, such as psychosis are still poorly understood and continue to be subjected to stigma and discrimination. Dealing with the diagnosis of a psychotic 'disorder' can be particularly difficult, as society often perceives the individuals with such diagnosis as violent and unpredictable (Byrne, 2001; Cromby et al., 2013). Being sectioned can certainly add another level of difficulty as the topic itself largely remains to be a taboo and even a source of humiliation (Beveridge, 1998). It is also plausible that this study carries an empowering component as it aims to give voice to those who are often unheard. In this respect, the purpose of current research is to present a platform on which justice to individuals' accounts is served by providing space and opportunity to contemplate upon the meaning of the experiences that may not be easily shared elsewhere. It has been long noted that reflecting about significant life experiences, including distress and recovery, may constitute a pivotal healing element (Hubble et al., 1999; Seligman, 1995).

1.4 Literature Review

1.4.1 Involuntary Hospitalisation: Ethical and Moral Concerns

Regulations governing compulsory hospitalisation (Mental Health Act, 1983 and 2007) state that its function is of dual nature - it aims to reduce risk to patients and public, as well as provide therapeutic interventions centred on mental health improvement. In other words, it sets to balance objectives of mental health and public safety

(Eastman and Peay, 1999). Involuntary treatments have a high ethical premium attached to them and therefore call for justification. The issue of depriving individuals of their liberty and the question whether such practices could be counterproductive had been debated for decades. The very distinct and unique legal provisions that allow the removal from the community and sanction compulsory detention, rest on a rationale that it is more humane and compassionate to minimise one's 'morbid' motivations, rather than to maintain or offer choices and freedom that one is unable to cope with, which may ultimately lead to more losses and possible harm to oneself or others (Church and Watts, 2007). Hope (2002), for instance, also argues that it is immoral to support one's 'perverse' choices that in fact may be incongruent with one's wishes or values when well. Such vision has been referred to as 'rotting with the rights on' (Davidson et al., 2006). A dominant objection against 'sectioning' is that it involves a violation of basic rights to freedom and self-determination, particularly when speaking about negative liberty (freedom from interference of other people and external restraint). On the other hand, freedom can be seen as having control and realising one's potential and such possession of power is known as positive liberty, which it is also argued that 'mental disorder' can nullify (Berlin, 1969). In this respect, it can be concluded that 'sectioning' can safeguard or restore one's positive liberty; though it is a political question whether the state should foster the negative or positive liberties or not (Berlin, 1969). Some propose that, on a fundamental level, involuntary commitment does not violate one's rights as they are *ipso facto* denied to an individual. This argument follows the logic that doubting one's sanity already signifies one's denial of his or her moral personhood, and therefore both individual responsibility and rights. In such a case, it is highlighted that the rights and responsibilities are not unconditional (Dennet, 1984). Finally, it is argued that since individuals may not be accountable, it is a duty of the state to prevent harm, especially to others. The main argument and justification for an involuntary management is, in essence, a paternalistic one (i.e. that is it's in the best interest of an individual) and it raises the issue of the conflict between autonomy and beneficence. For instance, it has been claimed that autonomy rests upon one's rationality. Hence restoration of the former through the involuntary treatment would also restore the latter (Christman, 2011). On a similar note, it is argued that interference that is aimed to evaluate one's autonomy is, therefore, justified. However, measuring rationality or in fact, what is helpful, involves value based judgements that are conditional upon social norms. In such a case, assuming principles suggest strong paternalism, where the risk for abuse increases. Strong paternalism, as opposed to soft paternalism, discards one's autonomy and capacity in favour of one's best interests. However, yet the question of which one to promote is again a political one (Salize et al., 2002; Berlin, 1969).

Hence, it seems that balance is difficult to achieve. It has been stated that individuals that are subjected to compulsory detention, at times, complain of being given too little or in fact too much choice, which oscillates between the feeling of being intruded upon or neglected (Roberts et al., 2008). It appears that the situation also poses a challenge for carers, who tend to feel a parental responsibility towards their relatives, irrespective of their age when witnessing that their loved ones may not be able to exercise their judgement fully during the acute level of distress. At the same time, it is often the case that services themselves are under constant scrutiny for failing to prevent people from making or 'choosing' risky or dangerous and self-destructive actions. Issues become further complicated when we start examining or deconstructing what constitutes a 'responsible' or a 'wise' choice, as this also alters depending upon the current political and social climate (Davies, 2004). Thus, both services, as well as the society, tend to operate within double standards (Roberts et al., 2008). In addition, there seems to be a prevalence of a blame culture. In other words, freedom and choice can be distinctly promoted until an incident occurs, which prompts an intense search for blame and an increased demand for restriction and control (Carvel, 2006). Nevertheless, it is highlighted that any decision to deny an individual their freedom of choice and impose compulsory treatment on them, is a decision that is made in challenging circumstances, where a struggle to mitigate various dissonant views of everyone involved is taking place (Roberts et al., 2008). Hence, though involuntary psychiatric care is commonly questioned, at the same time it is mostly deemed or accepted as necessary (Poulsen, 1999). It has also been pointed out that any debates regarding choice and involuntary treatment may reach disappointing conclusions since alternatives are not readily available (Holloway, 2007).

However, it seems that when it comes to a diagnosis of severe 'mental illness,' values such as choice and social inclusion are not infrequently compromised (Roberts et al., 2008). One perspective assumes that recovery is not plausible when one is controlled by others and therefore subjected to compulsion (Frese et al., 2001). It is argued that recovery is strongly linked to choice and power to make decisions and have control over daily living (Appleby, 2006). Some authors, however, claim that it is possible to aim for the recovery orientated practice in all settings (Roberts et al., 2008). It is also stressed that the overreaching therapeutic goal of detention is to gradually hand back the choice and power to the concerned individuals (Roberts et al., 2008). It is pertinent to bear in mind that by nature, compulsion is more prone to misuse, when compared to any other interventions and hence, it is crucial to safeguard its good practice (Fulford and King, 2008). It has been noted that due to the power relations that are implicated in compulsory detention, there is a recurrent fear that compulsory psychiatric treatment may not be as benign, beneficial or life enhancing (Vassilev and Pilgrim, 2007). Compulsion also contains a direct conflict of values between the individuals concerned and others around them. Thus, it has been highlighted that in

order to deal with complex and conflicting values within mental health services, it is essential to develop a value-based practice that seeks to explore values and experiences of those directly concerned – patients. This is of particular significance, as detained patients' and professionals' perspectives can often be characterised by an unbridgeable chasm (Dorkins et al., 2008; Bartlett, 2011).

Furthermore, in the light of medicalising and legalising approaches to involuntary commitment laws, it has been claimed that mental health care has been primarily concerned with managing alleged risk from patients towards the public and not placing enough focus on the individual needs of the patients, appropriate interventions and promotion of their civil rights (Szmukler, 2001; Brown, 2006). Concern has been expressed regarding the paradoxical use of language in 'mental health,' and sociological work on risk and trust has been explored. Some authors even concluded that 'mental health services' are a myth by outlining their preoccupation with 'mental disorder' and control (Vassilev and Pilgrim, 2007). Brown (2006) also points out that portrayal of individuals diagnosed with 'mental illness,' reduces them to being 'villains' or categorises them as dangerous and 'abnormal', which thwarts endeavour to acknowledge the need and vulnerability of such individuals. The assumption that there is a direct association between having a diagnosis of 'mental illness' and dangerousness continues to prevail, despite the evidence indicating that actual danger seems grossly overestimated (Mullen, 1997; Brekke et al., 2001; Large et al., 2008; Vinkers et al., 2009). Stigma itself can leave a dehumanising effect, and when it is accompanied by illogical panic-based and injudicious responses, it may leave individuals in distress, which not only makes them more vulnerable but also puts them in a moralised position (Castel, 1991; Furedi, 1997). It has been acknowledged that the issues surrounding politics, language and discourse in mental health may be endless. What may be evident, is an ongoing tension between extensions of compulsory powers and a collaborative approach to care; a difficulty of negotiating the need and the risk (Roberts and Wolfson, 2004). Professionals often seem to be facing a challenging task of balancing the potential of liability for negligence on the one hand and even the prospect of an assault on the other (Owen et al., 2009).

1.4.2 The Issue of Trust

Attention is also drawn to the importance of trust in mental health services, as some argue that there is a paucity of research on this issue (Brown et al., 2000). It is believed that trust and trustworthiness lie at the core of professionalism and at the heart of all interpersonal relations that are in turn embedded in larger systems and institutions (Bauman and May 2001; Jessop, 2002; Luhmann, 1995). Vassilev and

Pilgrim (2007) point out that since patients with psychiatric diagnoses are treated in an exceptional manner (as under normal circumstances an ill individual can expect that their autonomy will remain untouched), the expectations that no harm will be done can be shaken. Polices driven by the risk that directly shapes in-patient psychiatric care may not only undermine patient's trust and faith in the service but also foster an atmosphere that is not conducive to trust and collaborative relationships within the organisations. Not being in control is inevitably connected to mistrust; to a position where it is the other, that pulls strings. In other words, people feel mistrustful when they fear that someone else's agenda and purpose are in conflict with their own (Williams, 2007). Patients' vulnerability, in conjunction with responses to their alleged 'dangerousness', suggest that trust in psychosis services is a complex and problematic phenomenon. On a fundamental level, patients' position of vulnerability warrants trust in order to approach and receive treatment. However, on the other hand, there seem to be many factors within the services that in the eyes of a patient may seem untrustworthy. Hence trust may be comprised of a presumption that the *truster* is *willing* and *able* to place *trustees*' needs first and has no agenda to the contrary (Williams, 2007; Poortinga and Pidgeon, 2003). This concept can easily become misplaced as patients may perceive professionals being more preoccupied with risk minimisation (though sectioning and forced medication), as opposed to effectual treatment, support and reintegration (Rose, 2002).

Vassilev and Pilgrim (2007) also note that where there are coercion and formalisation, there is distrust, which in turns reinforces the need for further coercion and legalisation. It is further proposed that involuntary detention not also violates patients' expected rights and values associated with autonomy, beneficence and non-maleficence, but the concern is ultimately directed to individuals who are directly affected by such impinges. Individuals, whose pathways lead to psychiatric services have often suffered early neglect, oppression and a range of traumas and insults (Bentall, 2004; Read et al., 2003; Whitfield et al., 2005) and in such a context, concern has been expressed regarding the impact of coercive environment on patients' well-being. It is argued that trust would be of great significance for patients experiencing psychosis, whose vulnerability may be amplified not only due to experienced uncertainty, possible paranoia (or understandable fear and caution) or limited insight and confusion, but also due to the existing stigma, which the treatment itself may further reinforce by feeling intrusive and unwelcomed (Brown et al., 2008a, 2008b). It is suggested that a situation in which voluntarism and respect for human rights are diminished may cause individuals to distrust professionals in the future. It has been highlighted that other variables, such as social biases and inherent inequalities that seem to be ingrained within psychiatry, may add extra weight to the already existing biographical vulnerabilities of the patient, as it has been documented that race, class and gender, all contribute to the risk of becoming a psychiatric patient (Rogers and

Pilgrim, 2005). Thus, increased levels of uncertainty at times of psychotic crisis makes the function and maintenance of trust a vital component, but it is also more difficult to enact. Early attachment styles and experiences may shape the propensity for trust and mistrust and also influences the nature of the psychosis itself (belief about self, others, interpersonal style and affect-regulation) (Berry et al., 2007). Trust is speculated to be a vital determinant in patients' effective engagement and cooperation with the treatment. The asymmetric power dynamic between professionals and patients, combined with a tendency towards control, may erode pathways to trust and destabilise its existence (MIND, 2004; Brown, 2008b; Vassilev and Pilgrim, 2007). However, such *betrayal of trust* can be conceptualised in terms of both 'normality' and 'abnormality,' as it stems from routine care as well as its corruption (Vassilev and Pilgrim, 2007). It is argued, however, that although some individuals are helped to some degree in psychiatric in-patient settings, there are too many iatrogenic risks and implications involved in such a process that negate justifications for mental health improvement (Vassilev and Pilgrim, 2007).

It certainly can be concluded that a 'perfect' model, in this case, does not exist and that the risk of adverse effects is often weighed against the probability of achieving favourable outcomes. However, the question remains whether it is morally acceptable to implement a potentially harmful intervention, especially when it is resisted. It seems that a definite answer as to whether involuntary treatment is right or wrong (and helpful or unhelpful), cannot be easily provided as the discussion is inevitably interwoven with issues related to the very foundation of psychiatry (i.e. its status as science and the very definition of 'mental disorder' and beneficence), as well as political, philosophical and human rights issues, along with the potential for political abuse and social control. Issues and questions centred on treatability and dangerousness are also implicated, and so are the discrepancies between all the above mentioned, non-exhaustive list of perspectives. It is evident that the current practice may be far from ideal and more open investigation on the subject is, hence, required (Salize et al., 2002; Christman, 2011).

1.4.3 Psychosis, Insight and Treatment

It is often accepted that lack of insight or awareness is a feature of serious psychotic breakdown and therefore it results in non-compliance with the treatment (Farnham and James, 2000). Some even go as far as to argue that the lack of insight constitutes a permanent state of distress, associated with psychiatric diagnoses such as schizophrenia (Amador and Strauss, 1993; Amador, 2006) or more, generally speaking, individuals with a history of involuntary treatments are unlikely to possess insight

(Amador, 2006). Mental capacity or more precisely the lack of it has also been at the centre of the ethical debate concerning the use of compulsion by psychiatric services. Furthermore, it has often been argued that patients' lack of insight into their 'mental illness' is often responsible for the negative evaluations of their treatments (Cooke et al., 2005).

Interestingly, a systematic review by Okai et al. (2007) investigated the mental capacity of psychiatric patients and revealed that the majority of psychiatric in-patients do have the capability. Authors have concluded that although incapacity is common, the majority of patients in psychiatric wards are capable of making treatment decisions. Risk factors, associated with diminished capacity, are linked to psychosis and severity of the 'symptoms,' as well as involuntary treatment and its refusal (Okai et al., 2007). A qualitative study by Abma (1998) also noted the paradox of patients being vulnerable and incompetent but also competent and capable of agency and decision making. It is also pertinent to note that various authors have critiqued the very Western conceptualisation of insight, arguing that the term and its foundation is relative and based on comparative judgements (Perkins and Moodley, 1993; Johnson and Orrell, 1995; Beck-Sander, 1998; David, 1998). The concept of insight implies that it is an objective cognitive phenomenon (Cooke et al., 2005). Poor insight is also treated as a cognitive error, indicating that insight is a value-laden idea that may undergo change along with social norms for behaviour or medical concepts of illness (Saravanan et al., 2004). The notion of insight usually consists of the following dimensions - awareness of abnormality of psychotic symptoms, acceptance of prescribed treatment, awareness of the social impact of illness and specific attribution of symptoms (David, 1990; David et al., 1992; Sanz et al., 1998). Thus, the very definition of insight assumes the congruence between patients' and clinicians' views and the meanings of distress; the latter is holding power and authority to define and legitimise specific social norms. In other words, the patient who refuses to accept well-founded diagnosis is perceived as missing insight into their 'illnesses'. The paradox of such assumptions has been widely highlighted, as psychiatric diagnoses are often imprecise and intertwined with various diagnostic biases, such as those related to ethnicity or gender (Veen et al., 2004; Minsky et al., 2003; Schwartz et al., 2000). Also, medication is often the first or the only psychiatric intervention (Kinon et al., 1993; Morrison and Bentall, 2002). It seems that coercion is seen by many psychiatrists as an essential tool making the assumption that patients do not know what is in their best interests (Kinon et al., 1993; Morrison and Bentall, 2002). There is, however, evidence suggesting that significant proportion of patients fail to respond to antipsychotic medication; although hard to estimate, the proportion of 'antipsychotic non –respondents' is believed to be between a quarter and a third of those who receive medication (Kinon et al. 1993; Morrison & Bentall, 2002). What often seems to be overlooked is that the reasons for the patients to cease treatment may be

perfectly rational, as their medication may be ineffective or side effects unbearable, yet it is often regarded as an indication of patients' lack of insight and that more invasive treatment approach is needed (Hoge et al., 1990). Research also indicates that mental incapacity among individuals admitted to a psychiatric ward is not only linked to psychosis (mania and delusions) but also to ethnic minority groups (Cairns et al., 2005). Socio-cultural perspectives interpret insight as a cultural construct (Tranulis at al., 2008; Kirmayer and Corin, 2004). Insight seems centred on the meaning that was constructed around one's distress, which in turn is mirrored in individual's background and experiences, as well as social determinants, particularly actual or anticipated stigma (Tranulis at al., 2008). Help-seeking behaviour is also considered to hold an important place in the concept of insight. However, it has been noted that patients may simultaneously seek help (action) from diverse sources (Tranulis et al., 2008).

Furthermore, meta-analysis study investigating insight in psychosis revealed that results from previous studies regarding the nature of the relationship between insight and symptomatology are, on the whole, inconclusive. Thus, there is little evidence to support clinical and disease model or neuropsychological and deficit-based model (Mintz et al., 2003). Lack of insight can be viewed as an understandable defence against the potentially devastating realisation of one's state and these biases, in fact, seem to constitute 'the norm', laying on a continuum and encompassing all experiences (Moore et al., 1999; Saravanan et al., 2004). Tentative evidence exists to support psychological denial model (Cooke et al., 2005).

In line with the above, any future research or reflection regarding insight should emphasise cross-cultural validity and reliability, as well as pay attention to methodological concerns related to the insight assessments, in order to capture the complexity of representations (Saravanan et al., 2004). Such multi-angled approach transforms insight from an apparently transparent and objective state of affairs to a very complex and contested process, which appears very different from the perspective of a patient and a clinician (Kirmayer and Corin, 2004).

1.4.4 Retrospective Views on Involuntary Treatment

Some studies suggest that once capacity and insight are regained, individuals may grant a retrospective approval to their experience of surrogate treatments. For instance, a study by Owen and colleagues identified that 83% of patients regaining capacity after being admitted to London psychiatric facilities, expressed retrospective approval of the decisions being made on their behalf (Owen et al., 2009; Bartlett, 2011). It has been concluded that such findings have a potential to moderate concerns about both overriding patients' wishes and advance decision making by individuals

diagnosed with a 'mental illness' (Owen et al., 2009). It has been however counter-argued that individuals' change of the view regarding their involuntary interventions may not constitute genuine or autonomous expressions (Owen et al., 2009). In addition, other studies could not replicate such impressive findings regarding the patients' retrospective views on compulsory treatment and revealed that those who changed their views and concluded that their treatments were justified, did not alter how they *felt* about their involuntary admission. For instance, it was noted that many of those who perceived their treatment as justified did not still feel grateful for it (Priebe et al., 2009). Such stance, as authors postulated, resulted from a subjective feeling of injury that coercive treatment and consequent deprivation of autonomy can inflict. It has also been found that patients who are coerced, tend to be less satisfied with their treatment as compared to those who are not coerced (Gardiner, 1999; Gardiner and Lidz, 2001; Katsakou et al., 2010*).*

It is, therefore, concluded that one couldnot assume that patients will grow to become appreciative of their treatment (as the prevalent 'thank you' theory suggests) and it is pertinent to be aware that although in hindsight, individuals can perceive it as necessary, they may have nevertheless experienced it as aversive and volatile (Gardiner, 1999; Gardiner and Lidz, 2001; Priebe et al., 2009; Katsakou et al., 2012; Quirk et al., 2003; Dinos et al., 2004; Turton et al., 2011). It has been argued that negative reactions of patients, however, remain largely unacknowledged by professionals, carers or the courts (Haglud et al., 2003).

1.4.5 Psychiatry and Biomedical Model

The legal system, in relation to mental health and its professional knowledge base, has been a source of critique and in fact, a large bulk of the doubts concerning legitimacy in this arena emerged from within psychiatry itself. Many psychiatrists have questioned prevailing norms of psychiatry, as related to biological reductionism for medical labels of distress, the mandate of the profession for social control and its use of the state to suppress any signs of deviance, in order to safeguard public order (Pilgrim and Rogers, 2005; Vassilev and Pilgrim, 2007). Psychiatry adopted a biomedical-model approach to mental distress which can be perceived and experienced as dehumanising. As Robert Whitaker elaborates*: 'A medical system where the patient is always wrong...for so long the voice of those who are treated has been ignored. It has not been listened to. They have been seen as unreliable witnesses to their own life. It is the only area of medicine I know where you ignore what the patient has experienced"* (Whitaker, 2011; p.56).

Criticism regarding conventional psychiatry has centred on the profession, not only for being unscientific, but also for being unsuccessful in helping the most distressed individuals in the society (Whitaker, 2005; Healy et al., 2005). Existing retrospective studies suggest that despite the advances of more than a century and numerous endeavours in psychiatry, outcomes for patients with severe distress did not result in an overall improvement (Whitaker, 2005; Healy et al., 2005; Jablensky et al., 1992; Bhugra, 2006; Murray and Lopez, 1996). Research also seems to suggest that individuals experiencing psychotic distress in countries where psychiatric services are not considered to be well – resourced do better than those in countries with more comprehensive and developed psychiatric care (Jablensky et al. 1992; Bhugra, 2006; Murray & Lopez, 1996).

Furthermore, there is a significant body of evidence suggesting that division of symptoms into discrete categories, as indicated by the modern psychiatric diagnostic system is invalid and unreliable (McGorry et al., 1995; van Os et al., 1999). There is no doubt that receiving a diagnosis can lead to a wide range of different emotional responses. Many individuals may feel relieved or pleased to receive an explanation and finally know what is 'wrong' with them. However, Dr Peter Breggin, a reform psychiatrist, poses an important question regarding psychiatric diagnoses. He raises the questions of whether diagnosing ourselves or even accepting the mental health diagnoses of psychiatrists might actually be harmful. He highlights that psychiatric diagnoses, as supported by research, are over-simplistic and unrealistic. What is more, he asserts that they are often created in order to serve the interests of the pharmacological industry, providing the key to what medication is required. Breggin's argument is that mental health diagnoses are a profit centre but also, unlike medical diagnoses, they are unreal and rooted in opinions frequently shaped by bias and prejudice. They may provide a false illusion created by the medical aura surrounding psychiatry; hence it is argued that there is a danger in limiting ourselves to such diagnoses, with their potentially lifelong consequences. As individuals, we are far too complex to fit into such pre-defined boxes. Breggin further argues that psychiatric diagnosis ignores human experiences and provides an inadequate and distorted attempt at explaining our suffering (Breggin, 2008). Psychiatric diagnosis, therefore, does not seem to be empowering or enlightening in that respect and may make us feel helpless and discouraged as well less likely to take responsibility for our own psychological and spiritual transformation. Most of all, it enables others (i.e. mental health professionals) to assume authority over our lives –leading to the loss of things of importance: freedom, self-efficacy and self-control. It may appear that psychiatric diagnoses provide us with essential information about ourselves and our emotional world, yet such explanations may be a seductive illusion. Hence, Breggin states that acceptance of psychiatric diagnosis may deprive individuals of a healing opportunity which involves looking at ourselves in a caring and empathic way. Such a journey entails identification of the source of our anguish, as the key lies in understanding

details of our lives which is a prerequisite to assuming responsibility and creating adaptive changes (Breggin, 2008; Breggin and Rowe, 1991).

Moreover, from the earliest days of psychiatry, the importance of environmental influences in mental distress has been underestimated (Crow, 2008). For example, studies have shown that in over a century of research, costing billions of dollars, no significant evidence has been found to demonstrate that psychosis or so-called 'schizophrenia' is caused by chemical imbalances, brain structure abnormalities or genetics (Williams, 2012). This indicates that the fundamental assumption behind the profession stating that 'mental illness', as the very term implies, is caused by biological factors and can, like any other disease, be treated with drugs has been proven to be flawed (Crow, 2008; Goldberg and Weinberger, 2000; Tosato and Lasalvia, 2009; Joseph, 2004, 2006; Hamilton, 2008, Ross and Read, 2004; Read et al., 2009). So far, not a single biological marker has been identified, and no physiological tests exist, that would diagnose so-called *mental illnesses* such as 'schizophrenia' (Williams, 2012). Paradoxically, research indicates that antipsychotic medication itself can reduce the volume of the brain and cause neurodegeneration. Such irreversible abnormalities caused by drugs have been cited as evidence that schizophrenia is a brain disease (Moncrieff and Leo, 2010). Evidence suggests that medication can cause as much distress to patients as the symptoms that the drugs are meant to treat (Van Putten et al. 1981; Finn et al. 1990).

There is no doubt that terminology and language used have a powerful impact on structuring our thoughts and responses. The biomedical model has reshaped and dominated society's understanding of how the mind works. Some points out that, as a consequence, the very concept of free will has been shaken, as if we are prisoners of our neurotransmitters (Williams, 2012; Read et al. 2006; Lam et al. 2005). The term *patient* also contains exclusively medical connotations of care and treatment such as those related to medication; the term may imply a passive role where an individual is stripped of responsibility for their own well-being and recovery – it is where one is placed in the hands of experts, waiting to be fixed. It is, therefore, pointed out that the message psychiatry may convey to individuals in distress could be summarised as '*you cannot do it by yourself*' (Williams, 2012). Paradoxically, once again, research seems to suggest that recovery is not only possible but is inevitable (Bentall, 2009).

One of the alternative terms to problematic diagnoses is a notion of *psychosis* that, as argued, represents less radical connotations and allows for examination and integration of commonalities between experiences of individuals with various diagnoses, focusing on problematic and unsettling experiences such as hearing voices. In this respect, the term psychosis has often been viewed as representing a paradigm-changing shift, providing a challenge to the dominant 'schizophrenia' term. However, it is also argued that the term psychosis is overly broad and lacking consistent and

clear-cut definition (Boyle, 2006). Boyle (2006) argues that, at times, the term is generic, encompassing different psychiatric conditions. At other times, it is ambiguous or used interchangeably with 'schizophrenia' or other diagnoses (such as 'bipolar disorder'), or even as its precursor, which causes further confusion and complications. Furthermore, used in research examining environmental influences on the origin of distress, the term psychosis is often presented as a stable category that hints yet again to a biological source. It may be concluded that ultimately it is difficult to escape the medical constructs and language that dominates the current literature on the subject.

In addition, research indicates that biomedical explanations of distress are linked to more stigmatising attitudes and behaviours, as they portray 'mental illness' as unpredictable and enigmatic (Read et al., 2006 and Lam et al., 2005). By social definition what is often classed as 'abnormal behaviour' is something that is not approved at a particular time or space and is naturally subject to variation (Cromby, Harper and Reavy, 2013). The distinction has been made between anomalous and psychotic experiences (Williams, 2012). Anomalous experiences are considered to be contrasted with consensus reality. Consensus reality exists within societies or cultures, sharing a common set of beliefs and values agreed to be valid. One may be experiencing subjective reality that is not in alignment with surrounding consensus reality; however, it is important to point out that consensus reality does not represent universal or objective truth and may indeed vary greatly from culture to culture. It is therefore not helpful to assume that, in such cases, one's subjective experiences described as delusions or hallucinations should be labelled as psychotic. Many authors such as Williams (2012) therefore define psychotic experiences as anomalous experiences that lead to significant distress. Such distress is subjective to an individual and may result from an anomalous experience or from an action that was a direct result of such anomalous experiences. It is pertinent to highlight that many so-called normal experiences such as stage fright or bereavement may cause distress. Likewise, many anomalous experiences may not cause distress at all and may even be considered helpful or spiritual. This raises the following important question - *what is normal?* In medical terms, normality is classified as contributing to well-being and health. Thus, behaviours such as tattooing, extreme sports, smoking, body piercing or drinking alcohol could be labelled abnormal. By statistical definition, abnormal activities would include those that are rare or unusual. As such being a member of a royal family would be labelled as abnormal. Psychotic experiences such as hearing voices are considered to be abnormal, particularly in the West, yet research indicates that, such experiences are very common in the so-called 'normal', non-clinical population that has not been in touch with psychiatric services. It is estimated that, in most countries, fewer than 1% of the population receive a diagnosis of schizophrenia at some point in their lives. However, it seems that about ten times as many individuals experience anomalous states such as hallucinations (Posey and Losch,

1983; Bentall and Slade, 1985; Tien, 1991; Bentall, 2004). There is also a controversy related to the very definition of a delusion (Boyle, 2002). According to the DSM, delusion constitutes a false belief that is held despite incontrovertible evidence to the contrary, and that is not accepted by an individual's culture as an ordinary belief. Nevertheless, a significant proportion of the general population, especially in the West, believes in ghosts, clairvoyance or reports on telepathic experiences. Many people believe in extra-terrestrials or reported seeing UFOs (Harper, 200; Hornstein, 2009). Furthermore, it is a challenge to disprove a belief in god/s or time travel, and not all political, moral or religious beliefs are based on clear empirical evidence. Interestingly, Peters and her colleagues (1999) conducted a study that compared in-patients experiencing psychosis and 'ordinary' individuals, with those who were part of a new religious movement (Druids and other members of the Hare Krishna religion). The results were intriguing, as even though the members of the religious group would not be considered as mentally unwell, the two groups could not be differentiated by delusional beliefs. It seems that it may be rather easy to label others as delusional, particularly as it appears that a diagnosis represents a biased social act, where the diagnostician's perception of reality is regarded as superior or privileged – as closer to so-called *objective* reality. Hence, it is argued that the term abnormal is confusing and unhelpful (Cromby, Harper and Reavy, 2013). Homosexuality was once labelled a mental disorder and hearing voices is granted a normal status or perceived to be a spiritual experience in some cultures in the world (Johns et al.;. 2002; Lange et al. 1996; Morrison, 2001). Experiences such as delusions and hallucinations seem to be universal, yet whether they are viewed as evidence of an illness varies greatly according to a local set of customs and beliefs (Morrison, 2001; Bentall, 2004 and 2009). Research also indicates that the key difference between voice-hearers that received psychiatric treatments and those that avoided it, lies in the individual's relationship to the voices - namely non-patients viewed themselves as stronger than their voices (Stephens and Graham, 2000).

In light of the above, it is also argued that the prevailing mainstream view that schizophrenia is a chronic, severe, disabling brain disease is not only unscientific but can be damaging in nature (Williams, 2012). Williams (2012) points out that such a statement can be found in almost every major page or publication on the topic. Not infrequently, it is also stated that *schizophrenia is a chronic brain disorder*, yet at the same time, acknowledgement is made that *scientists do not yet know which factors produce the illness* (Williams, 2012). Such mixed and contradictory messages are commonly conveyed by the highest authorities on the matter (Williams, 2012). Ironically, it is therefore often overlooked that all research provides us with significant evidence that '*schizophrenia*' is most likely *not* a disease of the brain.

The biological disease concept also assumes that discussion on the content of psychotic *symptoms* is arbitrary and harmful. In contrast with the biomedical-model, a

phenomenon such as voice-hearing is viewed as personally significant and a meaningful experience that needs to be explored and understood. Such a process would entail learning how to deconstruct the message that the voices convey, which is likely to represent an individual's internal and external world, an aspect of oneself, often mirroring unexpressed and inaccessible emotions as well as painful or unbearable affects (McCarthy-Jones and Longden, 2013). Embracing the perspective that psychotic experiences are entirely *normal* or common phenomenon can help to combat internalisation of stigmatising and pathologising views by allowing individuals to gain self-acceptance and facilitate their sense of agency (Bentall, 2004).

The research suggesting that psychotic experiences, in essence, constitute common phenomena that lie on a continuum in the general population is, hence, of great relevance (Johns and Van OS, 2001; Millham and Easton, 1998).

1.4.6 The Traumagenic Neurodevelopmental Model

The Traumagenic Neurodevelopmental model (Read et al., 2001) has been regarded as the most integrative position that seems to effectively capture the complexity and the reciprocal interactions between social, psychological and biological factors, by emphasising the evidence that our environment shapes our physiology throughout our lives (Read et al., 2001, 2004; Beck and Van Der Kolk, 1987). The research shows that over-reactivity and dysregulation of the HPA axis (hypothalamic–pituitary–adrenal) was found in abused children (Walker and Diforio, 1997), similar to the dopamine imbalance, which has been so frequently quoted as evidence supporting biogenetic basis for presentations associated with diagnostic concepts, such as schizophrenia (Read et al., 2001; Nemeroff, 2004; Cichetti and Walker, 2001; Ageman et al., 2001; Bremner, 2002). In other words, brain abnormalities can be caused by childhood trauma and can persist into adulthood by forming vulnerability for further distress, whether it is manifested as psychotic experiences or other psychopathological complaints (Heim et al., 1998, 2000; Myin-Germeys et al., 2003, 2001). This oversensitivity to stress can be a consequence of early life adversity, with or without a genetic predisposition (Read et al., 2005).

1.4.7 Psychosocial Evidence

Research indicates that the relationship between interpersonal trauma and psychosis is a causal one (Read et al., 2005; Spataro et al., 2004). Childhood trauma has been

associated with the severity of distress, regardless of how *severity* is defined (Read et al., 2005). Content of both delusions and hallucinations that are characteristic of psychosis, have been found to be directly related to the abuse suffered (Beck et al., 1987; Read et al., 2003; Ellenson, 1985; Heins et al., 1990; Romme and Esher, 1989, 2000; Romm et al., 2009). Similarly, childhood trauma has also been implicated for suicidal behaviour, as well as clinical expression and effective functioning in individuals diagnosed with bi-polar disorder (Etain et al., 2008). In addition, research on diagnostic issues suggests that there is a significant overlap between the constructs of schizophrenia, dissociative disorders and post-traumatic stress disorder (PTSD) (Ross, 2005; Muenzenmaier et al., 2005; Seedat et al., 2003).

There appears to be a lack of research investigating the relationship between trauma and catatonic and disorganised presentations. However, it has been proposed that catatonia is a result of severe physical and mental stress (Kahlbaum, 1973). Some authors still view it as a response to a terrifying incident (Moskowitz, 2004). Recent research also indicates that so-called negative symptoms, associated with the diagnosis of schizophrenia, may be a consequence of the psychotic episode itself, in conjunction with hospitalisation, which can be experienced as traumatic (Harrison and Fowler, 2004). It can even be induced by antipsychotic medications, as one of their side effects can result in the form of depression, known as neuroleptic dysphoria (Weinmann and Aderhold, 2010; Weinmann et al., 2009). On the other hand, it has also been suggested that negative symptoms can be linked to trauma based avoidance strategies and numbing (Genron et al., 2004; Muenzenmaier at al., 2005).

1.4.8 Psychodynamic Perspectives

Psychodynamic perspectives assume that psychosis is characterised by mind's inability to integrate certain aspects of mental and external reality. As psychogenic factors are implicated in the psychotic crisis, the psychodynamic theory proposes that the unconscious mind expels parts of external or internal reality that are simply too indigestible or overwhelming. Such a strategy, in a desperate endeavour to create safety, allows the person to continue with the belief that the aspects of the painful reality do not exist. Thus, modern psychodynamic theories regard both the form and the content of psychosis as significant sources of information that to some or greater degree, are shaped by unconscious forces. On the whole, in the non-psychotic state, the painful reality is maintained and endured, while in psychosis certain inner experiences (thoughts, feelings, and sensations) are perceived as concrete and real, and not as a mental phenomenon that carries symbolic meaning. These matters are believed to be threatening and need to be managed through physical means. Thus, a wide range of mechanisms that operate within a psychotic crisis, such as auditory and

visual hallucinations, tactile processes, thought distortions and ideation, are assigned to the mind of others or any inanimate objects. They are experienced as making an attempt to force their content back in – leading to persecutory experiences. An attack on links – an active splitting and severance of connected components of information or thoughts, and rejection/expelling of remaining fragments is an important psychodynamic mechanism distinct in psychosis, and is known as denial, fragmentation, splitting off and projection (away from the self) (Bion, 1959; Freud, 1924; Gabbard, 1994; Sinason, 1993; Cullberg, 2006; Jackson, 2001; Martindale, 2007; Garfield, 2009).

Hence, psychoanalytic literature conceptualises psychosis as a diminished sense of identity (Frankel, 1993; Selzer and Schwartz, 1994) or a complete detachment from the world, yet simultaneously experiencing terror of any social encounters because of the fear of not being able to effectively respond to emotionally provocative events (Lysaker and Lysaker, 2010). Psychosis is often also viewed as a state characterised by an experience of emptiness and meaninglessness, or rather an inability to forge meaning (Bak, 1954; Bion, 1967).

1.4.9 Cognitive Model

Garety et al. (2001) highlighted that psychotic distress could be best understood by connecting the phases between phenomenology and social, and psychological and neurobiological dimensions of explanations, with a cognitive perspective, representing an important component in this chain.

Thus, based on a widespread agreement that onset of psychosis has a biopsychosocial origin as it follows painful life events, adverse environments, substance misuse or periods of marginalisation, the model assumes that two pathways exist for psychotic breakdown– one proceeding through both cognitive and affective shifts; and another through affective disturbance alone, although it is argued that the first route is more prevalent (Garety et al., 2000; Garety and Hemsley, 1994). The model proposes that cognitive disturbance may be conceptualised in two ways - either as a result of 'weakened influence of stored memories of regularities of previous input on current perception' manifesting itself in unstructured and ambiguous sensory input and leading to unintended memory materials to intrude into one's consciousness (Hemsley, 1993); or as a consequence of newly developed difficulties in self-monitoring processes of actions, which transpires as an inability to match individual's own intentions to act as their own and therefore perceived and experienced as alien (Frith, 1992). Basic cognitive disturbances, therefore develop into anomalous conscious experiences (e.g. thoughts experienced as voices) and such perceptual

shifts, forming the psychotic prodromal phase, are experienced as a novel, external and therefore threatening (Garety et al., 2001). The model however emphasises that it is a biased conscious appraisal (such as jumping to conclusions, theory of mind deficits, externalising attributional bias) of the anomalous processes in conjunction with the intense emotional state that further fuels the original perception that such confusing experiences are externally caused which, in turns, further substantiate the psychotic beliefs (Freeman et al. 2000). In addition, safety behaviours prevent the opportunities to obtain any dis-confirmatory evidence and therefore shifts in acquired beliefs (Freeman and Garety, 2000). Meta-cognition also seems to play a significant role. Thus any pre-existing assumptions regarding uncontrollability of thoughts may lead to an increased psychotic distress (Freeman and Garety, 1999). Appraisals related to the experience of 'mental illness' as chronic, shameful and stigmatising [which may have some foundation in reality (Bean et al. 1996)], may induce a depressive state (Birchwood and Iqbal, 1998).

As mentioned above, in more rare cases (for example with a diagnosis of a delusional disorder), it appears that the triggering event, instead of causing cognitive processing disruption, causes disturbance only on an affective level, which in turns leads to direct activation of biased appraisal and maladaptive self and other schemes. Subsequently, an externalising appraisal (delusion) for the traumatic life events and the disturbed affects is formed. Thus delusions can exist independently of hallucinations (Garety et al., 2001).

1.4.10 Intervention and Treatment

As Read and colleagues (2005) point out, the link between psychosis and childhood trauma is an obvious one and carries significant clinical implications. It is important to consider the biological plasticity, as the effects of childhood trauma are not irreversible. For example, neuroimaging studies have demonstrated that psychotherapy itself can alter both functions and structures of the brain (Fuchs, 2004). Individuals diagnosed with psychotic disorders, however, are rarely asked about abuse and are unlikely to be offered therapeutic input due to the strong prevalence of biogenic aetiological beliefs among psychiatrists and other mental health staff (Read, 2005; Young et al., 2001; Read and Fraser, 1998). As Read et al. (2005) highlighted, wide range of psycho-social treatments exist that have been shown to be effective for psychosis (Morrison, 2004; Brenner, 2000; Martindale et al., 2000) and therefore should be widely available to everyone in psychotic distress, such as psychodynamic (Silver et al., 2004; Gottdiener, 2000; Rosenbaum et al.. 2013), systemic approach (Aderhold and Gottwalz, 2004) or cognitive therapy (Kingdon and Turkington, 2004; Martindale et al., 2000).

1.4.11 Phenomenological Understandings and Views of Self-experience in Psychosis

Phenomenological inquiry makes an attempt to understand and conceptualise the phenomenon in question in the closest possible accordance, with the actual subjective experience of that phenomenon, which has also been the case for psychosis (Keller, 2008; Nixon et al. 2010)

For instance, Davidson (2003) reflected upon self-experience in psychosis and proposed that individuals with psychosis experience lack a story of their own and feel unworthy of possessing such a story. Sass (2000), on the other hand, viewed psychosis as an alienating and extreme form of self-awareness. Such hyper-reflexivity is deemed to lead to fragmentation, rendering spontaneity and understanding of basic processes challenging. In this respect, the person stops experiencing and ceases to be a subject of awareness. According to a contrasting view, common sense in psychosis collapses. Such view is based on assuming that the issue does not result from excessive reflection, but from breakdowns in the preconscious by severing links between embodied feelings, judgments and the world shared by others (Lysaker and Lysaker, 2010). Boss (1979) also reflected upon the psychological experience of psychosis by suggesting that it can be characterised by an ''encroachment on one's ability to 'be open to what is encountered' (p.235), entailing radical incompletion, related to free and self-reliant selfhood. The reflections of Boss (1979), in particular, echo the sense of drastic incapacity and loss, and his account depicts a self that finds itself overwhelmed, by what it confronts and perceives (Lusaker and Lysaker, 2010).

Bleuler (1950), Kraepelin (2002), Laing (1978) and Boss (1979), all remark upon the disordered nature of psychic life that is characteristic of a psychotic crisis. Laing (1978), however, was one of the most iconic figures to reflect on self-experience in psychosis and his ideas represented rather radical existential reformation of perspectives regarding 'mental illness.' His comments were met with great opposition from traditional psychiatry. Laing's (1978) observations in '*The Divided Self,'* presented psychosis as essentially an alienated state. Laing (1978) wrote that an individual with psychosis experiences ' rent in his relation with his world… and a disruption of his relation with himself'. He further explains that such an individual is unable to feel 'together with' others or 'at home' in the world, and feels restricted to experience him or herself as 'a complete person' (p.17). In addition, Laing (1978) pointed out that psychotic world is full of terror as if it was "liable at any moment to crash in and obliterate all identity" (p.45). It has been argued that Laing (1978) obtained a finer feel for what it is like to be when immersed in the psychotic world (Lysaker and Lysaker, 2010), as he elucidated that the psychotic experience contains a profound sense of

alienation, incompletion and terror. In essence, Laing (1978) perceived a person in psychosis as a reflective subject, suffering and juggling with the fate that seems and remains his or her own (Lysaker and Lysaker, 2010).

Various other theorists, drawing upon German and French philosophy, as well as psychiatry, have also explored the structure of consciousness in psychosis. For instance, Minkowski (1987) commented that in psychosis, the person no longer 'knows how to live' (p.91), that he or she knows where they are, but do not feel as if they belong to that place. Phenomenological views of psychosis have also been influenced by Blankenburg (2001), who rendered psychosis as a state in which both the self and the world are incomprehensible. Parnas and Handest (2003) commented on the lack of attunement to the world, as being a characteristic feature of the psychotic state. Mishara (2005) proposed that psychosis is also indicative of an interruption in bodily systems, making attendance to novel information difficult and can make one lose their connectedness to their physical self and the body. Dialogical psychology, in turn, challenges the assumption that a stable or core *self* exists and instead treats it as an inter-animating constellation. It also views psychosis as a diminishment in self-experience, which results in challenges for sustaining dialogues among self-facets in worldly interrelations (Lysaker and Lysaker, 2001, 2002, 2005, 2008; Lysaker et al., 2006).

Although the above represents only a generic review by elucidating some of the phenomenological accounts from existing literature on the subject, it can be concluded that phenomenological analyses of psychosis often highlights the presence of anxiety or feelings of void and emptiness, as well as disturbed psyches by tying to breakdown such experiences in perceptual systems (Lysaker and Lysaker, 2010).

1.4.12 Patient Experience of Psychosis

Existing theories and research significantly advance the knowledge base of psychosis. However, it is also important to account for the first person dimensions and consider that psychosis is a state that interrupts lives of people who experience it and they must then continue in their struggle to find meaning and create security. As Stanghellini (2004), noted such omission in approach to psychosis can eradicate "madness from the man who embodies it" (p.46). The challenges of communicating with the other whose subjective world differ from a dominant reality, has been described by Jaspers (1959), who also embraced phenomenological approach by emphasising the need to reach out to the patient, with an attempt to understand his/her frame of reference. Various studies investigating the experience of psychosis (e.g. Hellzen et al., 1998; Teising, 2000; Kilkku et al., 2003; Koivisto et al., 2003) noted

that psychosis is often experienced as an uncontrollable sense of self, in conjunction with overwhelming and exhaustive changes in one's perceptual, emotional and physical states. Such position is often described by patients as denoting vulnerability and intense distress and therefore inability to cope with the demands of daily life. Patients reported perceiving not only themselves but others sensitively and regarded their close ones as necessary, pertinent and a meaningful source of support. Furthermore, psychosis was also reported as being a state of confusion, fear and terror (Koivisto et al., 2003). Kilkku et al. (2003) also noted that psychotic breakdown tends to be described by individuals as a culmination of the long lasting process - a draining life situation that eventually leads to depleted resources.

A growing body of literature has also presented an alternative view of psychosis, which, as argued, is often dismissed by scholars. It suggests that psychosis can be in many ways perceived not only as psychologically transformative, but also spiritual in nature, and therefore it constitutes a powerful healing agent that enables the individuals to reshape their lives in previously undiscerned, but constructive manner (Buckley, 1981; Eeles et al., 2003; Lukoff, 1985; Kasprow and Scotton, 1999; Koss-Chioino, 2003; Murphy, 2000; Perry, 2005).

Thus, it could certainly be concluded that reified concepts, such as *schizophrenia* or *bio polar* refer to very complex psychological relationships. As presented above, understanding psychotic experiences can be aided by using concepts and principles from mainstream psychology. None of these professional perspectives is necessarily superior to the other, as no single theory can provide fully satisfactory knowledge about the phenomenon (Lawson, 1997). It has been noted that better understanding of potential phenomenological difficulties that occur in psychosis is required to enrich not only the existing bio-psycho-social accounts and corresponding research, but also to potentially point different types of interventions, aimed at better addressing existing complexities of inter and intra subjectivity in the phenomenon of psychosis (Lysaker and Lysaker, 2010).

1.4.13 Patient Experience of Involuntary Hospitalisation

A qualitative study of Stenhouse (2011) and Barker et al. (1999) revealed the experience of dissonance between the expectations and actual experiences of receiving support from staff in the acute psychiatric ward. Qualitative user-led study of Gilburt et al. (2008) reported that although some participants identified few positive experiences, the majority of them reported numerous negative instances. Factors that users appreciated included being listened, understood and valued. Most individuals described experiences associated with lack or poor communication and

staff unavailability. Many participants also mentioned the negative experiences of coercion, which does not necessarily attribute to the legal aspect of the detention, but to the consequences of it, resulting from the lack of freedom and compulsory treatment, such as a restraint and forcible medication. Coercion was often perceived by patients as being 'brainwashed' and being part of the 'game' – a consequence that even results in disobeying staff. Those that experienced being restrained described it as an assault. Other studies also revealed that when control or discipline are experienced as a threat to patients' sense of personal freedom, various counter techniques are employed, such as false obedience and dissimulation or attempts to escape (Letendre, 1997; Steinholtz Ekecntranz, 1995). A study by Mancini et al. (2005) examined the accounts of fifteen adults regarding how they recovered from a psychotic crisis. All participants identified barriers to recovery that included paternalism, coercion and judgmental attitude of professionals. Almost half of the participants also reported side effects of medication being a barrier in the recovery process. Factors that facilitated recovery were identified as supportive relationships and meaningful activities.

Interpersonal relations with staff have often been identified as an essential feature related to patient experience and satisfaction (Stenhouse, 2011; Elbeck and Fecteau, 1990). Research has also demonstrated that meaningful occupation of in-patient wards seems to be a major route to recovery (Collins et al., 1985; College of Occupational Therapists, 2006). It has long been highlighted that in-patient wards, without a clear and maintained focus on treatment, may result in staff operating on a default level and performing tasks routinely, which warrants a mere ward maintenance and can even lead to neglectful and abusive culture (Martin, 1984). Walton (2000) for example characterised wards regarding 'institutional aimlessness'.

Some studies focused particularly on patient experience of receiving help in the acute ward. Pejlert et al. (1995) research, for instance, revealed that patients often felt alone during their treatment. The study by Koivisto et al. (2004), on the other hand, suggested that patients felt that their treatment was helpful in terms of alleviating their distress, although unstructured due to the undefined care by ward staff. Thus, it seems that patients had to draw their own conclusions as to what should constitute care. Moreover, care did not seem to reach the inner world of the patients experiencing psychosis. Help and care were construed by patients as offering protection from vulnerability and empowerment to stabilise and restructure their own selves, in order to manage their lives better. Watts and Priebe (2002), on the other hand, found that coercion and imposition of a psychiatric treatment can become an obstacle to the recovery of the patients with psychosis. Similar findings were reported by Thornhill et al. (2004), as the main theme that emerged was the need to escape or endure the unwanted psychiatric treatment. Authors of another qualitative study (Lilja

and Hellzén, 2008, p.1) concluded that '*the experience of psychiatric inpatient care could be interpreted (...) as a struggle for dignity in the face of discrimination and rejection'.* Other qualitative studies on the experience of an involuntary psychiatric hospitalisation yielded similar results by reporting themes centred on being disrespected as a human being (Olofsson and Jacobsson, 2001), being neglected, ignored and violated. However, positive occurrences have also been identified as regards to being cared for and supported (Johansson and Lundman, 2002; Gault, 2009).

Katsakou and Priebe's (2007) thematic analysis reviewed five qualitative studies of involuntary psychiatric care (Olofsson and Jacobsson, 2001; Olofsson and Norberg, 2000; Johansson and Lundman, 2002; Jonesd and Mason, 2002; Quirk et al., 2003). Each of these studies focused on slightly different aspects of the experience and some methodological issues were presented, such as the small sample size, the research aims and questions not being stated clearly. Nevertheless, the findings of the review revealed that on the whole, involuntary admission to an in-patient ward was perceived as negative, although certain positive instances were also described. The main areas that were identified were related to perceived autonomy and participation in the decision-making process, the feeling of being or not being cared for and finally a sense of identity. The review reported that the most common theme is emerging from the data centred on violation of autonomy, rights and influence in their treatment. Participants also described their struggle with the environment that was perceived as strict and occupied with dominating and rigid rules they did not understand. The common thread included the experience of physical violation and coercion, linked to being restrained, segregated or forcibly medicated. The prevalent theme therefore that emerged from this meta-analysis highlighted various losses (of liberty, rights and power) and indicated that the experiences mentioned above could lead to the feeling of failure and powerlessness. Another theme that was identified captured the participant's perceptions of quality of care received which, as reported, tended to colour the overall views on the hospital experience. The review noted that the participants mostly conceptualised their experience of care as pointless or inappropriate and the predominant experience seemed to be that it was deprived of warmth and support of staff competency. Furthermore, on the whole, it seemed that the participants felt that their hospitalisation was not conducive to their well-being, as the main emphasis was on the medication that has adverse side effects; the opportunities for activities were scarce; privacy and personal space were limited, and other patients were frightening, at times. The final theme was also negative and outlined the emotional impact of the hospitalisation, with feelings of being devalued. It has been reported that the common experiences evoking intense emotional response were related to feeling that the professionals were not interested in the patients; were not acceptant of them or were displeased or even irritated with them.

As a result, patients felt rejected and disappointed by the mental health system in general which, induced feelings of hopelessness and pessimism about the future, as well as contributed to lower self-esteem. The study revealed that patients often experienced doubts regarding their own value and worth and felt that they were being treated like criminals and not as a 'normal' healthy individual. Experiences of being punished for being ill were also common. Participants described feeling dehumanised and had their integrity violated. Such experiences often lead to the feelings of denigration and stigmatisation, after discharge. In addition, sectioning was also experienced as a major disruption to one's life. On the contrary, studies also unravelled some positive experiences. For example, although participants stated an overreaching violation of autonomy, they also reported instances that were characterised by collaboration with health staff and participation in their effective treatment. Furthermore, although the situation was construed as coercive, it also involved times of freedom and flexibility, which was often met with gratification. Moreover, in some cases, participants felt they were being looked after and receiving valuable care. A positive relationship with staff decreased patients' sense of insecurity. Equally, connections with other patients or relatives were also deemed important. Finally, some concluded that the hospital was a place of safety and that their hospitalisation was necessary and unavoidable and in some cases, could lead to enhanced self-awareness and beneficial outcomes in the long term. Authors of the meta-analysis reported that although the analysis surfaced both negative and positive experiences, it was unclear whether such instances were described by different patient groups that experienced hospitalisation as negative or positive as a whole, or by the same individuals who managed to identify both drawbacks and beneficial components of their treatment. Furthermore, authors of the review pondered about the characteristics of the patients and whether there is a link to how the involuntary hospitalisation is perceived. It has therefore been pointed out that the differences between distinct groups of patients could be investigated. However, various studies have attempted to explore variables that may be associated with the dissatisfaction levels, which in some cases led to the conclusion that dissatisfied patients are more likely to be, for instance, young, single, female, 'personality disordered' or diagnosed with psychosis. These factors, generally speaking, are linked to the more severe and chronic psychopathology. On the other hand, the same meta-analysis studies of socio-demographic factors suggest that higher satisfaction levels are related to greater age, less education, being married, and having higher social status (Hall and Dornan, 1990). However, some studies found no associations between clinical and socio-demographic characteristics (Katsakou and Priebe, 2006; Priebe et al., 2009) and it has been suggested that it is patients' experience and evaluations of the treatment they receive that influences their views (Priebe et al., 2009; Katsakou et al., 2012). However, it appears that yet again, the evidence is gathered from quantitative studies and is inconclusive. Crawfold and Kesse (1999) also argued that the goals of such an

approach are unclear and identify the risk factors for a 'disease,' which ultimately implies that any negative views about the services are the result of patients' characteristics and have nothing or little to do with the features of the services they receive.

1.4.14 Impact of Involuntary Hospitalisation: Status and Identity

Torres and Bergner (2012) formulated that involuntary psychiatric admission, regardless of its perceived fairness or justification, creates a loss of one's status or in other words, it compromises of *a loss of the status to claim a status,* which lies at the core of humiliation. Such a loss occurs in reference to the norm of the social status claims that individuals possess or are eligible to make. Humiliation, as an effective response can be evoked by the experience and perception that one is unjustly degraded or debased to a lower or inferior position by the other. If individuals do not receive dignified and respectful treatment, which they believe they deserve and are deprived of a right or eligibility to make status claims on their own behalf, it can result in an annulling experience in the relational, communal and societal domain. It has been highlighted that although shame and stigma have been the focus of mental health research in general, the experience of humiliation itself can be potent in individuals with mental disorder diagnosis and is even further aggravated by compulsory admission (Torres and Bergner, 2012; Svindseth et al., 2013). For instance, a quantitative study that investigated patients' perceived level of humiliation during their psychiatric detention suggested that certain individuals may be more vulnerable to experiencing feelings of humiliation during their hospitalisation, such as those that are not in paid employment, exhibit hostile or suspicious behaviour or express entitlement or grandiosity. Thus a high level of humiliation has been largely associated with patients' factors here, a tendency that has been subjected to critique. However, its direct link to the compulsory admission has also been outlined (Svindseth et al. 2010 and 2013).

Townsend and Rakfeld's (1985) qualitative study indicates that the impact of involuntary hospitalisation includes loss of self-efficacy and decreased self-esteem as well as causes social stigmatisation. Gilmartin's (1997) qualitative exploration of two former psychiatric in-patients revealed that for these particular individuals, hospitalisation was perceived as contributing, instead of resolving their ongoing difficulties and consequently exacerbating their depression and further lowering their self-confidence. Hughes and colleagues' (2009) qualitative piece of work focused on the investigation of the impact that involuntary psychiatric commitment has on self, relationships and recovery. Although, overall a diverse picture emerged as half of the participants reported having had generally an indifferent or positive experience and

noted that their sense of *self* remained intact; the rest of the sample, however, seemed to have experienced adverse changes in their self-image as well as a loss of identity, which was perceived to be hospitalisation induced. Some participants stated that their own aggressive or inappropriate behaviour was a consequence of being caught in a conflict with the ward staff and other professionals. For instance, feeling dismissed by staff or being frequently restrained led to a loss of self-worth or a loss of identity. Furthermore, ward restrictions and lack of occupation also contributed to the reduced self-adequacy.

1.4.15 In-patient Ward: Safety and Risk

Thus, it seems that the involuntary admission to a psychiatric ward can potentially expose patients to numerous threats, including loss of personhood (Goffman, 1961; Rosenhan, 1973) and medical disempowerment (Ryan, 1998). However, there is also a risk of violence posed by other patients (Sainsbury Centre for Mental Health, 1998; McGeorge et al., 2000), as well as sexual harassment risks (MILMIS, 1995; Barker, 2000), which have been highlighted in the literature. A qualitative study by Quirk et al. (2004) examined patients' strategies for managing risks in a psychiatric in-patient ward. Authors pointed out that research had often demonstrated that psychiatric in-patient care is neither safe nor therapeutic for patients. It is highlighted that wards can be the most anxiety-provoking institutions that are concentrated with risks. Current research, hence, focuses on staff rather than the patients' perspectives on risk management (Owen at al., 1998). Findings of Quirk and colleagues (2004) reveal that although some patients do find the wards to be safe places, considering the crisis they found themselves in before the admission, it is an environment that can nevertheless, be experienced as volatile. Although many risks, such as physical assault are often attributed to patients only, authors argue that they are best conceptualised as an interplay of social and organisational factors, including low staffing level and poor surveillance. The findings from Quirk et al. (2004) study reveals that patients tend to undertake active steps, in order to make the environment safer for themselves as they find that they cannot always rely on ward staff to do this for them.

It appears that the wards can be a very challenging place to live in; they can be experienced as boring, filled with tension and even characterised by bullying and threats of violence (McGeorge et al., 2000) – all undermining their therapeutic value (Quirk et al., 2004; Holloway, 2005). It can, therefore, be difficult to form meaningful social relationships there (Quirk and Lelliot, 2001; Bowers et al., 2002; Higggins et al., 1999). Furthermore, reports also indicate that nurses commonly spend insufficient time with patients (wards are often characterised by low staffing levels) or overreact to potential crises or threats of violence, through the use of control, restraint or

medication and excessive dependency on emergency procedures. Moreover, overreliance on agency staff, who are unfamiliar with the patients, can at times, in combination with above factors, exacerbate the problems and even increase the risk in the wards (Quirk and Lelliot, 2001, 2004). Mental health staff working in the in-patient wards are faced with contradictory demands and mandates, as they are required to relate to patients with due care, while treating them promptly, in order to prevent the wards from becoming overcrowded. Thus, it has been argued that the staff focus is often centred on 'emptying beds' (Rhodes, 1991). Some authors construed nursing care in terms of 'therapeutic superficiality,' as due to the complexity of demands and pressures, as well as other organisational constraints and challenges, nurses themselves remain unsupported and therefore struggle to meet the patient, as a person (Hummelvoll and Severinsson, 2001).

1.4.16 Conclusive Remarks

Hence, what seems to emerge from the literature is that involuntary detention to a psychiatric in-patient ward is a complex process that is composed of various stages and can potentially elicit a wide range of subjective responses. Examining studies that explored patients' perceptions of psychiatric in-patient care revealed several instances that are characterised by both negative and unhelpful experiences as well as helpful and supportive. Negative experiences seem to be centred on inadequate communication with ward staff (Steinholtz, 1995), feeling alone during the in-patient period (Pejlert et al., 1995) and perceiving staff as diffuse, absent, indifferent in attitude (Lindstorm, 1995) or unhelpful (Joseph-Kinzelman et al., 1994; Letendre, 1997). Joseph-Kinzelman et al. (1994) and Monahan et al. (1995) reported that other experiences associated with involuntary care also include lack of freedom and choice, as a result of which patients can be exposed to intense feelings of anger, sadness and fear, as well as the state of entrapment and helplessness. Finally, patients also tend to report receiving scarce or lack of information regarding their treatment (Lovell, 1995). However, it is also essential to stress that the research suggests that the patients appreciated being in an environment, where they felt accepted, as allowances were made for the expression of 'bizarre' behaviours and where there were plenty of opportunities for mutual support, advice offering and friendships (Quirk and Lelliot, 2001). Individuals also reported 'the good nurses, emanating motherly care' (Lindstorm, 1995) and trust (Hellzen, 1995). For instance, in the study by McIntyre et al. (1989), patients also highlighted that talking to a staff member constituted the most beneficial aspect of their treatment. Thus, for instance, Swedish qualitative study by Johansson et al. (2002) interpreted the patient experience as transpiring both experiences of support and violation. Research indicates that the experience of being

locked in and controlled can evoke both feelings of being protected and cared for, as well as gives rise to resistance and protest (Olofsson, 2000).

Nevertheless, it has been accentuated that as a whole, there is virtually no data that would shed more light on how overriding the treatment wishes, precisely impacts on clinical improvement (Gardner et al., 1999; Kane et al., 1983; Schwartz et al., 1988) or why some patients seem to view their hospitalisation positively, while others do not (Katsakou and Priebe, 2006). Existing research suggests that the loss of autonomy can have significant implications, although contextual factors may also be of consequence, in terms of influencing patients' perspectives, such as the manner in which one's treatment decisions are overridden, as well as the strength and quality of the therapeutic alliance established between a patient and professionals involved in their care (Owen et al., 2009). Finally, addressing negative experiences of patients may pose a challenge for professionals and mental health services, as it raises ethical and humane issues. It appears that, at present, no efforts have been made to deal with patients' identified concerns regarding involuntary interventions (Katsakou et al., 2012). Significantly, more research on the subject is needed. Thus, present study constitutes a step towards filling in the 'gaps' identified in the existing literature. The aim of this project is to expand on current understanding of patients' experience of involuntary treatment in an inpatient psychiatric ward, by attempting to gain deeper insight into participants' personal world and the impact such treatment can have on individuals' well-being and recovery process.

Chapter 2: Methodology

2.1 Overview

The study focuses on former patients' experience of being involuntarily treated on an in-patient psychiatric ward, as a result of the psychotic episode. This chapter outlines a rationale for the chosen methodology and describes epistemological standpoint adopted for this research. Further, the chapter describes the methods and procedures used in this study and concludes with a section on personal reflexivity.

2.2 Design and Research Approach

Qualitative measures are considered to be of great value in this research, as not much is known about research topic in the question (Aranda and Street 2001). Moreover, there are significant gaps in the existing knowledge concerning patients' experiences on a closed ward under section and there has been an overreliance on quantitative methods in place (Quirk and Lelliott, 2001). Qualitative approaches do not seek to investigate general laws but aim to capture the content and complexity of socially constructed meanings that cannot be assessed by numerical data (Willig, 2001). The goal of qualitative research is not to test any preconceived hypothesis on a large sample, but to enrich existing findings by trying to understand, describe and interpret personal and social experiences of a relatively small number of participants (Smith and Osborn, 2008).

2.3 Ontological and Epistemological Stance

Adaptation of a particular stance towards the nature of knowledge or reality (known as ontology) and its construction (known as epistemology) is pivotal, as it informs the entire research process. It may be pertinent to point out that ontology and epistemology are mutually dependent and therefore difficult to distinguish (Crotty, 1998). As Crotty (1998, p.10) argues, ''*to talk about the construction of meaning (epistemology) is to talk about the construction of a meaningful reality (ontology)*''. Thus, ontological and epistemological stance governs theoretical perspectives associated with the study, which in turn are implicitly mirrored in the research questions and through which selection for methodology or plan of action is dictated,

followed by choice of research methods, accordingly. As such, this process represents characteristic hierarchical stages of decision making within the study (Crotty, 1998).

2.3.1 Ontology

Ontology is concerned with the nature of being (i.e. *what is*) and as Punch (1998, p.170) puts it, *"to what exists in the world, to the nature of reality".* The ontological view that the researcher adopted in order to develop this study is *constructionism. Constructionism* stands opposed to *positivism,* which has a more traditional approach and seeks to adopt an objectivist ontological perspective on the nature of reality; it is a belief in a knowable *world out there*. Thus, according to *positivist* view, ontology reality is regarded as a single and universal objective order, independent of human cognition or the perception that can be uncovered, investigated and defined, through the application of rigorous scientific methods (Coghlan and Brannick, 2005; Madill et al., 2000). *Constructionism,* on the other hand, abandons the notion of *objective truth* (Reid et al., 2005) by maintaining that truth, reality, social world, knowledge and meaning are not patterned and predictable, but are instead constructed differently by different people, with different rituals and interactions and out of the engagement of their minds with the world. In other words, social phenomena exists and develops in particular social and cultural contexts, and such reality is *relative*, bound to context and time, fluid and ever evolving, as individuals participate in their creation of perceived truth, in the light of social interactions (Leavy et al., 2011 and Crotty, 1998). It is an approach that forgoes the belief in true and fixed meanings and maintains that truth is a matter of perspective. Ambiguity, paradox and descriptive, relational meanings lie at the core of *constructionism,* as an ontological perspective (Merleau-Ponty, 1968).

2.3.2 Epistemology

In philosophical terms, epistemology is linked to ontology and is concerned with *how* we know what we know - it is, therefore, a theory of knowledge (Davies, 1991). Thus, to meet the needs and purpose of this study, an objective stance is being rejected and instead a relativist and interpretive epistemological stance are embraced, where *"social actors are seen to negotiate the meanings for actions and situations jointly*" (Blaikie, 1993, p.96). Within *interpretivism* as epistemology, reality is constructed as highly subjective therefore . Accordingly, such research adheres to an inductive theory and out of data generated approach. Thus, such position assumes that the social world can be understood via views and perspectives of individuals or social actors, who are enmeshed in meaning making processes (Leavy et al., 2011).

Hence, the ontological and epistemological stance informs this research and represents the goal of understanding a complex world of lived experience from the perspective of those who live in it. It is not a pursuit that would seek to determine whether individuals' accounts are 'true' or 'false' (Reid et al., 2005). What it *is* - is a search for meaning.

2.4 Theoretical Perspectives

This research aims to focus on social and psychological inquiry by seeking an understanding of subjective meanings and values; hence, its process and data will be examined through the lens of *phenomenology*. As a philosophical and theoretical position, phenomenology is the study of the experience (*how we experience*) that is concerned with nature and meaning of phenomena. It places emphasis on how the world is perceived through experience or in our consciousness. Phenomenology is associated with narratives, subjectivity and lived experiences; it is a paradigm that seeks to understand meanings of human interactions and events, affirming the importance of the perspective of individuals, their experiences and their view of the world. The key concept and a central focus of the investigation are participants' *life-world*, compromising of objects around us as we perceive them, as well as our experience of our self, body and interpersonal dynamics (Ashworth, 2003). Life-world can be defined as a world "*that appears meaningfully to consciousness in its qualitative, flowing given-ness; not an objective world 'out there', but a humanly relational world*" (Todres et al., 2006, p.55). An individual's sense of selfhood, embodiment, sociality, spatial and temporal contexts, project, discourse, affect and mood as atmosphere are considered to be essential characteristics of the life-world. The overall aim of the phenomenological research is to extract all the dimensions of the structural world that are socially shared with the components that are experienced in unique, individual ways (Ashworth, 2003).

While it can be argued that phenomenology falls under the category of being descriptive (i.e. its aim is to describe rather than explain the phenomenon), a division exists between descriptive versus interpretive or hermeneutic, phenomenology. *Interpretive phenomenology*, as inspired by the work of hermeneutic philosophers, believes that the very basic structure and meaning of phenomenological description lies in interpretive activity. It is, therefore, highlighted that whatever is experienced has already been interpreted (Heidegger, 1962). Some authors embrace an intermediate position, whereby description and interpretation are viewed as a continuum (Finlay, 2009).

2.5 Interpretative Phenomenological Analysis (IPA)

Methodology refers to the tools utilised in order to know the reality; however *reality* is defined (Wainright, 1997). Jonathan Smith's (Smith, Flowers, and Larkin, 2009) *Interpretative Phenomenological Analysis* (IPA) was chosen as an appropriate experiential approach for this study, as it aims to gain insight into the lived experiences by getting as close to the participant's personal world as possible (obtaining an insider perspective). It therefore seeks to understand what a given experience (phenomenology) is like and how individuals make sense of it (interpretation). IPA (Smith and Osborn, 2003; Smith, Flowers and Larkin, 2010) "*is an approach to qualitative, experiential and psychological research, which has been informed by concepts and debates from three key areas of the philosophy of knowledge - phenomenology, hermeneutics and ideography"* (Smith et al., 2009, p. 11).

In relation to other phenomenological approaches, IPA interprets belief, affirming the words of participants and accepting their stories. IPA is an *idiographic* form of inquiry that pays rigorous attention to subjectivity, hot cognition and in particular to variation in data, keeping a close focus on meaning and at the same time moving to a general nuanced account of similarities and differences in cases, capturing instances of convergence and divergence at the same time (Smith et al., 2009). Interestingly, Halling (2008) argues that idiographic form of inquiry can also be general in the sense that it may focus on general structure of experience by looking at a specific experience of one individual's story in the first instance, secondly by exploring themes common to the phenomenon being studied and finally by being concerned with philosophical and more universal aspect of being alive. The art is to move back and forth between experience and abstraction – between experience and reflection – all at various levels. Thus, the goal of this research is to explore life-world of each *individual,* who are sectioned and treated on a closed ward (by focusing on the explication of individual differences) and at the same time strive to move towards exploring the more *general* essence of the lived experience of *being* in a closed ward under section.

The small sample being characteristic of a qualitative design allows for a richer depth of interpretation/analysis. However, it means that it is not possible to make any conclusions or generalise findings to a larger population. IPA does not seek to find a single answer or truth; rather it aims to present a rich, coherent and legitimate account of participants' stories. Participants in the IPA studies are recruited by common experiences (*homogenous sampling*), and the objective is to demonstrate how the phenomenon is understood in a given context, in interaction with the environment, as well as from a shared perspective (Smith, 1989).

2.5.1 Rationale for IPA Methodology

In terms of complementarities and contradictions with other approaches, IPA affinities with grounded theory and discourse psychology, as well as it is informed by *symbolic interactionism* (whereby meanings are constructed both on social and personal level) (Blumer, 1969; Smith, 1996). Thus, IPA positions a person as a cognitive, linguistic, physical and affective entity (Smith et al., 1999). Additionally, IPA endorses social constructionism views on social and historical processes in experiencing and making sense of our lives (Eatough and Smith, 2008). Nevertheless, IPA has, distinctly, adopted a psychological approach (Willig, 2001), particularly when compared with other methodologies, such as grounded theory (Willig, 2001) or narrative analysis (Smith, Flowers and Larkin, 2009), and since it is not concerned with the role of language either (which would be of interest to discourse analysis), it seems best suited for psychological studies such as this one, where the detailed quality of individual experiences is being addressed; after all, IPA has a strong connection to psychology (Willig, 2001). In addition, in contrast with certain approaches such as Thematic Analysis, IPA is theoretically bound to the pre-existing theoretical framework and therefore possesses the phenomenological, epistemological and ontological coherence, dedication and consistency that are deemed pivotal by the researcher (Larking et al. 2006; Joffe, 2011).

The pertinence of hermeneutics in IPA and the fact that the research is a two-stage interpretation is also often highlighted. It is a dynamic process, which depends on and is complicated by researcher's own conceptions. It, therefore, involves the researcher, striving to make sense of the participant personal world through interpretative activity, which is known as a *double hermeneutic;* such inter-subjective interconnectedness between researcher and researched characterises phenomenology and IPA (Reid et al., 2005; Smith et al., 1999). Furthermore, IPA is not merely about describing and packaging the participants' statements; instead, it is an art of interpretative activity, however at the same time staying in touch with the text (Smith, 2004; Smith, Flowers and Larkin, 2009). Thus *"IPA has been developed specifically in order to allow the researcher to produce a theoretical framework, which is based upon, but which may transcend or exceed, the participants' own terminology and conceptualizations"* (Smith, 2004, quoted in Larkin, Watts and Clifton, 2006, p.113-114). For this reason, IPA is the most useful method to elucidate former patients' experience of being in a closed psychiatric ward under section.

Furthermore, IPA, as having its roots in psychology, is also distinguished from other phenomenological perspectives by acknowledging the central role of the analyst/researcher. Phenomenology accepts all aspects associated with researcher's subjectivity as inevitable. As a matter of fact, such inter-subjective interconnectedness between the researcher and the researched forms a distinct and characteristic feature of phenomenology. While some authors argue that certain presuppositions should be *set aside* by the researcher, others, particularly those of hermeneutic orientation (i.e.

IPA for instance), believe that such endeavours are not only fruitless but also undesirable; therefore, the possibility of *bracketing* researcher's experiences and understanding is denied (Finley, 2009). Smith (2004) argues that IPA is an inductive and idiographic method, which is phenomenological through its emphasis on individuals' lived experiences and perceptions. Hence, distinctively, IPA has a dual focus as it places emphasis on the unique characteristics of each individual participant (the idiographic emphasis) as well as on patterning of meaning across the accounts (Larking et al. 2006; Joffe, 2011). IPA is also more strongly identifiable with hermeneutic tradition, which does not adhere to the use of *bracketing.* Adherence to such hermeneutic (and interpretive) tradition has greatly influenced the selection of IPA as the most appropriate method for the current project due to researcher's own perspectives and interest in the research topic, as well as in the broader issues related to psychiatry. Thus, by placing researcher's subjectivity, self-awareness and self-reflection at the core of the process, the aim is to separate what belongs to the researcher and what is to the researched. It is, therefore, a very important step towards openness and bias recognition (Colaizzi, 1973; Gadamer, 1975). On the other hand, IPA has been criticised for not having clear guidelines, in relation to the incorporation and utilisation of researcher's reflexivity. However, this lack of rigidity may be viewed as a strength, rather than a limitation (Smith and Osborn, 2008). Researcher's reflexivity is therefore considered crucial. However, it has to be pointed out that as such it cannot take the focus away from the research participants and the appearing phenomenon (Finlay, 2009).

It is also argued that IPA has flexibility to deal with complexities of human experience, which combined with a rigorous framework and clarity of method, enables to account for context and needs of the researcher and the research (Smith and Osborn, 2008). Such constitutes as yet another asset that makes IPA a methodology of choice for this research. What is more, IPA is certainly more congruent with the researcher's personal reasoning, understanding as well as attitudes on qualitative inquiries. Finally, compared to other approaches, IPA carries more freedom and creativity and is of particular value in psychological and health care research, especially when unusual groups or situations are being taken into consideration, or in order to reach views of individuals that are not easily accessible and which often escape the perceptual field of professionals (Biggerstaff and Thompson, 2008; Willig, 2001). IPA is regarded as possessing the flexibility to deal with complexities of human experience, which combined with a rigorous framework and clarity of methods, allows for consideration of the context as well as the needs of the researcher and the research itself (Smith et al. 2009; Joffe, 2011; Yardley, 2008).

2.6 Ethical Considerations

2.6.1 Approval

This research follows the research ethics protocols developed by City University Research Ethics Committee, and it complies with the British Psychological Society's ethical guidelines and code of conduct (BPS, 2006; 2009; 2010). Thus, ethical principles as related to confidentiality, consent, withdrawal and distress management or detrimental impact are fully taken into consideration.

2.6.2 Confidentiality

Every effort was made to ensure confidentiality of any identifiable information that is obtained in connection with the study. It was ensured that participants' names were not linked to the research materials and all data is treated with full confidentiality. Hence, even if published, the confidentiality would not be compromised. Each participant was assigned a number used for identification purposes and pseudonyms were chosen by participants after their consent to take part, which was used in writing up stage of the data. Transcription process followed the interviews, in which audio-recordings were transferred onto the computer and removed from the note recording device. Next, backing-up copies and storing files in an anonymous format were created.. Following completion of the transcription process, audio files were transferred into the safe storage system (locked up memory) and are to be kept for a five year period, thus providing evidence that the research has been conducted (audit trail). This procedure complies with most scientific journals requiring original data, such as transcripts to be kept a specified period. It is hoped that the research will be published, however, if this is not the case, then all the data will be stored for up to two years and then destroyed. Furthermore, all the data is stored in electronic version, and anonymization and encryption measures were utilised appropriately (backup copies are created in order to prevent any accidental destruction).The consent forms along with demographic data are securely kept, and hard-copies are clearly labelled and retained in durable containers.

2.6.3 Consent and Withdrawal

All individuals were required to sign a consent form (see Appendix 2A and B) in order to participate in the study. Participants were informed that they could withdraw from the study at any time, without giving a reason and without any negative implications. Such also involved the right to exercise an option of removing their data from the study at any point in the process. Individuals were also informed of their option of refusing to answer any questions they are not comfortable with and yet remain in the study.

2.6.4 Distress Management

It is recognised that any inquiry about participants' experiences of being in a closed ward under section, their distress, recovery and self-concept can be sensitive and upsetting and can, therefore, evoke painful states. Furthermore, evidence suggests that being sectioned is a traumatic experience (Bentall, 2009; Morrison et al., 2003), and hence the study strived to ensure that the procedures are in place that aimed at preventing, managing and containing potential distress. During the data collection process, particular attention and consideration were given to identifying the signs of concern or distress that may arise, and it was ensured that all issues were addressed immediately. Participants were informed both via information sheet and again verbally, before the interview, that they had the right to pause at any time during the process, take breaks or reschedule the interview if they encounter any difficulty in continuing. Participants were also reminded about their right to withdraw at any time without giving a reason. While obtaining informed consent, participants were also required to give permission to contact their GP/key worker/care coordinator, should they become distressed during an interview (this information is also provided in *The Study Information Sheet – Appendix 1A and B*). Before the beginning of the interview, participants were reminded that should they become distressed, the interview can be suspended, and during the time spent to discuss their distress, the researcher is available to offer support of her therapeutic skills. If participants' distress was contained, only then the interview could resume. However, if participants were not able to respond to researcher's interventions and continued to appear overwhelmed by the process, the interview would be terminated and resumed at a later opportunity. Participants' GP/key worker would also be informed of the situation, in order to gain further inputs aimed at helping the participant to manage their distress. Finally, post interview *Debrief Sheet* (Appendix 3A and 3B) was given to all participants, which contains information about the sources of support and assistance, should they experience any distress, as a result of participation in the study. The

Debrief Sheet includes suggestions for possible sources of help and comfort and includes a list of national organisations offering support to individuals in crisis, along with their contact details.

2.7 Procedures

2.7.1 Sampling Considerations

Since IPA aims to provide a rich description of participants' narratives, it is deemed beneficial for the study to access individuals with a broader range of experiences. For instance, criteria for the number of hospital admissions were not set, and it was predicted that participants would range in these domains. At the same time, minimal inclusion/exclusion criteria have been ascertained to allow the sample to be homogenous and represent the complexity of the issues that this particular client group faces.

Recruitment inclusions criteria were as follows:

- Only individuals who were under compulsory treatment (detained and sectioned under Mental Health Act 1983 and 2007) were recruited. This research, therefore, aimed to investigate a unique experience that is likely to differ from a potential voluntary in-patient treatment (Craw and Compton, 2006; Hoge et al., 1997; Priebe et al., 2010).
- Additionally, only individuals who were treated within NHS organisations are included in the study as research reveals that there may be differences in quality of care received in an independent sector (Ryan et al., 2004).
- Inclusion criteria encompass individuals who experienced and/or suffered from psychosis and who are sectioned under Mental Health Act (1983 and 2007) on such basis. Inclusion criteria regarding the length of time since the last admission were also set. It was suggested that six months period must have passed since the last admission, in order to minimise the risks to participants, as well as enhance the capacity for self-reflection. The decision was reached by taking into account the complexity of processes related to psychiatric detention, transition phase into community and recovery (Nolan, 2011; Beveridge, 1998) as well as NICE guidelines recommending that all chronic PTSD sufferers should be offered a course of TFCBT or EMDR, of 8 to 12 sessions, normally on an individual outpatient basis, regardless of time since trauma (NICE, 2005). The latter is taken into account, as there are certain

indications that being sectioned can result in the diagnosis of PTSD (Bentall, 2009; Morrison et al., 2003).

Recruitment exclusion criteria includes:

- Exclusion standards enclose individuals with prior history of head injury/evidence of organic brain disease, learning disability or a previous diagnosis of alcohol or drug use/drug induced psychosis.
- Exclusion criteria therefore involve former patients, who are treated in private secure facilities on a voluntary basis.

2.7.2 Recruitment

The recruitment plans included contacting various national voluntary/charitable organisations that offer community-based mental health services and support (such as residential settings, supported housing, resource/day centres, psycho-educational/recreational and support groups) to individuals suffering from psychosis across London and surrounding areas. The examples of organisations that are approached include *Hearing Voices Network, Together for Mental Wellbeing, Rethink Mental Illness, Richmond Fellowship, SANE, Mind or InterVoice.*

Thus, the initial stage of the recruitment process entailed approaching a wide range of organisations via email, which provided a brief yet fairly comprehensive overview of the research topic, its aims and implications along with *The Consent Form*, *The Information Sheet* and *The Study Advertisement,* attached to the email for the organisation to view. The email included researcher and supervisors' contact details and a clear statement of study receiving an ethical clearance from the City University London. Organisations were then asked if they would be interested in offering some potential form of assistance regarding the recruitment process. It was suggested that any help on the matter would be highly valued and may involve passing on the study advertisement to potentially interested individuals or simply placing it on the organisation's premises or website. It was highlighted that any other alternatives and solutions suiting the organisation would be welcome and greatly appreciated.

An organisation that provided a prompt response to the email and through which all participants were recruited is SANE. SANE is a mental health charity that aims to provide emotional support for people with mental health difficulties and raise awareness and combat stigma about mental illness. SANE also initiates research

concerned with causes, impact and treatment of serious forms of distress (http://www.sane.org.uk).

SANE agreed to place a study advertisement on their website, as well as provide brief information about the study with an online link to *The Study Advertisement* (Appendix 4A and B) via social media websites. All participants were recruited through the same procedure. However the separately amended version of *The Study Advertisement, The Study Information* Sheet, *The Consent Form* and *The Debrief Sheet* for the recruitment of the pilot study participants were created. It is suggested by the organisation that potentially interested individuals were invited to approach researcher directly via contact details provided on *The Study Advertisement* which was an agreement that was deemed suitable for both sides.

2.7.3 Participants

All potential participants approached researcher voluntarily via email, and in some cases, additional telephone discussion was held in order to clarify the purpose of the study. All individuals were provided with *The Study Information Sheet, Recruitment Criteria* (Appendix 5), *Consent Form* and *Demographic Questionnaire* in the first instance (Appendix 6). Such was aimed at reflecting transparency and researchers' awareness that willingness to participate in the research depends on how well the participants understand what the research and the participation entails. Individuals were also encouraged to take the time to consider whether or not they would like to take part in the study. All participants were stimulated to ask questions about the study and in the end (also via email) required to sign a confirmation that they have familiarised themselves with the study procedures, as well as the recruitment requirements and were satisfied with them before proceeding to the next stage, which involved arranging an interview meeting.

The current project has seven participants in total, which included one participant from the pilot study. A full summary of demographic information and other personal characteristics of participants can be found in Table 1 below. All names have been changed into pseudonyms chosen by participants, in order to preserve confidentiality.

Table 1: Demographic and Personal Characteristics of Participants

Pseudonym	Age	Total no. of Years in Contact with Mental Health Services	No. of Inpatient Admissions Under Section	Longest Stay in Hospital	Last Admission	Diagnosis (current and the past, if different)	Being on Medication (currently: yes/no and in total no. of years)
Kerry	30	15 years	2	5 months	2012	Schizoaffective Disorder	Currently on: Yes Total: 14 years
Sally	32	12 years	2	5 months	2009	Bipolar disorder *Past:* Depression/Anxiety	Currently on: Yes Total: 5 years
Buster	46	25 years	5	9 months	2009	Bipolar Disorder	Currently on: Yes Total: 25 years
Annabel Alexandra	31	15 years	3	6 weeks	2006	Bipolar Disorder	Currently on: Yes Total: 15 years
888	46	12 years	2	1 month	2009	Bi polar BPD	Currently on: No Previously on medication: 2004-2006 and 2009-2013
Cait	48	37 years	4	20 months	2009	Dissociative Identity Disorder *Past:* Schizophrenia, BPD, PTSD	Currently on: Yes Total: 10 years
Valerie	51	11 years	5	14 weeks	2012	Depression, Anxiety *Past:* Bipolar Disorder	Currently on: No Total: 10 years

- Ethnic background: All participants are White British.
- Gender distribution: Six out of seven participants are female.
- Relationship status: Four participants are single, one participant is married, one participant is separated and one participant is engaged.
- Three out of seven participants have children.

2.7.4 Research materials

A digital audio recorder is used for individual accounts.

2.7.5 Interview Proceedings

Face to face interview meeting was arranged once individuals confirmed their willingness to participate in the study and if they met the recruitment requirements. Time and location of the interviews were determined by each participant. City University London was suggested by the researcher as a possible location for interviews. However, participants were informed that an alternative location according to their convenience could also be arranged. All interviews were conducted in a private room with only the researcher present, and City University London premises was indicated to be a suitable arrangement by all participants. Participants who lived outside of London expressed an ability and willingness to travel to the city and were offered a partial reimbursement of their travelling expenses by the researcher (it was agreed that the actual amount of reimbursement was to be suggested by the participants).

At the very beginning of each interview meeting, *The Study Information Sheet* was further, albeit briefly, discussed with the emphasis placed on the purpose of the study, confidentiality, risk and benefits involved and its voluntary nature, which was followed by signing *The Consent Form* and filling out a sheet on demographic characteristics. Individual interviews ranged from one and a half to three hours, approximately. None of the participants terminated or postponed the interview process due to distress. However one participant withdrew from the study before the interview because of being unwell. At the end of the interview, participants were provided with a *Debrief Sheet* (Appendix 3A and 3B) and an opportunity to ask questions that were answered in an informative way. Throughout the data collection period, the researcher's reflective comments on the process, including any additional information related to the participants were recorded in the field notebook.

2.7.6 Data Collection

The data was obtained using in-depth semi-structured interviews, which are a common and optimal method of collecting data in IPA on individuals' personal histories, perspectives, and experiences, particularly when sensitive topics are being explored (Smith and Osborn, 2003). The goal of the interview was to ask questions that are believed to be relevant to the individuals who experienced acute psychiatric treatment under section (based on the literature review conducted). However, the interview schedule was merely a foundation for the conversation, and it was not intended to be limiting nor prescriptive, as it was deemed important not to override the expressed interests of the participants. The initial question was characterised by a non-leading approach through lack of imposed agenda, encouraging participants to freely move in a direction desired and considered important, eliciting subjective experiences and unrestricted flow of expression (''Tell me about your experience of being in a closed ward''). This form of interviewing allows for engagement in dialogue and flexibility through which further questions and prompts are modified in the light of participants' responses, probing interesting areas that arose (Smith, 1989). These prompts were designed to enable participants to generate more in-depth expressions and elaborations and at the same time ensuring that they mirror aims of the study by eliciting experiences, perspectives, impacts and meanings (Appendix 7 for the *Proposed Interview Agenda*). Thus, the interview schedule was aimed at representing a flexible approach. However, its framework ensured that each interview commenced in the same manner (through non-influential approach facilitating spontaneous responses) as well as ended with an important safeguarding question ("Is there anything else you wish to add in relation to your experiences; anything my questions have not addressed?'').

Some basic demographic information was also gathered from participants, which included information about their gender, age, ethnicity, marital status, number of children, time since first contact with mental health services, diagnosis/nature of distress, number of admissions, last admission, number of episodes of psychosis and medication (*Demographic Questionnaire:* Appendix 3). However, it is pertinent to point out that this study does not have a primary concern with how patients' socio-demographic characteristics affect their views and experiences of psychiatric treatment. Demographic data is gathered as it may provide helpful supplementary information to participants' experiences and assist in providing a more accurate description of the sample. However, the main emphasis is placed on individuals' subjectivity. Face to face interviews were recorded (using voice notes recorder) and transcribed before being subjected to analysis.

2.7.7 Pilot Study

A pilot study was implemented in the first stage of the project primarily in order to pre-test the quality and objectives of the interview questions and style (including their wording). The objective of a pilot study was also to allow for an improvement in the study design and its outcome, before conducting the study on a full-scale basis. It is also hoped that it could help in identifying any practical issues in the research procedure.

Contamination is not regarded as a concern in qualitative inquiries. Thus, it is common to use pilot data as part of the main study (Gilbert, 2001). Although the pilot study did not lead to any significant modifications of the research materials and procedures and qualitative data collection and analysis is often viewed as progressive by nature (Gilbert, 2001), the pilot study interview does not form part of the final research sample mainly due to arising complication. Namely, the pilot participant's account was interwoven with and largely consisted of a private hospital experience (as the participant reported being transferred from the initial NHS ward to a private sector, due to lack of space in the NHS hospital) thus not fully meeting inclusion criteria for the study.

2.7.8 Transcription

All interviews were transcribed by the researcher. The transcribing was not concerned with any prosodic features. However, it included other speech dynamics that appeared significant and worth recording, such as pauses or laughs, as well as other behavioural expressions related to conveying signs of emotional struggles. This approach meets the IPA criteria for transcription (Smith, and Osborn, 2008).

2.7.9 Data Analysis and Interpretation

It is an analytic focus that forms the essence of the IPA. This analytic emphasis means that researcher's role is to direct their attention to participants' attempts in making sense of his or her experiences. IPA analysis aims to capture the richness and essence of the accounts and is based on the verbatim transcript and systematic search for annotating the text closely for insights into participants' experiences, perceptions and meanings (*coding*). Such process is characterised by a 'bottom-up' approach (i.e. generation of codes from the data) (Smith, Flowers and Larkin, 2009).

The first stage in IPA analysis revolved around the close reading and re-reading of the text. Some initial, loosely formed notes were made on the left-hand margin of the

text. These comments mainly consisted of *descriptive labels/codes* and were related to more tangible and immediately grasped significant statements or key phrases, pertaining to the phenomena being investigated. The process did not involve line by line, or sentence by sentence coding as this was deemed impractical by the researcher. Instead, the codes and labels were extracted from the text, through the identification and formation of the meaningful units. Initial comments also included researcher's thoughts and questions; for instance, those linked to the style or choice of expression by participants (paying attention to similarities and differences, echoes, contradictions and amplifications). The main goal of the initial level of analysis was for the researcher to familiarise with the data and open the dialogue with individuals' account.

The second stage was characterised by a more sophisticated, and most of all abstract way of relating to the text. The aim was to progress from a descriptive to a more interpretative approach, and it involved the integration of codes into more conceptual components, evoking more psychological concepts and terminology. Because of the personal involvement of the researcher in the process, the researcher's experiential, as well as professional awareness was brought to the fore at this stage of analysis and at the same time the emphasis was placed on the interpretations derived from the data. Phrases and terms emerging from the text and reflecting both participant's inner world, as well as researcher's interpretations, were recorded on the right-hand margin of the text and forms the *initial themes*. At this point of the analysis, it was of particular importance to locate expressions that were high lever enough to represent some theoretical connections, within and across cases that remain grounded in the specific issue.

The next phase aimed to identify patterns in the codes and merge initial codes and themes into higher order units or key categories known as *subordinate themes*. During clustering of themes, researcher ensured that the connections continued to be aligned with the primary source material. The core technique employed in order to group the emergent themes together was an abstraction (grouping of themes regarded as being related conceptually).

Next stage was characterised by a continuous reduction process and involved striving to forge a further connection between existing themes by moving across case to establish *master or superordinate themes* as broad *key categories* located in an ordered system. Next, 'master' list of themes was created that identified the main concerns and features recognised by the participants.

The final stage of the analytic process concentrated on establishing relationships between identified higher order units (i.e. master themes/core categories). In this

context, each transcript was treated as a case study report and therefore, the aim was to provide a conclusive integrated account or in other words, a foundation of a participant's story akin to a model or a *formulation*. At this stage, researcher moved onto the next transcript and followed the same procedures of analysis by using the master of themes obtained from the first interview. The emphasis was then placed on being alert to the emergence of new themes. The process was, therefore, cyclical and subject to constant modifications. Finally, the themes were drawn together and formed a consolidated list.

An audit trail on main stages of the analysis is included in Appendix 9, 10 and 11.

2.7.10 Results

It has been stated that the division between the analysis and writing up process is to an extent a false one. Writing up, essentially, involves translation of themes into a narrative account (Smith and Osborn, 2007). Thus, analysis became expansive whereby themes were explained, explored, illustrated and nuanced. Writing up stage aimed at characterising rich and exhaustive description of participants' lived experiences, and this was supported by verbatim extracts from individual accounts. Central to writing up stage was a careful distinction between what the participant says and the researcher's interpretation of it. At the very heart of such analytic commentary lies processuality and creativity (Smith and Osborn, 2007).

2.7.11 Discussion

Discussion section focuses on study's implications, as well as presents and evaluates the links that research analysis has with the extant literature.

2.7.12 Resources

The researcher did not incur any prohibitive expenses related to conducting this study. The main costs result from the standard computer/printing based components and commuting expenses (for accessing participants and/or offering commuting reimbursement).

2.8 Trustworthiness, Rigor and Quality

Although questions of reliability and validity have been raised regarding qualitative research methods, this approach is considered to be of great importance in terms of achieving the meaning that others give to their own situations. Critical claims regarding qualitative study propose that such research is inherently biased, while proponents argue that subjectivity is, in fact, a central component that brings strength to a qualitative inquiry. Furthermore, it is pointed out that researcher's insights and reflections are invaluable in reaching the rich description of the complex social system being explored (Marshall and Rossman, 1995). Qualitative research, as opposed to quantitative, is concerned with seeking illumination, deeper understanding and extrapolation (Hoepfl, 1997). Nevertheless, concerns with the issues of validity in qualitative research have been dramatically increasing (Cho and Trent, 2006).

It has also been proposed that qualitative design can aim to study the subject objectively (Smith, 1989). The term reliability, widely accepted in evaluating quantitative research, has been regarded as misleading and unnecessary in qualitative studies (Stenbacka, 2001). When referring to reliability, information elicitation is regarded as the most relevant aspect of testing, and it has been suggested that in qualitative inquiry, this would be equivalent to *quality* (Golafshani, 2003). The concept of quality in qualitative research aims to generate understanding and as Seale (1999; p.266) argues, in qualitative research, "*Trustworthiness of a research report lies at the heart of issues, conventionally discussed as validity and reliability".* As far as term validity is concerned, Hammersley (1995) redefined it by using the word *confidence*.

Thus, validity and reliability, being positivist evaluation criteria, were reformulated to fit into a qualitative paradigm, which in turn could be regarded as a subtle form of realism (Hammersley, 1995). Such parallel set of reformulated criteria is often conceptualised in terms of *trustworthiness, rigour and quality* (Creswell, 1998; Lincoln and Guba, 1985; Seale, 1999; Stenbacka, 2001). Davies and Dodd (2002) proposed that the term 'rigour' exists in relation to the discussion about reliability and validity that can be ensured by focusing on exploring reflexivity, subjectivity and social aspects of interaction during interviews. On the other hand, such specific measures that place emphasis on increasing validity in qualitative interpretative research have been criticised as having realist and positivist origins (Angen, 2000). Thus, for instance, member checking procedure has been argued to assume that there is a fixed truth (Sandelowski, 1993), reflexivity has been viewed as creating an illusion of objective reality and peer review for downplaying an integral part of the principal researcher in the process (Silverman, 2001). In fact, discussions around the very definition of

qualitative studies, as well as how they can be best evaluated are ongoing, and various positions are held on the subject (Creswell, 2007; Crescentini, 2009). Porter (2007) states that qualitative studies can be characterised by their method, as well as by their epistemological and ontological assumptions. Porter (2007), therefore underlines the benefits of adopting a realist approach to validity. Qualitative research has often been characterised by pluralism as well as uncertainty and flexibility, therefore encompassing a wide range of approaches as well as mixing of those approaches which can enhance the richness of the knowledge development (Lincoln, 1995; Roy, 1995; Dicks et al. 2006). As such, these issues often indicate the tension between epistemological purism and pluralism in qualitative research (Whittemore et al., 2001)

While it has been highlighted that subjectivism and phenomenological inquiry lies at the very core of this study, it is also deemed relevant to ensure that integrity and legitimacy in this research are established and maintained, as failure to assess the worth of any study can lead to dire consequences (Long and Johnson, 2000). As such, qualitative research entails a tension between rigour and creativity, between scientific methods and art of interpretation and perhaps some form of critical compromise, is required (Pyett, 2001). It is hoped that this research will be published and therefore it is pivotal that passes all quality checklists that may be used for reviewing qualitative studies (Crescentini and Mainardi, 2009) and that it is accessible and perceived as strong and convincing by a reader.

Trustworthiness, rigor and quality (Lincoln and Guba, 1985; Smith, 1989; Marshall and Rossman, 1995; Campbell, 1996; Hoepfl, 1997; Creswell, 1998; Seale, 1999; Stenbacka, 2001; Morse et al., 2002; Golafshani, 2003; Shenton, 2004) in this research project, based on the above literature review, are mainly facilitated through the synthesis and incorporation of the means, such as *purposive sampling*, *iterative questioning, researcher's reflexivity*, *rich and thick description or external auditor* (research supervisor examining the process in order to safeguard transparency of the process and to determine its limitations and accuracy).The above procedures refer to utilising different methods and sources for data analysis and multiple pieces of evidence known as *triangulation* (Creswell and Miller, 2000).

2.9 Personal Reflexivity

The research topic has become of particular interest to me as a result of my own experiences of working in a psychiatric ward for adolescents. I consider that the experience has been invaluable to my understanding of the severe form of distress and the way it can be perceived and experienced by individuals themselves. However, at the same time, this was an experience filled with deep disappointments and

frustrations. Undoubtedly, my internal struggles inspired me to pursue this project and, I believe, they will continue to drive me to advocate for a shift in psychiatric paradigm and treatment. I found my work in a psychiatric hospital to be extremely challenging – without a doubt witnessing very young people in profound despair and hopelessness constituted a large part of the difficulty. However, the central problem resulted from my own sense of helplessness and inability to make 'a real difference' in facilitating patients' journey towards their recovery. Thus, I felt that I was a part of the system that not infrequently, from my perspective, represents unjust and pathologising practices. It was an environment filled with potentially damaging effects of power imbalances through which patients' perspectives were often considered irrelevant. It was also time characterised by a scarce occurrence of meaningful activities, lack of psycho-education, and minimal or non-existent psychological interventions. It was disappointing to see that the treatment consisted mainly of medication and was focused on risk management, without taking into consideration psychological factors or environmental circumstances in which the young people were often brought up. I could not comprehend the predominant belief in maintaining immunity to being emotionally engaged with patients, which if occurred was deemed rather unprofessional. Such defensive attitudes seemed deeply embedded and therefore difficult to challenge. I could not help but derive an impression that detention on a closed ward and being exposed to all of the above-mentioned components, particularly in terms of staff-patient relationships was impeding the prospect of recovery. Sadly, at the same time, it was a place that, for many, offered security and refuge from the aversive and the abusive contexts of a family home, as well as 'the real' world out there. In hindsight, I also recognise the struggles and constraints that the ward staff were often confronted with and how they were reflected or re-enacted in the dynamics between both patients and other professionals. Nevertheless, it was frightening to see such a prominent manifestation of a biomedical model and the overemphasis on medication, which at times seemed to have been used as the means of behavioural control and simply aimed at symptom reduction, leaving such young individuals caught in a vicious cycle of never acquiring an opportunity to gain insight into their experiences and address the underlying cause of their difficulties. Having to think about the side effects of antipsychotics, their questionable effectiveness and knowing that such drugs have an enormous effect on the brain structure and reward system, it was disturbing for me to observe that not enough concern was given to what impact such medication might have on a developing brain in particular.

My emotional connection to the subject certainly created a challenge to engage in the project of such immersive and intense qualities. I must admit there was a time when I wondered whether I am able to or whether I should even commit to such a research topic at all. I was afraid that my passion and, one may say, bias could pose too much

of an obstacle. I was afraid that I might sink into more anger about what I perceived as marginalisation, stigma and unjust practices that affect those in severe distress in our society. I recognised though that my plea and empathy towards those who are ostracised results from my own early experiences of being marginalised. Deep down, I was, therefore, afraid that by immersing in this study, I would risk becoming bitterer and ultimately close minded, as well. At the same time, I simply was too compelled to pursue this project. I believe that it is of great pertinence to explore both conscious and unconscious reasons behind the choice of our career path and that includes the selected research topic. Looking back I know that my work in a psychiatric ward left me with unresolved issues and unprocessed emotions, which I had no way of discharging for a long period of time. Unknowingly, in a way, this study provided me with such an opportunity.

Based on my own experiences and the existing research, I anticipated that predominantly experiences and impact of psychiatric treatment would be perceived by participants as negative and largely ambivalent. At the same time, I genuinely hoped that there would be significant aspects of individuals' experience that are viewed as helpful and positive in some way. Having conducted the interviews, part of me has certainly felt saddened, as it became clear that individuals' experiences were conceptualised as largely aversive. Furthermore, conducting this research drew my attention to the state and conception of 'knowing'. Thus, certain analogies provided by participants seemed unexpectedly graphic and explicit in many ways. Perhaps, on some level, I have been arrogant assuming that what would largely emerge from the data would not be surprising to me. I could not have been more wrong, especially when it came to the issue of loss, and the illuminations that shed light on how the experience can alter one's subjective sense of self or the world view.

There is also no denying that the interview processes have been emotively charged. However, they constituted something akin to a transformative journey, as well as a healing experience for me. In other words, none of my initial fears came true. There is, however, a new 'me' that emerged as a result and I think that the change manifested itself in an inner shift, which ultimately allowed me to feel more at peace with my own experiences, as well as embrace more balanced and therefore less affectively or personally dominated attitude towards the issues concerning psychiatric treatment. Important to note though that while analysing one interview, in particular, I was feeling angry and indignant, and was overcome with a sense of injustice that participants themselves struggled with. In instances like that, it was crucial for me to step out of myself and be aware of the process and my 'countertransference' to the accounts. It could also be argued that my experiences and notions regarding psychiatric treatment in general, enhanced my sensitivity and attunement towards participants and their accounts. The theme of powerlessness in particular strongly

resonated and perhaps in some ways, propelled me to give a powerful voice to participants. However, I believe, this not only reflected my own identification and contentedness to the stories and a desire to compensate and provide somewhat corrective experience for the 'voiceless' but mainly mirrored and captured the very nature of the participants' descriptions being very poignant, vivid and impactful. I certainly found the interview process to be rewarding. I was particularly moved by my last participant's comment at the very end of our meeting who said, '*Finally, I've been listened to. Finally I've been heard'.* Without a doubt, this holds a significant meaning to me and elucidates the value of this project.

Undoubtedly, my position as a practitioner of counselling psychology, who identifies as integrative assimilative in approach practising centrally within the psychodynamic model, might have also influenced the data collection, interpretation and presentation. My therapeutic stance has certainly had an effect on the manner in which the accounts have been analysed, as I tend to embrace deeper level exploratory work with an emphasis on symbolism and metaphors. Nevertheless, I aimed to be mindful of tis and trying to strike a balance (so that my interpretation is not overtaken by underpinning therapeutic modality). On the other hand, my therapeutic style might have allowed me to reach a more in-depth perspective.

Since I hold a critical stance on psychiatry in general, I did endeavour to bring my knowledge, including my preconceptions, to the foreground, in order to immerse in a challenging process of separating what is *mine* and what emerges from the data. I felt that the therapeutic skills that I have developed throughout my training were pertinent in this process.

Phenomenology, as a research method, has strong links to psychotherapy and its essence has been widely applied to human phenomena in the therapeutic context (Adams, 2001). An analogy that comes to mind is by Bion (1970), who speaks of the therapist as being capable of approaching each therapeutic session without memory, desire or understanding and almost function in a Zen-like state of mind, empty of preconceptions and therefore, receptive to client's communications (Seinfeld, 1996). Bion (1970) highlighted that the therapist could only afford to 'forget' about the theoretical knowledge base if he or she is highly knowledgeable about it. The word *theoretical* can also be replaced with the *personal* knowledge base. In other words, there is a danger and lack of responsibility should our beliefs remain unexamined. Self-awareness and self-development are pivotal to counselling psychology training, as there is a stance that reflection on our experiences can help us identify our assumptions, which in turn can enable us to see more clearly and therefore practice more 'effectively'. I strongly adhere to such a belief. However, at certain times, I do feel that it would be grandiosely ignorant to conclude that it is even possible to know everything about oneself. I also think that it is crucial to highlight that our assumptions

may play an important function; for example, we need them in order to make sense of the world around us.

Expanding on what I have argued (Rationale for IPA methodology section), there is also a question of whether being cognitively aware of our assumptions is sufficient to prevent us from influencing the rest of experience. Perhaps there is an implicit denial of such a belief that ultimately overlooks the fact that the therapist, or a researcher for that matter, is human; such a view, therefore, has the potential to reduce any interaction to a mechanistic or a robotic one.

Thus, perhaps so-called non-contamination of the data can never be fully achieved. This is not to say that we should stop trying; on the contrary, this should constitute a continuous process, and we must aim to work towards it. Perhaps, the main issue is to know what to do or not to do with our assumptions; thus acknowledging that the researcher's values may be an inevitable part of the research process, and therefore, should be extensively discussed. Such also avoids dogma of an interpretive activity and cultivating tentativeness and creative uncertainty seems to be the most tenacious aspect. To me such a process essentially entails listening to the story, all while listening to oneself hearing and interpreting the story. Such an approach is aimed at transferring my therapeutic skills onto the data analysis. As Adams (2001; p.83) pointed out, '*the future is not in phenomenology, but in the way we do phenomenology with each other'.* Thus, I ensure that I have kept an open mind and continue to explore reflexively, in my role as a researcher in this investigation, where meaning and knowledge are co-constructed. In order to be aware of my pre-existing biases and those that emerged during the course of the research, I have fostered a constant reflective stance and kept a reflexive journal. This process aimed to substantially limit the unmindful tainting of the findings with my views and history.

2.9.1 Ontological and Epistemological Awareness

Although the methodology of this research project has been considered and identified, it is also argued that as a prerequisite, the researcher ought to be mindful of their own ontological and epistemological position, 'philosophy' or personal 'worldview' (David and Sutton, 2004). Perception of the world is certainly coloured by individual and historical factors, as well as by the very concepts that are available to us. In this respect, I must admit I am rather reluctant to strive to describe myself as adhering to one particular worldview, although I do acknowledge that having one may be necessary from an evolutionary, sociological and psychological angle. Thus, on the one hand I perceive the concept of identifying with one ontological position as potentially reductionist, on the other,paradoxically, not choosing one defines my very position on the subject and in many respects it could be concluded that it is in fact realist philosophy (a golden mean) that mirrors my relationship with and to the world.

Thus, in essence, as a practitioner, researcher and an individual, I do adopt differing ontological perspectives or ways of viewing social reality. The phenomenon observed very much depends on the position of the observer and every stance has its purpose and its limitations. I acknowledge that a positivist view has problems of objectivity and absolute reality and that relativism carries issues of validity. Not all social phenomena can be directly observable; however, it may be possible to make causal statements about differences between external and constructed reality. Interpretation and an insider perspective is crucial in order to gain an understanding of inter and intrapersonal relationships, to seek the answer to the important question 'why'. It is not merely about knowing, but also about meaning and not denying the very occurrence of appearances and dichotomies. Thus, it is important for me to 'rely' on an objectivist stance when deemed necessary. It undoubtedly forms my theoretical knowledge base, however always with an evaluating eye that questions the very notion of 'truth'. Just as a critical paradigm exposing power relationships, I highlight that 'reality' can be directed and created by social biases. The concept of truth is, therefore, disputable, and I may, therefore, agree with pragmatism by pointing that at times 'truth' may be what is useful. This does not mean that I would abandon striving to get closer to what may constitute 'the truth'. On many levels, I lean towards the approach in which knowledge is theoretically and discursively laden. I believe that such a continuous quest for exploration, understanding and therefore questioning is intertwined in this portfolio. Overall, I embrace multi-modalism, integration and pluralism, ambivalence, uncertainty, the unknown and contradiction that I believe best reflects the very complex nature of our existence and our position in the world. On a final note (also of paradoxical quality), as Charlie Dunbar Broad noted - being 'non-scientific' does not always mean being 'un-scientific' after all (Broad, 1958, p.103).

CHAPTER 3: RESULTS

3.1 Overview

The purpose of this qualitative, interpretive phenomenological research is to explore the experience and the meaning derived from being in a closed in-patient psychiatric ward under section from the perspective of former patients who were experiencing psychosis at the time of their hospitalisation. The research also aims to contribute to an understanding of how such lived experiences may impact on one's well-being and recovery process. The research question is - '*How do individuals experience and make sense of the involuntary treatment in a closed psychiatric ward and how it impacts the recovery process?*'

Thus, this chapter constitutes an attempt to present an answer to that question and an endeavour to do justice to the accounts as grounded in the data obtained from interviews with six individuals, about their views and subjective experiences. The basis of this chapter is formed by the presentation of the master themes and their clusters/subthemes as relevant to the research topic. A master table of superordinate and subordinate themes is also developed (Table 2). Master themes and their constituent superordinate themes are outlined, interpreted and discussed with each theme illustrated by the verbatim from the interviews. The chapter concludes with a brief summary.

Interpretative Phenomenological Analysis (IPA) of the six semi-structured interviews resulted in the emergence of four master/super-ordinate themes. These are as follows:

1. *A Struggle for Recognition*
2. *Terrifyingly Out of Control – Striving for a Sense of Agency*
3. *Transformation and Loss*
4. *The Comforting and the Sanguine*

Table 2: Master Table of Superordinate and Subordinate Themes

Superordinate and Subordinate Themes	No. of interviews in which the themes occurred
1. A Struggle for Recognition	6
1.1 The Abandonment and The Falling	6
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The findings of the current study reveal that an involuntary care on a psychiatric inpatient ward is experienced and conceptualised, especially initially rather negatively. Thus, the themes that centre on such negative components are presented first and then followed by the ones that list the positive aspects of the experience. It is pertinent to recognise that the above themes represent only one possible account of the experience and that the descriptions mirror a subjective interpretation of the researcher and other researchers might have focused on different domains of the narratives. The illustrations of the themes are chosen in order to capture the essence of the accounts and according to their direct link to the research question, however by highlighting and commenting upon the areas of divergence. Furthermore, the necessity to understand the depth of the narratives in this study is reflected in the length of the current chapter and thereby deemed justified.

Minor alterations have also been made to the verbatim extracts presented in order to enhance their readability. Missing material has been demonstrated by dotted line within brackets (…) and added material, not infrequently elaborating what was being referred to and presented within square brackets [….]. Finally, any identifying pieces of information are removed or changed, and the alias names used in the method chapter are maintained to protect the anonymity of the participants.

3.2 Superordinate Theme One: A Struggle for Recognition

The master theme *'A Struggle for Recognition'* emerged in the analysis of all interviews and therefore constitutes a common thread in the experience. This superordinate theme unfolded as participants described experiences that seem to have been characterised by a difficulty in being recognised. In other words, it represents an overreaching struggle to be fully seen, heard or known for who one is. In this respect, the theme also reveals the pertinence of having one's needs identified and met. One subtheme named *'The Abandonment and the Falling'* was also established, which aimed to add additional value to the understanding of the experience.

Thus, participants frequently described facing a recurrent experience of not being heard and of one's distress and its context remaining unacknowledged. Such experiences were often portrayed as frustrating, as well as detrimental in nature. In some instances, even a desperate attempt for communication and cry for help appeared to be met with dismissal. Such seemed to relate to both psychic and physical injuries. For instance, Cait's account depicts traumatising nature of the ordeal of physical restraint, which seems to be intensified by the experience of exposure and

vulnerability, triggered by perceived lack of understanding and support from staff on the ward. Here, Cait describes feeling ignored and shut off, in times of uncontainable anguish:

I didn't feel like I owned my arms or my legs (…) but I was aware they [the staff] were there but they were ignoring me when I was trying to say that I needed help 'cos (...) I felt very vulnerable and….the whole concept of…I guess it didn't help me 'cos having my trousers put down, I guess it's not nice for anybody but my past, for me that was just triggering and reminding and so I felt….(sigh/struggle)… I thought they were gonna do more than (…)…just inject, and I couldn't deal with that feeling, and I couldn't deal with those thoughts and (…)it was two male nurses doing one to one 'obs'…. (…) I woke I was kind of drooling from whatever I guess (…) but they didn't care..... nobody seemed to be bothered about the impact it has on you or how much it hurts…. (Cait, 45:1814-1832)

Similarly, Valerie contemplated upon her experience of desperately reaching out for help as her suffering and desolation seemed to have been invalidated. It appears that Valerie felt like she did not matter. Paradoxically, Valerie noted that she revolted to finding the support she needed. However, it was not always from the staff on the ward; a similar theme seems evident in the experience of other participants, as well. Valerie's description denotes the importance of the relationship with the other, the healing component of being listened to and understood highlighted in all the accounts:

*'I was desperate to talk to someone (…) I remember once spending six hours non-stop crying and (….) I resorted to ringing Samaritans, and they were brilliant (…)…I just wanted to be heard and…(…) and anytime I needed time (…) it was suggested to me I take one of those PRNs… anything but listen to me …. (*Valerie, 4: 121-152)

Annabel Alexandra, in turn, reflected upon her experience of feeling dismissed and treated almost like a child (not to be seen or heard and having one's maturity denied) or perhaps an invisible object, whose behaviour and presentation is merely evaluated and commented on, but whose opinion or expertise is not taken into consideration:

I remember those meetings and my parents used to come, and the doctors would be there (….) everyone was like…'she has been doing this today, I find that (name) gets to dada dada' …..[putting on a patronising accent], and it's like – I'm sitting right here!
(Annabel Alexandra, 14: 524-531)

The sense of *'trauma'* and *'betrayal'* was expressed by participant 888 (33: 1302-1305), who revealed painful disappointment from not being recognised as a person with own unique history and experiences. The sense of being de-individualised, invisible and non-existent (thus perhaps even dead on a symbolic level) seems to be captured by the following quote:

*(…) they were never doing it to me, they never saw me, I never existed (*888, 12: 475-476)

One of the most painful aspects of the experiences seemed to be related to the vicious cycle of being misunderstood and misjudged. Some participants reported that they were perceived through the negative lens and viewed according to the preconceived ideas as someone manipulative or even evil. In addition, many individuals reflected upon their experiences of being mistreated by staff and not being facilitated in basic care and therapeutic needs:

(…) Majority of them on that unit I just felt that they were just horrible and abusive and selfish and uncaring and…..(…)…it didn't feel at all like a therapeutic environment and…(long pause) like they didn't understand…kind of how I was feeling what I was saying, what I meant…umm and that everything I was saying was being misinterpreted or (…) they seemed to think I had malignant motivations (Sally, 8-9: 294-305)

Experiencing neglect was also noted. Buster, for instance, described a position of dependency and vulnerability due to one's psychotic distress and noted how, from her experience, the most basic physical care needs, such as '*to eat or have a wash'* as well as female related '*personal care'* was not being treated as a priority (hinting to staff preoccupation with medication and risk), which has dire consequences, related to exposure and further humiliation (Buster, 20: 754-772).

The current theme also includes references to stigmatising attitudes and treatment on the ward. In other words, being mute and lacking credibility is highlighted through this poignant exclamative statement made by Participant 888:

Because we're mentally ill, we don't have a voice! (888, 10: 407-408)

Participant 888 further conveys his experience of being on the ward by drawing on the following metaphor:

For me….you go onto a ward, and it's like being held by a throat on the edge of the cliff (888, 3: 120-121)

What comes to mind is the sense of being deprived the right for self-expression (as related to the symbolic meaning of the throat), feeling suffocated and muted, in

conjunction with the threat of falling/crashing or perhaps even some sort of death on a symbolic level (possibly a death denoting a state of constraint, disconnection from one's feelings and therefore an inability to *be*).

Finally, all participants conclude that the hospitalisation in general or most aspects of it, were neither truly helpful nor conducive to their recovery process (providing an indication of unmet needs and sense of being let down). The essence of this is demonstrated by the following extract from Cait's interview, which suggests that the treatment is often experienced as adverse and like an imprisonment:

> *Instead of it being a place where you feel like you have been healed or helped you come away feeling you've escaped (...)* (Cait, 3: 94-98)

3.2.1 Subtheme One: The Abandonment and the Falling

The present subtheme addresses the sense of isolation and abandonment, which emerged as a recurrent phenomenon among all participants in the study. Thus, the theme draws upon common ways in which individuals described their feelings of being left alone and to own devices, while being in the ward and what felt like an abrupt discharge or lack of adequate after-care, which in many cases resulted in deterioration of one's well-being and distress (referred to as *The Falling* by the researcher).

In some instances, however, definition and meaning ascribed to the word and sense of abandonment varied slightly between participants. For instance, Valerie describes herself in the ward as belonging to the category of '*The Forgotten People'* (Valerie, 6:215) or as researcher then refers to as *'The Unfaceable'* (as Valerie stated that none of her friends could *face* visiting her on the ward), which is further captured by Valerie in the following quote:

> *'The abandonment for me was the biggest thing (…..) feeling of being abandoned in there by the staff, the people on the outside…* (Valerie, 16: 604-606)

Abandonment is viewed as an essence or the worst part of the entire experience. It is also outlined by Sally, whose denotation of abandonment was deemed as somewhat more expansive and specific, as she describes the profound and utter isolation she experienced, as frighteningly exposed and unprotected while at the mercy of staff supremacy in the ward:

If I really think about it underneath is just that feeling completely abandoned, these people [staff] can do whatever they want to me umm… (…) just in that moment….when you know that person can hurt you or is hurting you and there is no one there to help…(…) yeah just feeling profoundly alone, left to deal with that on my own, with absolutely no resources that I can use to help me, nothing I can do myself (…)….so I suppose in terms of those particular memories about hospital that's the kind of essence of it… (Sally, 25-26: 959-979)

Furthermore, participant 888 described his experience of a closed ward as *'an abyss'* (888, p.13, 503) which makes one ponder upon symbolic meaning of such depiction, as related to the perhaps bottomless chasm, void, nullity, depression (*The Falling*) or terror. Such emptiness and boredom, intertwined with distress (here possibly evident through the description of '*pacing'* specifically), as well as the sense of abandonment and identification with loneliness, may be represented through the following extract, which appears tinted with tones of sadness:

We're just like, you know 'cos all you do is pace 'cos there is nothing, nothing to do, (…) there will be no staff anywhere (…)it's just this empty cavernous space (…) one patient sat there by themselves, they all hurdled in the office (888, 11-12: 449-455)

Buster, in turn, captures her sense of abandonment by comparing her experience of the ward to an exile or banishment:

It's almost like being in the boarding school with nothing (Buster, 44:1686-1687)

Abandonment, as linked to 'The Falling', has been characterised by many participants as the experience of an abrupt or premature discharge, triggering a state of vulnerability; being 'dropped' to reality, which subsequently becomes too overbearing. Thus, for instance, Annabel Alexandra (46: 1724-1730) pointed out that her experience was '*quite negative'* as she noted: '*a lot of it was down to myself being better'*. Feelings that hospitalisation was not helpful are prevalent among participants. Annabel Alexandra's reflections on discharge also illustrate how this can have a potential in raising feelings of un-containment and loneliness on what seems like an incomplete journey towards recovery:

I just felt like I was on my own after I went out the hospital… (Annabel Alexandra, 46: 1724-1730)

Discharge is a time when one has to deal with and process, at times the debilitating impact of hospitalisation. This recurrent theme is demonstrated by the following, vivid description by participant 888:

*When I leave the ward, it's just like 'someone helps him to the taxi….[accent]' – no care plan, no nothing, so I sparrow down, (…) I was praying for death; I was so (…) I would wake up in the morning – fucking hell I'm here again! (*888, p.16, 638-643) *''so the impact of being in the ward is afterwards, and it normally takes several years to recover from that impact* (888, 30: 1193-1194)

3.3 Superordinate Theme Two: Terrifyingly Out of Control – Striving for a Sense of Agency

In essence, the second thematic cluster aims to capture the recurrent theme in all participants' accounts - the experience of powerlessness and/or entrapment in its various manifestations and frequently an attempt to restore the control and autonomy that individuals felt deprived of as a result of their involuntary detention.

The theme also signifies experiencing an infusing sense of threat and vulnerability and highlights the components that seem to indicate the occurrence of trauma at the core of the very loss of control. The theme composes of four preliminary categories: *Living in fear*; *Deprivation and re-attainment of power*; *The battle and resistance – under attack and refusal to submit*; and *The absurd.*

3.3.1 Subtheme One: Living in Fear

The subtheme '*Living in Fear'* refers to the experience of feeling unsafe in the ward even at times when, paradoxically, one feels that sectioning provides a refuge that safeguards from exposure to potential danger of some sort. In addition, the theme sheds light on the existence of parallel processes, whereby the sense of insecurity expands beyond the hospital treatment and continues to impact one's life and choices. In this respect, the theme represents the traumatic or re-traumatising nature or elements of the hospitalisation, as emerged from all the participants' accounts in the study.

Participants often accentuated experiencing a lack of safety, as the ward often felt unsettled and chaotic. For example, Buster (9: 316-335) commented how '*quite often*

there is a slam down' on the ward. Feelings of insecurity and of being '*genuinely scared',* were at times linked to being exposed to *'unpredictable'* (Annabel Alexandra, 2: 53-56), *'aggressive'* (Buster, 9: 316-335) and disturbing behaviour of fellow patients. For instance, Buster (9: 316-335) recalls '*a guy who humps the walls'.* Buster also explains that although hospitalisation is meant to warrant safety, it does not necessarily mean one *feels* safe. This subjective experience is shaped by the mirroring and the vicarious processes, as it is not only what happens to oneself but also what one witnesses happening to others (being restrained and injected) on the ward, which can have a profound impact on one's well-being and corrode one's endeavours towards inner calmness, strength and general recuperation. These feelings of constant apprehension, sense of walking on eggshells and being confronted with somewhat unceasing and perhaps even growing a sense of uncertainty and elusiveness in relation to one's position of safety on the ward can impede one's recovery process. This has been captured here by Sally's description:

Even when you were treated badly or neglectfully you see other people being treated like that…umm, so it's like I maybe ok and safe (…) right now but who knows what's gonna happen next (…) so that added to that sort of fear umm (…) and I was more vulnerable and less able to deal with symptoms of my mental health… (Sally, 36-37: 1416-1425)

This looming and impending sense of threat on the ward is associated with feeling profoundly vulnerable, unprotected and defenceless in a world with no rules of law or legal repercussions. This is elucidated by participant 888 (46-47: 1840-1848) who envisioned an inconceivable scenario where *''several nurses can rape you'* and *'nothing would happen''.*

All participants reported experiencing some form of the scarring incident on the ward. However, for some the entire experience has proven to be deeply traumatic or re-traumatising, as the events and the meaning derived tapped into the material of their painful childhood. In other words, it re-opened an old wound by eliciting similar *feeling tone complex*, reminiscent of past traumas and left one haunted by new harrowing memories on top of the old ones. Valerie explains:

'I witnessed a hmm…an assault in there on hmm a young girl (…) and I still get flashbacks of that because it reminded me…I suppose of my childhood really (…)…when I was about six (…) I witnessed my father beating my older sister around the backyard with the spade, and she would be all black and blue marks around her stomach and me sitting inside feeling powerless and feeling I should help her (….) I had exactly the same

feeling when suddenly hospitalised; I wanted to help this young girl but I couldn't (…) (Valerie, 2-3: 66-94)

Valerie (3: 94-102) also reports having flashbacks of being ''*restrained and manhandled*'' on the ward and describes her experience as not only something that will never go away but also the most '*terrifying*' (3: 94-102), which is captured by the following reflection:

Horrific, it really ….it was worse that when my parents died….or anything, it was just the worst experience of my life…most difficult for me, painful hmm….. (Valerie, 17: 645-649)

Participant 888 also drew a powerful connection between his experience of the ward and his traumatic past. Child rape analogy that 888 relied on is redolent of being put in a position, where one has no control over one's body in particular (i.e. being and feeling utterly powerless) thus signifying forceful, penetrating, intrusive and invasive nature of the ordeal that tends to evoke feelings of shame and degradation. However, it is also reminiscent of one's vulnerability of being exploited and a violation of trust that is placed on the caregivers:

(…) for me, it's a repeated experience of being raped as a child by my mother and my grandfather Hmm it's almost exact gestalt of the child abuse environment (888, 5: 196-198)

Buster, for instance, compares her ward experience to being in a castle. Metaphorically, a castle represents a place of safety; it is, after all, a symbol of strength and power, as well as help as it is meant to offer protection from the outside world or oneself just like the wards (i.e. asylums) do. However, paradoxically a castle can also cause imprisonment for some, and as Buster elucidates, it is also a place of torture, which demonstrates power exertion/coercion and submission, as well as a state of being victimised and perhaps even punished:

I would say it's almost like a castle (…) but just because it's hmm almost like I suppose a place of safety, but then I don't, and also I suppose I think people get their heads chopped off from castles (laughs) maybe I'm thinking a torture place as well, I do think of a locked ward as a place of torture from (…)...having people hold me down and things like that…(Buster, 46: 1764-1774)

Buster making a striking remark related to torture and heads being chopped off from castles seems reminiscent of pain in the face of something one fears. However, decapitation is also symbolic of an act of public theatre of punishment and

humiliation. Losing one's head (head as being a pinnacle) is also symbolic of becoming disjointed and out of balance, but most importantly, it is an emblem of a deep wound or death (for Buster this might have been indicative of a loss, which will be expanded in the next superordinate theme). Identifying striking similarities between accounts, it is pertinent to note that Buster is not the only participant who spoke of torture; participant 888 also made a few references to the ward being '*a torture environment*' (4: 140-141, 13: 532-533, 51: 2025-2030).

The final component of the current theme makes reference to '*living in a permanent state of fear*' of losing control (Buster, 40: 1549-1552) in the aftermath of being sectioned. This sense of threat has its origins in the factors that intertwine both the ward experience and the psychosis itself. In other words, what becoming unwell represents now. Cait (12:485), who refers to her experience as '*hell on earth'* also noted that the scars from the wounds inflicted by the ward may never go away (29: 1180-1181) and that she may have to find a better way of dealing with them. Cait's experience seems to represent institutionalisation process, which after discharge presents itself as being ''*frightened to actually put the kettle on, in case it wasn't allowed*' *(*3: 110-111). Cait also explains how being traumatised by the ordeal manifests itself, not only by a paralysing fear of venue she had been hospitalised in but also as an irrational, yet understandable dread of the prospect of staying in any hospital overnight, which on a symbolic level may mean being deemed and judged unwell, leading to the first instance of entrapment and loss of control. Thus, Cait is one of the participants that expresses her distrust of professionals and the system, which as she suggests may potentially have a detrimental effect on her well-being, as it impedes her ability to seek or receive necessary help:

(…) the thought of being in [general] hospital overnight was so bad, a fear of what if I go in and they won't let me out, I refused to have a general anaesthetic for my procedure (…) it feels like a silly irrational fear, but I understand where it comes from (…) so I guess those kinds of fears as time goes on as I get older I might well have to live with (…) (Cait, 28: 1147-117)

3.3.2 Subtheme Two: Deprivation and Re-attainment of Power

Significant parts of each interview tend to be linked to or centre on the issues of power and control, as participants often talked at length about their experience of powerlessness and the coping strategies they employed, which in some cases are aimed at making the unbearable bearable.

One of the interview questions drew on the concept of the magic wand ('*what would you do if you had a magic wand while on the ward'?*) and the response of participant 888 seems to have captured the essence of the ultimate sense of powerlessness, constraint and paralysing effect that might be elicited by one's position on the ward whilst under section. The fact that 888 struggled to envision the possibility of having some sort of influence on the ward seems poignant. Hands are not just symbolic of identity (here relating to the one's position/status on the ward perhaps), but also a choice, expression, strength and protection. The words '*no hands to wave a wand'* makes one wonder if, metaphorically speaking, they are cut off or bound – which may refer to being in an incomplete or deprived state, thus, referring to an experience of deep sense of injustice, whereby one is deemed helpless and in the hands of the powerful and omnipotent system:

It's pointless…it's the pointless concept, it's redundant, you don't have any hands to wave a (magic) wand, metaphorically speaking, when you're on the ward... (888, 46: 1831-1833) They're the ones with the magic wand! (888, 47: 1867-1868)

Sally, on the other hand, described a vivid and painful memory of being at the mercy of the all–powerful other, thus no longer being an author of one's life. Sally talked about the ward reinforcing the idea that she had no say in regards to what happens to her, her whereabouts or her body, which appears to constitute a traumatic memory and a frightening prospect, by which Sally continues to be haunted. The following extract illustrates this helplessness:

Every time I swallow a drug, I kind of remember that – the nurse standing there with a psychiatrist when HE decides whether to go ahead and restrain me to give me an injection or let me swallow this little cup so that one image that flashes in my mind (Sally, 23-24: 896-900)

Others, such as Valerie or Buster describe their subjective experiences of entrapment. Buster emphasises the loss of freedom that is associated with the denial of essentials of life as one is kept in captivity. Buster's metaphor seems to indicate that she felt oppressed and institutionalised, as well as degraded. Viewing herself almost like an animal on the ward may be reminiscent of inhumane treatment, Buster felt she was being subjected to, along with a sense of estrangement from one's status and purpose in life (as one does not belong to the cage, but is perhaps treated as dangerous or wild):

It's like (…) keeping an animal in a cage really… (Buster, 9: 342-343)

Valerie also captures her experience of entrapment as related to being concealed from the world and confronted with physical limitations thus perhaps feeling repressed and constrained, as well as losing some aspects of self, which transpires through the following account:

It felt to me as if I was locked away there, it felt like being in one of those storage lockers; that's (…) the only way I could describe it. (Valerie, 2: 54-56)

Storage locker, however, may also be symbolic of security that the ward might have provided and taking into consideration all Valerie's reflections on her experience of being sectioned – such component seems to be present and related specifically to surviving and being kept alive.

Some participants also highlight the patronising treatment they felt they received in the ward that made them feel like a child again (through denial of maturity and infantilisation). Thus, as a child, one is also totally powerless, helpless and depended on the other. Annabel Alexandra describes an incident in which she was stripped naked by the nurses, when she attempted to shower with her clothing on, as a result of feeling exposed and unsafe, which evoked a profound sense of powerlessness and humiliation, as well as led to a painful realisation of the power that the staff held over her:

It isn't fun that they've got all the power, but actually they literally have all the power, they can do whatever hell they want (…) just like you would with the baby wouldn't you (…) it's almost like (…) they did see you as a child, so they were gonna strip your clothes off in the shower (...) (Annabel Alexandra, 24: 889-896)

Valerie also talks about her experience of powerlessness, through a condescending treatment and a feeling that mirrored the position and drama of being a child. This – in conjunction with being degraded and having to submit and comply with authority, just like a child would be expected to do seemed to have led to the feelings of shame, exasperation and resentment:

And you do what you're told like a child…you feel like a child again and…even queuing up for a medicine that just sickened me…(…)….waiting and you dare not go to your room (…) (Valerie, 15-16: 593-598)

Some participants also reported experiencing a double bind situation or hitting a brick wall, despite one's efforts to overcome upheavals, combat injustice or influence one's situation, which is represented through the following quote which reflects 888's despair at that particular moment:

So I have to talk to the nurse… who assaulted me about the complaint I wanna make about the nurse who assaulted me….forget it. I just went back to my room and cried… (…) (888, 25: 1016-1023)

As it emerges from the data, experience of powerlessness can be frightening and an unbearable position to be in. Thus, many participants describe their struggle to regain a sense of control on the ward. Valerie (1:21), who noted that powerlessness was *'the worst thing'*, highlights how the prospect of ending her own life (in other words being in charge of it) was a source of consolation and a desperate attempt to maintain some power (Valerie, 16: 620-630). Sally reveals her distress resulting from not being treated as an equal, which is linked to having no control or input in the ward. Thus, her hurt and anger are conveyed through her rebellious and disruptive behaviours, such as wiping the names off the board, which seemed like an act of despair coming from a place of pain. Sally's frustration '*with lack of control*' also accumulated when psychiatrist said '*he would come, but then he wouldn't come,'* which led to her saying 'you *have to make an appointment to see me (….) 'cos I have (…) visitors coming'* which seems like an understandable demand that one is to be approached with well-deserved respect. Such endeavours, however, were only futile but also backfired through misunderstanding as Sally was then viewed as '*grandiose'* (pathologised), which further illustrates the ultimate and utter powerlessness individuals often described (Sally, 32: 1247-1258).

Buster makes an important distinction by pointing out that it is the locked ward that makes the experience horrible and scarring, not the psychosis itself (Buster, 42: 616-630). She recalls how appealing against her section was a way to resist the helplessness she was submerged in. She delivers a depiction that signifies the prevalent and overriding state of omnipotence as well as her own continuous grapple with the aftermath of such experience and its significance, and finally, her struggle to put into words or come to terms with the unthinkable it seems:

''I would somehow appeal against my section (…) and fail miserably every time (…) so when I was doing that I was trying to get some control, trying to get myself out and trying to work out what do I have to do, how can I help myself in any way, and…and realising I can't, I couldn't even go to the shop (…) I couldn't even do anything so…I don't; it's umm…it's almost like an impotent feeling, you just can't, there is nothing you can do, you can't get yourself out, you can't talk to anybody, you can't make yourself understood, You-you-you can't build relationship with anybody (…) I don't, I can't think of umm…I don't know…I don't know (laughs) I can't think…I don't know it's hard…'' (Buster, 50: 1927-1944)

However, Buster also describes a positive and meaningful occurrence, when the perseverance, thoughtfulness, creativity and initiative of her psychiatrist made her feel engaged and included in her care and empowered at the time of inner chaos, confusion and sense of ineffectiveness:

but then other time I would go in manic, and I would ask umm medical question, and he gets up on the white board and do it in like a manic style which was weird (..)…he's the only person who had ever done it but actually kind of worked as well (…) 'cos I felt like I did understand it (Buster, 37: 1404-1416)

3.3.3 Subtheme Three: The Battle and Resistance – Under Attack and Refusal to Submit

This subordinate theme is developed as some participants distinctly pondered upon their struggle and a fight with the hospital staff and/or the system. The current theme witnesses the use of language that has references to war or a battle. The theme also resonates the experience that is characteristic of the strong refusal to submit and accept one's circumstances and ordeal or fate. Thus, the theme continues to struggle with the issue of coercion and encompasses feelings of hurt and anger, as related to a deep sense of injustice or even oppression noted by some individuals.

Cait delivers a rather poignant metaphorical depiction when asked to paint a picture that best captures the essence of her experience in the ward. She describes it as an image filled with darkness, which can be symbolic of loss, grief, emptiness, wickedness (as related to the shifts in self-image), depression and fear and this interpretation appears to connect with the remaining themes that emerged from Cait's interview. Black colour is also reminiscent of the unknown as the absence of light points to invisibility and perhaps being hidden from the world. Thus, through this image, Cait clearly describes being under attack. It feels as if the picture represents her as a prey that portrays the story of vulnerability – in other words, a target that is being poked at, punished or even symbolically executed. Arrows are also redolent of penetration, as they constitute a potent reminder of hunting, war and death. Finally, both darkness and the arrow are also suggestive of power and authority that one is under:

I would probably paint lots of arrows because (…) I did feel like I was being just shot at all the time and there were lots of things that seemed to just… make you feel like you were being got at, or you know being misjudged and being treated the way I was; you feel as if people are literally taking hits at you… (...) It would probably be very black and just lots of arrows are attacking someone because that's how it felt at times… it felt being under attack. (Cait, 27: 1111-1119)

Participant 888 (30: 1199-1200), whose reference to being '*a tender prey*' draws a similarity with Cait's illustrations (as shown above), and depicts his resistance and refusal to submit to a coercive situation that is deemed unjust. Thus, participant 888 unfolded the following scenario, which although in the first instance may appear humorous, but contains a profound sense of pain and a desperate attempt to regain some control, which may have manifested itself in some retaliatory endeavours (knowing the rules and 'playing the system'). The account also conveys some anger and possibly hurt that bubbles through the surface. At the core of this excerpt, lies the injustice and pathologising practices, which 888 described being subjected and that led to an infliction of trauma (here restraint being categorised as an assault):

'cos as a child you can't oppose your parents, but as an adult, you can… so umm I realised after the assault, right okay gloves off, no fucking rules, fine we're gonna fucking play with you; I know when the emergency alarm goes off you have to fill in a report and you don't wanna do any work, you wanna sit on your ass and watch TV, so because they ignored the patient, I was like right (…) so pick a time when it's handover (laughs), 'cos they're occupied. So it's like right, up to that end of the ward there is an emergency alarm next to a toilet, you wanna take that one, yeah okay (…)I take this one it's right next to my room, so we set our alarm….(..) and they got bursting into your room, 'you pressed the emergency alarm?!' (with accent, shouting) – 'Oh and you called me mentally ill, did you see me press the emergency alarm? ' (888, 11-12: 438-458)

Some participants like Sally and 888 reflected upon their experience of the power imbalance and the dynamics that occur between them and the staff in the ward. Sally (who also reported on her continuous futile fight to get through to the staff in order to establish dialogue and more equalised relation with them) cogently concluded that her experience was that of a division that was characteristic of a conflict rather than cooperation (Sally, 18: 680-682, 28: 1055-1057). Participant 888 described his experience as being reminiscent of a battlefield as he realised that the staff-patient relationship on the ward had persecutory qualities that he had to shield himself from:

Okay I know what the rules are, it's you against us, not us against you (…) (888, 5: 195-196) (…) if you've never been on a battlefield, you've got no idea. (888, 18: 710-711)

3.3.4 Subtheme Four: The Absurd

This theme reproduces the common threads described by most participants - the paradoxical nature of the system and the manner in which the ward is operated, which individuals needed to adapt to. The theme focuses on the features of the experience that have been portrayed as unacceptable, incomprehensible and inappropriate. They were directed to a sense of dismay and risibility and at times also seemed to contain disturbing and warped elements. In this respect, the theme aims to capture the contradictory and confusing qualities and the inconsistency and rigidness of the environment and its rules. Finally, the theme links to the sense of being double bind and tapping into the experience of powerlessness.

For instance, both Buster and Valerie contemplated upon the parts of their experience in the ward that was classed as preposterous and described through the lens of the absurd and the thoughtless. Valerie highlighted the issue of being caught in the farcical process of satisfying bureaucratic administrative requirements rather than assessing the actual merit of the activities taking place. She pointed out how art therapy represented 'a box ticking' exercise that '*was a real insult'* to her intellect that brought her back to when she '*was four years old*' (Valerie, 19: 724-730). This denotes being treated instrumentally and with the lack of respect. In other words, there seems to be an experience of disparagement and absurd infantilisation that Valerie refers to – a sense of receiving patronising and inconsiderate treatment. Buster also recounted her memory and was reminded of the heedless and inconsiderate treatment she felt she was being subjected to. The particular incident she recalled suggests that it felt very derogatory and disrespectful to her and was centred on the sense of being neglected and not being paid proper attention (as well as being a burden to staff, as suggested by the words '*to shut somebody down'*). This probably resulted in indignation about the entire scenario:

> *Once (…) I was colouring with some colouring pencils, and they were all blunt (…) it's disgusting you just don't sit somebody down to shut them down with blunt pencils (…) sometimes I think there is not a lot of thought, there wasn't you know.* (Buster, 19: 725-731)

Some also identified their experience of the ward as instilling or adding to the confusion of the existing psychotic state. Buster (19: 722-723) pointed out how some clocks '*never told the right time'.* In this respect, one may further wonder about the mirroring and the parallel processes; perhaps the system is depicted as unwell, troubled or disconnected in some way and therefore contains some psychotic elements on a symbolic level, as illustrated by the following:

You know the ironic nature (…) the TV room had a sign saying 'Smoking Room' and the Smoking Room had a sign saying 'TV Room'… and I said this is absurd! (888, 44: 1722-1726)

Some participants reported being placed in an anomalously inconceivable context that appears not only paradoxically twisted and warped, but also characterised by a double bind and a no-win situation, where one's efforts or actions can easily but unexpectedly backfire. For instance, Sally (37:1448-1452) recalled her dismay when she informed the staff that a fellow patient had been involved in an incident and it was interpreted as *'interfering with the others patient's care'.* The existence of the distinct and incomprehensible implicit rules has also been highlighted by this incident. Sally (9: 322-325) further recounted how a member of staff was *'told off for being too soft with patients'*. An expectation that patients should be approached more coarsely and with unbendable attitude is '*ridiculous,'* but at the same time part of the world, one becomes accustomed to. The following extract further illustrates such phenomenon of an inverted mountain:

You put yourself in the crazy environment when you're being abused….you say hey…you know if this happens to you on a tube or a bus, you stand up and say- this is unacceptable! But in a psychiatric unit, this is considered to be a symptom of an illness… (888, 26: 1025-1030)

Furthermore, Sally's account captures a common experience among participants that pretence and false compliance seems to be the only plausible way out. This seems to signify the paradoxical, but also sad and an alarming survival strategy that may be employed by some patients, which are antithetic to one's well-being and recovery process:

If you want to get out of here – you just need to tell them whatever they want to hear… (Sally, 18: 661-662)

3.4 Superordinate Theme Three: Transformation and Loss

In essence, the current master theme captures the process of change. It relates to participants' experiences that encompass any significant shifts, both internal and external, that occur as a result of their involuntary admission to a psychiatric in-

patient ward. The theme also attempts to demonstrate the mechanism through which the meaning is derived and re-constructed. At its heart, the theme aims to represent a journey that led to an altered relationship with oneself, others, one's future and the world. It embodies transformations in participants' subjectivity and behaviour, which includes perceptions and feelings that are distinctly elicited by their experiences in the ward, some of them signifying an ability to adapt warranting psychological survival. The theme also demonstrates the process of mirroring and internalisations and centres on interpersonal dynamics and their significance. In other words, it relates to the importance and implications of how one is perceived and treated by others. Consequently, it denotes a process of becoming a different entity and of becoming bereft – that is, losing something of great pertinence and substance. At the core of the current theme lies a sub-theme, '*Losing Oneself: Self and Identity Redefined,'* which forms a quintessence of the phenomenology associated with being in a closed ward under section that emerges from participants' accounts in this study. It seems to reach the greater depths of the experience by illuminating how it can contribute to a shift and reorientation in one's sense of self.

Finally, the current theme is composed of six preliminary categories: *Disillusionment and Distrust; The Punishment – Attribution of Blame; Losing Oneself: Self and Identity Redefined; Hopelessness, Meaninglessness and Fatalism; Facing Shame and Stigma; The Confusion.*

3.4.1 Subtheme One: Disillusionment and Distrust

The current subtheme is essentially concerned with the experience of disenchantment and a betrayal of trust. Most participants in the study described either a precise moment during which some sort of rude awakening transpired, or talk about a process that led them to an expanded vision and the world stripped of illusions. Such process frequently involved having expectations and hopes dashed and a crude realisation of one's position, which ultimately resulted in an altered world view.

Cait (26:1057-1058) mentioned how her disillusionment related to a realisation that ''*people that you've just arrived to, were going to look after you, don't understand you….*''. Cait described a precise moment during her first restraint on the ward that resulted in a state of bewilderment as she encountered the painfully incomprehensible. Such experience consequently unfolded a rude awaking in relation to one's pervasive position of powerlessness as Cait's (46:1855-1869) '*entire image of hospital staff changed within seconds'.* Sally, for example, elucidated how fundamentally drastic and turbulent her ordeal was. She noted how she had initially believed *'staff were angels'* (2: 62) and explained how her expectations that she would

be well looked after disintegrated completely. It seems Sally's relationship with authority was reconstructed as she became weary of professionals, no longer felt safe in the world or had faith in the concept and implementation of justice. It also appears that Sally arrived at a frightening realisation that the rights she regarded as integral and untouchable to her existence, are in truth untenable, groundless and elusive:

Turning the world upside down, this level of upheaval, it was everything you know… my previous expectations of how I would be treated by (…) were completely dashed by the way the staff were with me, my beliefs how, what rights I have in society (…) I don't know you can just be put in prison without a trial and repeatedly assaulted, which was what it felt to me like at the time (…) (Sally, 30: 1162-1169)

Annabel Alexandra's moment of disillusionment unravelled during the interview, while she was exploring her experience of having been stripped naked by the nurses in the shower. Her recollections of the ward contained patchy and hazy memories. At times, she also painted a mixed picture that consisted of contradictory components she struggled to reconcile with. The following excerpt demonstrates how, for the first time, she clearly discerned the darker side of her experience, which was centred on the severity, impact and meaning of the shower incident, as she allowed herself to connect to the pain that seemed to have remained locked within:

[Silence] I don't know it's just a bit weird [emotional]…. Maybe because at the time [holding tears]… I didn't get upset (…) but now – shit it was quite awful…… [Emotional] but I suppose that's what I mean how it comes back a little bit (…)….but now it's not very funny…. (…) [Reaches out for a tissue; laughs nervously] Yeah I suppose so [cries briefly]…. I think it's like what's come out just discussing it a bit…. (…) I suppose it's been worryingly awful and I kind of forget…because you just wouldn't wanna be vulnerable would you, you like oh my gosh…… (…) (Annabel Alexandra, 26-27: 994-1017)

Finally, participant 888 provided a horror movie analogy that conveys the experience of the betrayal of trust, whereby a rescuer (the system) transpires to be the perpetrator. Perhaps running through the woods symbolises a place of darkness one is desperately trying to escape from, distress and vulnerability of a psychotic breakdown. Furthermore, it appears that meeting a rescuer is equivalent to being placed in the ward for safety and recuperation. Ultimately, one's 'naivety' is pitted, as it turns out that one has been deceived and entrapped (here embedded by the cabin in the woods) and that the treatment received is ultimately traumatic and iatrogenic.

Again, there is a painful realisation that one is no longer protected and therefore, silently in a dangerous situation, while appearing sheltered to the outside world:

Because there is that betrayal of trust, it's like those horror movies where you know the a woman is running through the woods and she meets the guy who appears to be a rescuer and as an audience you feel a sense of relief and then he says don't worry, I've got the cabin nearby, and she gets in and then there is this awful sense of dread, oh fuck this person isn't the rescuer, it is the perpetrator (….) it's sublayer of powerless, it is being abused by people who have legal responsibility (….) (888, 8: 306-317)

3.4.2 Subtheme Two: The Punishment and Attribution of Blame

One of the themes that emerge from the data relates to the presence of punitive components that seem to have been triggered for many participants in this study by being sectioned – either through the fact that one had to be arrested, to begin with (which also might have set a foundation for the entire experience), or mostly by one's relationship with members of the staff on the ward. Thus, a current category, in essence, connotes the sense of being treated like a criminal; as if one has done something wrong. Throughout the interviews, participants frequently drew on a prison or even execution analogies and used language that resonated with experiences related to the trial, condemnation and imprisonment.

Some participants described the experiences of being punished and penalised by staff in the ward. Buster (48: 1862-1867) explained how during restraint '*some nurses do it to a gentle degree and some do it to hurt you'.* Sally's excerpt also, disturbingly, seems to denote retaliatory and sadistic undertones that have been portrayed through the staff-patient interactions in the hospital and how participants, at times subjectively felt:

Sometimes I would have just kind of be punished by the staff… sort of irritating them… when they wanted they would lock all patients in the rooms and they, they would sit and play card games with each other…and you're not allowed to get out (…) into the living room or anything (…) (Sally, 7-8: 263-269)

Participants also highlighted how they felt that the ward did not always foster an atmosphere that conveyed caring and nurturing, but rather a sense of being watched, judged and treated with coldness and suspicion. For example, participant 888 (34: 1326) compared himself to being a Joseph K. character from 'The Trial' novel by F. Kafka. Valerie (19: 762-764) in turn, indignantly reported how she perceived nurses to

be more like the police or referees. Buster (48: 1827) revealed feeling like a criminal as she compared some staff to jailers and described how they exerted their power over her and displayed aggression through their actions or body language. She depicted her experience in more detail through the following account, which seems to convey the sense of being treated worse than a criminal and subjected to an aggressive treatment, even though vulnerable and innocent. She makes reference to a sense of injustice and the inexplicable facets of the experience:

(…) a lot of them are big tattooed guys you know, they look like bouncers, they don't look like nurses, they look more like people that you would see in jails (…)and I remember this guy had like a massive chain on with all his keys and he would do it in a like a very aggressive way, like constantly swing his chain (laughs) with his key – like he was a jailer you know (…) it's not reminiscent of nursing in any way, it's very much aggressive, you wouldn't, you probably would not see anybody in the bar being restrained like that (…)…that would be very extreme to see six people jumping on one person, especially male to female, and (….) I can really remember umm and not really understanding why they're doing it a lot of the times. (Buster, 47: 1790-1810)

Cait explained how the restraint triggered severely conflicted responses in her. On the one hand and a purely emotional level, it seems, Cait experienced restraint almost as a deserved punishment as it evoked in her profound feelings of guilt and shame. On the other hand, Cait experienced puzzlement and bewilderment as her logic assured her that she had no reason to feel remorseful and therefore be apologetic:

[after restraint]…[struggles] I guess (…) I didn't understand what I did wrong to get, to be so punished and I kept asking what I had done and apologising (laughs), which looking back is probably ridiculous (laughs) 'cos I don't know what I was apologising for… hmm… (Cait, 45: 1835-1839)

Cait (*11:421-428)* also elaborated how she felt '*worse than a prisoner*'. Having been stripped of one's rights and freedom, along with the judgmental attitude she was subjected to was interpreted and subjectively experienced as punishment for being '*a terrible person*'. It seems that the internal formula unfolded as 'I am treated badly, therefore, I must be bad'. Valerie provided a similar account related to the experience of one's inadequacy, failure or 'badness within'. Again, the meaning derived from being sectioned and detained in the ward seems to be centred on punishment. Valerie placed emphasis on the fact that the punitive experiences and their internalisations stem from her traumatic past. However, she clarified that they were re-awakened and fortified by ward experiences - the imposed constraints and the manner in which one might have been approached by the staff:

The system reinforces that with their behaviours, I mean that comes from me the idea that…because I haven't somehow managed to cope with life that is failing on my part, and I need to be punished 'cos that's what always happened to me when I was young (…) but then that message gets reinforced while you're in there with their behaviour, and it can be very simple behaviours like…hmm…taking your hair straighteners away from you (…) I'm gonna be punished more by the system… hmm…because….(…) I am a bad human being, I mean… while I was in there I believed I was evil; you know really pure evil… (Valerie, 30: 1172-1187)

3.4.3 Subtheme Three: Losing Oneself: Self and Identity Redefined

Overall, the current theme endeavours to epitomise pivotal self-transformations that all the participants alluded to, throughout their interviews. On the one hand, the theme incorporates experiences of degradation, objectification and pathologisation; on the other, it recounts the endurance of various losses that in some cases also seemed to have been manifested through the analogies and correlations, related to death itself.

Cait elaborated how being subjected to judgments placed constraints on her ability to express herself, which compromised her freedom to *be* and therefore resulted in a loss of authentic self. Perhaps, if one is unable to display one's emotions spontaneously and fully, one can also become disconnected from oneself – a state that can be akin to the death of certain aspects of the self. Thus, Cait elucidated how it no longer felt acceptable and safe to reveal one's true self to others and although such inhibitions allowed her to protect herself at the time of her sectioning, they no longer served her nor were conducive to her well-being, when out of the hospital. What Cait's description also seems to highlight is the damaging, as well as pervasive and enduring effect of her involuntary admission on a sense of self:

> *(…) you want to prove to the doctor that you are well 'cos you want to get out, so you end up …(…) putting a front on (…)...you kind of become this false persona (…) and you kind of lose yourself in that process, 'cos I lost the ability just to be, to just express myself the way I did before (…) I lost that ability because it became unsafe to do that and people made assumptions (...) and then you come out, and you're like it's hard to feel then you can express yourself again and…I think some of the things that happened when I was on my sections… kind of took away part of my dignity forever (…)* (Cait, 5-6: 200-219)

In the above excerpt, Cait also reported that her experience of the ward led to a loss of dignity that she may never be able to retrieve. Valerie, on the other hand, explained

how she had felt de-individuated (being assigned to the category of 'mad people') and therefore pathologised (i.e. deemed as lacking credibility), which shook her self-confidence and also resulted in a loss of self. Moreover, both Cait (as shown above) and Valerie's accounts illustrate that such experience has a potential of inducing permanent and irreversible changes in one's psyche and experience of the self:

I think these blanket rules (…) I am losing my identity, you know I'm the same as them, I need to be categorised with all of them…hmm…mad people but you know that can't be trusted and (…) you lose confidence in your own hmm beliefs… (…) actually you lose yourself while you're in there and it takes a while to get that back when you come out… (….) You know…would I ever be the same again? I doubt it. (Valerie, 21: 797-817)

Moreover, Cait talked in detail about the maladaptive transformations that occurred within her inner world that was gradually instilled by how she felt she was being viewed by others throughout her hospitalisation. She described the very process of change: from self-acceptance and self-compassion that was centred on seeking insight and understanding, to self-pathologising attitudes that located fault at an individual level. Cait explained how she internalised other's perceptions of her, and ultimately became a diagnosis. It seems that Cait's self-image had been shattered and drastically altered and consequently replaced with a subjective feeling of being *nobody*. Such derogatory and condemning relationship with oneself denoted that Cait felt like she had become a person of no value or authority:

(…) when I first got unwell (…) I had some idea what the reason was (…) and I kind of…could say to myself that is why I was unwell, and it was okay being unwell (…) but as time went on and the fact that more and more people ignored that, the cause, then you just become a label (…). I kept thinking that maybe that label, the reasons I was unwell were really insignificant (…) and it was all my fault that I was unwell (…)… because other people view you as label you can kind of end up viewing yourself as a nobody… (…) (Cait, 21-22: 869-890)

All accounts in this study point to the process of objectification. For example, Cait (44: 1802-1803) mentioned *''being treated like a piece of meat''* during the restraints and 888 (20: 798-799) referred to himself as *''purely an object in an institutional process''.* Sally, in turn, elucidated how she felt she was being subjected to an attitude of patronising superiority and division and not treated as a person in her own right. Sally (4:116-121) reported feeling '*completely equated with her illness* and noted that as a result she *'stopped being a human in a lot of ways'*. As such this captures dehumanisation process and a transition from a subject to an object to the label.

Furthermore, Sally (5: 164-168) explained that she '*could have been a rock or an animal or anything,'* adding she *'did not have any say in it'*. Such analogies denote vulnerability, helplessness and also perhaps being perceived as wild, untamed or uncivilised (or not worthy of being acknowledged). Sally's description seems to reveal allusions of being subjected to an experiment and feeling like a creature to be observed and owned (or enslaved?), an object divested of free will that can be obtruded upon or even something akin to being a peculiarity. The rock may signify inanimate or lifeless state (deadness?) and feelings of inferiority and being approached as having no value or even soul:

I felt like I just became….an object for them to kind of impose their…..ideas of what they thought should be done (…) not engaging as kind of subject like a human but as sort of observation of this is what WE think, this is what SHE thinks (…) (Sally, 4: 127-133)

Participant 888, in turn, delivered a disconcerting description of his specific experience of being disregarded, degraded and even dehumanised by a staff member's actions. He described an incident that made him feel as if he was being equated with a contagious disease or embodying an evil entity that others have to shield themselves from. 888's depiction conveys, understandably, a deeply inflicted wound and consequently an appeal for a humane and respectful treatment, which however appeared to have been met with contempt and dominion:

(…) an agency member of staff came onto the ward (…) I've never seen him before (…), he didn't speak to any member of staff, he didn't speak to any patients, he went directly with his newspaper to the linen cupboard, took out white sheet and put it over the chair and sat down and began to read his newspaper; so I approached him and asked him for something in the office, he goes so I pulled the white sheet out and I said you know 'you can't fucking catch the mental illness from us, it's not a flu, we are not demons, treat us with some kind of humanity'! And his reply to me was: 'Yeah, I have the power, not you' (….)' (888, 10: 292-403)

When asked about the feelings that such an experience evoked in him, 888 proceeded to clarify:

What does it feel like? You know when someone's died and you cry for days? That's what it feels like. If I knew you well enough Anna I would've shown you what it feels like but I don't know you well enough and to be honest, I've got to get on with the rest of my day… (888, 10: 420-424)

The answer provided is indicative of the severity and intensity of the distress and desolation that was triggered by such an ordeal and which had a profound impact.

Thus, it appears that allowing oneself to uncover and fully connect to such pain does not feel safe as it would expose one's vulnerability and prove to be too unsettling, if not unbearable and uncontainable. Yet, 888's elaboration also suggests that being dehumanised and degraded can be experienced as the death of something or someone precious and significant in one's existence, something that on a symbolic level constitutes a part of self and one's identity. It, therefore, seems – it is a moment where the self, as one has experienced and discerned it in one's own eyes and through the eyes of others so far, all of a sudden becomes annihilated and obliterated; a moment where the period of affliction and mourning begins.

Another example that captures the experience of degradation and sense of ultimate worthlessness is demonstrated by another of Cait's narrative. Cait alludes to having undergone an internal shift that manifested itself in some sort of de-selfing and self-estrangement. In addition, she suggested that having no rights and privileges that once were so integral to one's existence automatically stripes one of their humanity and reduces one to a mere object that is deemed below the value of garbage – perhaps to be ridden off and thrown away and completely disregarded. She therefore may be indirectly posing an important question - what fundamentally constitutes and embodies our humanity, what it means to be a human and what makes us who we think and feel we are. Perhaps, she felt not only given up on but also undeserving to uphold a certain status. Perhaps Cait felt she was to be looked at with contempt and disdain. It also may seem that one is not only totally depraved but also erased and becomes equated with nothingness. Along with degradation and debasement, there are experiences that are filled with humiliation and related to being invaded and violated:

> *(…) it made me feel that kind of sense of being worse that a prisoner (….)I felt like I was an absolute worthless piece of rubbish hmm…(…) at some point I wasn't even a piece of rubbish 'cos I felt as if wasn't worth picking up 'cos (…) it just felt so kind of judgmental (...) and I used to think that I could see how people judge people being in prison (…) and for me I was sitting there and thinking (…) I am worse than that because I am here now and I have no rights, and I have no voice and (…) I am not entitled to access what I want, I'm being watched to go to the toilet (…), and I'm being watched when I sleep (…) and so I felt degraded…(…) I was just (….) the lowest of the low…(…)* (Cait, 12-13: 485-516)

Sally also explicated how she found herself in an overwhelming bewilderment about *how to be* after one of her hospital admissions (as the subsequent one proved to provide a needed corrective experience in the domain of self-belief). Her depictions highlight the twisted and the warped, whereby the mistreatment has become equated with care, as all her objections were categorised as a symptom of her 'illness'. Sally

described how she had suffered a blow to her self-confidence and lost ability to validate her subjective experiences, which resulted in an impeded capability to respond to 'red flags' in her future relationships for some time after the hospital admission. The severity of the self-doubts she incorporated from others around her became so intense that at some point, Sally seemed to experience a state of dissociation, reminiscent of derealisation and identity confusion:

(…) at the time you can be saying you know –I don't like the way I'm being treated or whatever but everyone around you wants to say 'well this is the best place for you' (...)well that's not sort of a subjective experience at all... and…so that in itself made me kind of really doubt my own perception of what was happening (…) of course having a diagnosis as well (…) and that kind of extended above being in a hospital (…)actually I mean it was so bad at one point, kind if that my confidence was so completely crashed that I sort of look around and feel almost surreal, kind of can I believe anything I am seeing (…)….because I felt like staff could do anything they wanted to me, or that they could speak to me nastily, but I was constantly they were caring and (…) maybe it's just your illness… (Sally, 9-10: 324-363)

Some participants also highlighted how the medication they were given in the ward drastically altered how they felt. Some like Valerie (19;719-721) or Annabel Alexandra (32: 1181-1189) talked about being '*zombified*' – feeling numb or dead inside, merely going through the motions of daily living; while participant 888 (22: 864-873) used the word '*atrophy*' instead and talked about self-alienation and self-detachment as he explained how medication hindered his access to his '*emotional world*' and delayed his ability to process the losses associated with experience by placing him into a simultaneous position of '*living-dying'* or in other words degeneration and decay. Sally described going through some unpredictable and unexpected bodily changes that were medication induced and reinforced the idea that she no longer could rely on anything that was previously so basic, natural and stable and therefore taken for granted:

So it was just added feeling of…no longer having anything about myself that I can rely on…(…) you suddenly realise actually they can just give me a pill and it's all shifting sand (..) (Sally, 30: 1146-1156)

In hindsight and a metaphorical language, Annabel Alexandra perceived herself as a *drooping exotic flower* during her time on the ward. The flower in its uniqueness seems to be misplaced by being positioned in a mental institution and as a result, undergoes some sort of transformation, suffers some kind of a loss. The type of flower

mentioned is betokening many things: uniqueness, magic, spirit, luxury, singular brilliance, passion, lushness, joy and vitality, as well as blooming/growing potential. As such, it is symbolic of Annabel Alexandra's manic state at the time of her admission that throughout the interview was conceptualised by her in terms of freedom and exhilaration, a childlike state of bliss. The fact that the flower is drooping is indicative of its inability to flourish and therefore some deprivation and unmet needs. It appears that the picture Annabel Alexandra painted represents some sort of halted potential or a loss of specialness or freedom to be, loss of opportunity for self-expression and creativity (as the flower is also symbolic of a heart). Thus the flower or the *self* becomes inhibited and suppressed. The curving of the flower yet again is an allusion to ending and death, while drooping may also indicate a disappointment and a gloomy scenario, a falling and being pulled down. To place the flower metaphor in the larger context, it may be pertinent to note that during her interview Annabel Alexandra also referred to a loss of confidence and not being able to fulfil one's potential, which was a consequence she suffered from being unwell over the years. However, pointing out that it was the psychosis in combination with the sectioning that had such an impact (as opposed to other participants' highlighting that it was the ward experience itself). The following excerpt aims to support the above interpretation:

Maybe like a really exotic flower but like drooping down, so like it all special and dadada…, but actually is a bit…is not very happy…so…(laughs) (…) It's exotic because it's psycho-manic, so you think that you are like magical (laughs) …umm… but I suppose having to be put in a mental institution is a bit sad, yeah so maybe it hasn't got enough light and staff… so really if all the manic people have their own way they would just like run around and do their own thing (laughs).. but it gets curved very quickly. (Annabel Alexandra, 31-32: 1136-1174)

Buster's depiction almost resonates with kidnapping and robbery (belongings were taken away) imagery, with hints of being destitute through one's vulnerability and which leads to unintentional loss of personal property in the midst of one's psychosis. Buster describes a position of having no resources or means of subsistence, being completely impoverished, devoid and barren, which also suffices to the loss of parts of self and total nothingness:

I think if somebody took you tonight and took you somewhere like that and took all your personal belonging off you… (…) I lose all my personal belongings when I'm high as well, I can't even look after my clothes (…)…everything gets lost, or I give it away…so you actually lose every part of yourself, you know there is nothing (...) so it's almost like you don't have personal effects… (Buster, 43: 1655-1668)

Many participants also mentioned a sense of missing out on life's opportunities and events; lagging behind the world. Such sense of suspension, where one's plans and aspirations are put on hold and where one endures unforeseen or even violent interruptions to one's life was in detailed described by participant 888 (3: 127-139) and Buster, who talked about feeling misplaced in time and being left with blank and empty spaces to fill after the period of isolation and disintegration from the outside world. As one lives a life of oblivion for a while, the impact of being lagged behind only adds to other losses, and as Buster (42: 1633-1647) puts it, '*losing chunks'* constituting the great loss of *'everything'.*

3.4.4 Subtheme Four: Hopelessness, Meaninglessness and Fatalism

The current theme was common in the accounts of all the participants and their experiences of dismay and despair when it seemed that their dreams and hopes had been shattered, and life as they knew it has disintegrated. Frequently, participants revealed experiencing a sense of disbelief and a struggle to come to terms with the implications of their hospitalisation and/or a diagnosis, and many described a feeling of being doomed or as Cait (23-24:972-980) puts it - becoming *'a psycho patient'* who is in and out of hospitals all the time – with recovery that seemed beyond one's reach. The theme also makes references to the experiences of boredom and lack of activities in the ward which, as emerged from the data, often resulted in having no sense of purpose or meaning. Finally, the theme touches upon the challenges of bearing the unknown and uncertainty, in relation to one's discharge date.

Many individuals reported experiencing a sense of hopelessness. For some like Sally (34: 1300-1327), the context in which a diagnosis was received on the ward was intertwined with the negative impact of the hospitalisation and eventually seemed to contribute to a sense of doom and annihilation. Sally appeared to have experienced a sense of dread that her life is not only over as it approached its downfall, but will only be full of disappointments and upheavals; she feared she '*would always struggle'* with. Sally explained how she felt when she was conveyed a stigmatising and pathologising message by *'old school'* professionals that her efforts to alter her destiny would only be pointless and futile, which felt '*numbing*' and '*crashing*'. Valerie, in turn, while leaving hospital recalled being told by the nurse that she will *'probably revert to old ways'* when she went out*. 'No hope gave at all',* as Valerie (p.9, 331-337) puts it, in relation to embarking upon and maintaining one's recovery path. Having a chance for a fulfilling life was also an experience Annabel Alexandra described. It, therefore, seems that one's potential and capabilities have often been denied here, which encapsulated the fatalistic and a bleak prospect of the future or in other words a sense of being given up or being a lost cause:

It's occupational health, they try to get you back to…(…) she did try to set up all these plans to do and I was just exhausted from taking all these pills all the time, and (…) and I remember (…) she was like – there is no hope for you (laughs) (...)then next time I saw her I'd finished university and was in a job (…) and she was just like – I never thought that you would ever be able to do any of those things, and to me I found that really rude, I was like why on earth not? (Annabel Alexandra, 39: 1454-1467)

Some participants recalled responding with great sadness, sorrow and heaviness as they realised that their life became engrossed and associated with being in an in-patient ward; thus reflecting upon one's past aspirations and visions and having to confront what appeared like a reality that was now deprived of seedlings of hope and zest for the future seemed at the time almost indigestible:

you feel very sad that life has got to that (…)you wake up in the morning in this hospital how does it get to this you know, it's not what I ever envisaged for my life really… (Valerie, 10: 390-395)

Some participants talked about the difficulty of not knowing when their section was going to end and, like Cait, wishing that the roles were reversed, so that those '*who section people'* (Cait; 11:467-470) would experience what profound impact it can have. Such sense of meaninglessness and endlessness was experienced by many and as Valerie (17: 649-652) puts it evoked '*that hopelessness feeling in there,'* highlighting the need for *'a goal when you're going to those places'.* Finally, the sense of nothingness and ceaselessness surrounding lack of stimulation on the ward is conveyed by the quote from Buster's interview (8: 305-309), who reduced herself to being a *'plump waiting to see the doctor next week'* suggesting that one feels like a fallen, dropped object or a part of the mass that is merely existing, whose brain is left to rotten – a factor perpetuating madness rather than promoting a needed sense of normality:

When you have got nothing to do and the days are that long...I don't know how you wouldn't go mad (laughs) (…) there is literally nothing, nothing, next to nothing (…) it's very mind numbing even though you're not well (…) (Buster, 2542-2550)

3.4.5 Subtheme Five: Facing Shame and Stigma

Many participants in this study described how sectioning, and/or a diagnosis of mental illness created a mark of disgrace and therefore constituted a source of profound

humiliation. For some individuals, such shame was associated with one's ego-dystonic presentation during psychosis (and self-exposing behaviours), while others perceived their involuntary hospitalisation as a confirmation of some sort of defectiveness. In other words, an indication that one was not suited to the outside world. Still, others highlighted that their 'madness' was portrayed (for instance unmanageability) as a burden to the family or a deterrent and irritation for staff in the ward, at times even becoming a subject of revile. All in all, the theme captures the experience of stigma and taboo, as well as a sense of marginalisation and ostracization that in its various manifestations, seem to have resulted from individuals' experience of being sectioned.

Some participants pointed out that the experience of shame and stigma surrounding their hospitalisation, as well as distress expressions, might have contributed to their depression upon discharge. Participant 888 (45: 1794-1798) pointed out that one becomes 'a *damaged good'* as a result of sectioning. It seemed that the humiliation resulting from the experience could be so overwhelming that there is a need to shut off from the world afterwards, as illustrated by the following quote:

I think part of depression you get afterwards… it's all the shame and embarrassment because you can remember (…) things you've said to people (…) and it's mortifying, you don't want anyone to remind you of your craziness… (Buster, 6-7: 227-234)

Cait also talked about feeling disgraced and blemished in the ward, as well as continuously at risk of being subjected to judgments and prejudice as a result of being detained. She elaborated how being sectioned is '*a secret you want to keep'* and how the coercive aspects of the experience stripped her of autonomy, which to her meant that she had somehow failed at life. This left a lasting and profound impression on her psyche:

> *(…) I still feel that my sections are on my (…) my medical records and I know, I get the impression at least that some professional they automatically judge me because of that (…) because you are...I think ashamed of the fact that you have been sectioned because how it made me feel at the time…(…) for me it was like I wasn't capable of making decisions or taking decisions about me and that right was taken away from me… hmm… and I just feel that's kind of left an impact.* (Cait, 6: 214-248)

Buster (14:520-524) talked about feeling marginalised and rejected by others who saw her *'having an episode*' and realised that '*people (….) don't really like to get close to somebody with mental health issues'*. Buster also mentioned being underestimated in

relation to possessing insight while in psychosis and therefore described the pain of having been a subject of ridicule:

''…people think when you're manic that you don't pick up on any social-social things, you know somebody raised their eyebrows – 'oh she's you know'…. (…) (Buster, 34: 1294-1295)

Finally, Valerie elaborated how the inner feelings of being viewed as '*mad*' led to a profound sense of humiliation, which was also tainted by the derogatory stories about asylums she had heard as a child that was internalised to add to the self-demeaning and self-stigmatising attitudes. It appears that the meaning Valerie derived from her hospitalisation was centred on being a worthless individual or a misfit, whose behaviour was so extreme, unacceptable or even evil that she had to be condemned and forcefully removed from society:

You only lock people away that are no use to society really….either criminals or….people that are just….of extreme behaviours so…. Having that attached to you….hmm… it's always going to stay with you, you know that your behaviour was so outlandish that they had to lock you up, and I don't know whether that comes from my childhood because my mother used to give me horrendous stories about people being locked up in asylums and you know being brought up in Catholic Ireland (…) and…the asylum we used to call the mad house(…) so…. I suppose there is a feeling inside me as well… that you're mad, you're just mad… (Valerie, 15: 560-576)

3.4.6 Subtheme Six: The Confusion

The theme, as the name suggests, refers to the variants of confusion that the two participants, in particular, explored in depth, during their interviews. First of all, the confusion relates to entering a transformed state – namely a psychotic world, which in itself was portrayed as bewildering and confounding. Participants reported that the psychosis made them less conscious of their circumstances and the environment around them. However, paradoxically they acknowledged that, at the same time, they had a tendency to undermine their own awareness, due to the preconceived notions surrounding them, related to lack of insight in psychosis. Secondly, the very transient nature of the ward itself, at times exacerbated one's confusion (Buster, 18-19: 701-709). Furthermore, some of the participants' memories of their time at the ward were hazy and uncertain (Annabel Alexandra, 39: 1438-1439). The sense of confusion also persisted after discharge. For Buster, confusion resulted from a sudden and perhaps premature confrontation with the reality of the outside world that she had been excluded from for some time, which manifested itself in not remembering and not

knowing how to be or function and therefore highlighted the effects of institutionalisation. Annabel Alexandra (60: 2228-2231) also noted being left with unsettling disconcertion and bemusement related to the meaning and function of her psychosis, as well as objectives of psychiatric treatment in general, which denoted her struggle to reach a clear evaluation, regarding the usefulness of her hospitalisation. Poignantly, both participants also concluded that it might have been more conducive to them, in the end, to have lacked some awareness on the ward, as it would have protected them from discerning the reality of one's behaviour or shielded them from confronting the disturbing elements of the ward.

Both Annabel Alexandra (51-52: 1924-1935) and Buster also elucidated how their psychosis diminished their credibility to the outside world and made them doubt perceived reality. However, it seemed that, at the same time, they both managed to learn how to validate their own subjective experiences and therefore distinguish psychic from external events. The following quote has been selected to depict the essence of the current theme:

I would say to her [mother] they restrained me in my bedroom (…) you could look at the bang on my head, look at the marks on my arms and she doesn't react, and I think she doesn't believe me (laughs) (…) and I kind of think….have I got that in a muddle, did it actually happen or is it my psychosis (…)? But I know when I was in a locked ward I've definitely been segregated, I had lots of people hold me down (…) (Buster, 10: 371-382)

3.5 Superordinate Theme Four: The Comforting and the Sanguine

The final master theme that emerged from the data highlights the positive, constructive and corrective components of the experience of being in a closed ward under section while experiencing psychosis. Furthermore, the theme's name and its reference to darkness aim to reflect and summarise the overall negative tone that seems to have run through the participants' accounts in this study – as it was an experience that as a whole was conceptualised as rather negative or even scarring. However, it was also a journey that in the end had the potential of instilling a new meaning and transformation, as well as warranting growth for many. Thus, while the previous themes carried various tones of loss and struggle in general, the current theme focuses on gain, benefit, gratitude and value and consists of the following four categories: *Exhilaration and fun; The Care and belonging; Light in the darkness; Search for meaning and resolution.*

3.5.1 Subtheme One: Exhilaration and Fun

The current sub-theme outlines the light, the humorous and the effervescent elements of the experience that two participants in particular recounted.

For instance, Annabel Alexandra (20: 757-759) revealed, although with some caution to how her transparency may be perceived, that her experience of the ward was both *''awful and exhilarating at the same time'*. Her hesitation was related to the invigorating and the blissful parts of the entire picture, which for her were associated with the opportunity to connect with similar others and be playful and creative in a childlike state of disinhibition that the mania facilitated. Annabel Alexandra (21: 807-820) talked about having no responsibilities, being able to '*watch TV'* and enjoy *'nice food'*. It seems that she was benefiting from being sheltered from a harsh and perhaps overwhelming reality of adulthood. In other words, it appears that having no obligation to act or make a decision was, in fact, welcoming for her in many respects. Paradoxically (as one was admitted involuntarily after all), Annabel Alexandra also talked about being free (to run around or express herself) as well as being contained:

I was psychotic – it can be quite fun (laughs) like…. you're not really meant to say that! But it's not always….it was quite, it was all just…like you just run around….and had friends and did lots of art and acted a bit like a child…having temper tantrums …
(Annabel Alexandra, 1: 18-23)

Participant 888 also talked about meeting and bonding with patients who were *'really funny'* (45: 1783-1785) and having fun on the ward once he *'knew where the boundaries were'* (23: 931-932). He also highlighted how humour (even a dark one) and an ability to discern the sarcastic and the paradoxical (in the context of an experience he shared with fellow patients) helped him to cope with the ordeal and repair the destructive impact of it (here the use of the word 'holocaust' denotes the destructive and debilitating nature):

I feel we got really well on the ward… umm we had a lot of fun actually, he's one of those patients that keep you going because they're the one that can see the irony of what's happening, and sometimes you have to laugh to recover or to survive it, so a gallon is humour, even the holocaust type humour. (888, 49: 1964-1967)

3.5.2 Subtheme Two: The Care and Belonging

The Care and Belonging places emphasis on the significance and the impact that the quality of the relationship with others had on participants' well-being during their hospitalisation. This sub-theme aims to capture the memorable and special moments of care and containment from members of staff on the ward that some participants highlighted and reflected upon. The support of and identification with fellow patients have been described as particularly invaluable by participants in this study.

Participants' accounts revealed that while their relationship with staff on the ward often proved to be altogether challenging and arduous, peer support consistently played an important part as it fostered an atmosphere of mutuality, belonging and understanding. Some participants like Annabel Alexandra (20: 757-759) pointed that being on the ward offered her with a rare opportunity to meet special individuals with the unique calibre and many participants formed meaningful and lasting friendships and attachments on the ward. The following excerpt illustrates this:

> *Peer support…we had a lot of…I'm still in touch with a couple of people I met on the journey…hmm…because the support that we gave each other (…) it was always very much a mutual thing, was really helpful, and they probably understand more that the nursing some sometimes (laughs) (…) yeah it made a big difference too…* (Cait, 39: 1581-1589)

Participants also recalled special memories created with the members of the staff who were committed to their roles and values of care. Since many participants construed their relationship with staff on the ward as awry, such recollection of befriending *'some of the staff'* in the end (888, 23: 920-924) or experiencing moments of being looked after, attended to and receiving individualised support were of great significance. The following quote by Buster demonstrates this:

> *Not everybody is unkind…obviously some people are in their profession for the right reasons and are genuinely kind to you...I mean I can remember on the acute ward like my hair gets terrible you know and I can't wash my hair… (…) I remember nursing assistant would blow dry my hair for me and another one brought some special conditioner for me (…)…and that was really nice.* (Buster, 25: 980-998)

For others, like Cait individual staff members who were considered caring, respectful and accommodating in their approach facilitated one's recovery process as they

promoted partnership through empowerment, practised individually tailored and a de-shaming approach to patients and therefore helped to restore one's sense of normality, dignity and humanity. Thus, providing a desperately needed overall corrective experience:

> *One of the staff I met was…she was more fluid how she approached patients so…(…) and how (…) she saw people as people (…) (…) so she made you feel a little bit like you were… a part of the process instead (…)* (Cait, 30-31: 1242-1257)

> *So I guess (…) they treated me like a human being and they treated me like me (…) that I think mattered and that helped me (...) gain some dignity back, and I think that helped me in the long term to start turning around.* (Cait, 31: 1284-1298)

3.5.3 Subtheme Three: Light in the Darkness

The current subtheme centres on the helpful and beneficial parts of the experience and captures participant's ability to discern the bright side of things.

Three participants – Sally, Buster and Valerie, all highlighted that although the experience was traumatic and horrible for them, it did keep them safe. However, Sally (1: 22-24) used the words *'probably kept me safe,'* which denotes some uncertainty or hesitation and Valerie (8; 280-282) although listed being kept alive as the main or the only positive, she also added the words, *'but at a cost'.* The quote by Buster, however, exemplifies the protecting component that did appear to be of huge relevance after all:

> *My acceptance point of having experienced the locked ward, where would I be if I hadn't been put in that place of safety you know, I know it was horrible but if I've been just left to roam (…) and get lost and be a missing person (…) you just create the worst case scenario in your head.* (Buster, 51-52: 1979-1985)

Another example of the positive side of the experience (here describing in the larger scheme of things - the function and benefit gained from one's hospitalisation) is captured by the following excerpt from Valerie's interview:

> *It gave my family some peace of mind as they knew I was safe and it also gave them a break from me 'cos…emotionally I was very demanding on them.* (Valerie, 22: 855-857)

Participants also mentioned that during some of their recent admissions, exercise was prioritised, which was described as an improvement and a positive shift (Buster, 7: 260-265). Valerie highlighted how it was the ward that happened to introduce her to psychological therapy which *'has worked wonders'* (22, 846-855) and she also recalled enjoying food *'thoroughly'* on the ward and learning new recipes (22: 873-876). Another participant, Cait highlighted how she learnt to make most of the art therapy during her admission, which enabled her in self-expression and aided her recovery (Cait, 34: 1415-1424). Finally, Sally pinpointed that simply being surrounded by other people was somewhat soothing and certain physical aspects of the environment provided the much-needed order, containment and comfort, in the times of darkness, loneliness and chaos:

> *Simply the human contact of feeling people around me was reassuring and helpful (…) having a clean environment, so it's sort of….umm…clean linen and that kind of staff that is, in contrast, to being very depressed and just living in a horrible place at home (…)…so that, that almost sort of…felt supportive, that was quite nice…* (Sally, 22: 822-830)

3.5.4 Subtheme Four: Search for Meaning and Resolution

The present sub-theme, as the very name implies, focuses on finding or constructing meaning from one's experience, which includes seeking or reaching acceptance, forgiveness or resolution. It tells the story of survival and recovery, self-reinstatement and resilience.

To start with, Sally talked about her struggle with coercive treatments and described her own exploration of an ethical dilemma that sectioning process represents. Her initial aversion and resistance to it, however, appeared to diminish as she endeavoured to consider carers' perspective on the issue empathically. Thus, Sally's journey perhaps represents a quest for not only understanding and acceptance, but also a resolution of her own hurt and possibly vexation:

> *While I was in the hospital… umm… I was like – this shouldn't be allowed to happen and staff and probably for a couple of years after that I completely thought of ethical grounds I was completely against any kind of forced treatment but I spent a lot of time talking to carers (….) so my feelings about it sort of gradually became well… if you think someone is very ill then maybe that's the best thing*. (Sally, 3-4: 107-116)

Annabel Alexandra's (31: 1154-1155) view on her experience constituted an exception among other participants, as she noted she has not *'learnt anything from that experience'* perhaps implying how unavailing it felt. Most participants, however, accentuated how the impact and the meaning that hospitalisation carried for them, in the end, mitigated some of their struggles or succoured them through an acquisition. Sally, for instance, also elucidated how eventually hospital admission helped her to become strong-willed, self-assured and more determined in having her needs met:

> *I suppose in a roundabout way … the positive thing about the hospital (…) I am more assertive who I work with (…) and I'm okay if you think I'm demanding (…) but I'm going to be, and that's worked very well (…)…so I suppose in that sense having a negative experience in the hospital has made me assertive now (…) but it made me a lot less assertive in a lot of aspects of my life for several years after.* (Sally, 21:793-801)

Participant 888 (25: 879-985), in turn, reported that he feels '*emotionally clear of it'* and that he has *'recovered'* from experience (30: 1194-1195). Participant 888's reflections also indicate that the hospital admission, although traumatic, allowed or perhaps 'pushed' him to take time to focus on himself and his well-being (to reconnect with self), as he finally managed to address long-standing personal issues that were negatively impacting his life, which eventually enabled him to pursue his career aspirations and build a secure and comfortable life for himself:

> *And in all of that if I look and say….(…) I have an income now that's been better than ever (…)...that has allowed me to do certain things I would never be able to do….(….) in terms of taking the time to repair (…) I needed that time to (…) go back to that self-dialogue… (…) am saying that there are some things of value* (888, 35: 1395-1410)

It appears that what has aided 888' convalescence was not only time but also an embracement of a stance of compassion and empathy towards staff hardship, constraints and their very own psychic pain that, as he explains, is not infrequently delegated and transferred onto patients. Thus, 888 appears to have drawn on the psychodynamic insight that enabled him to reach an understanding of the interpersonal dynamic between staff and the patients on the ward that occur on the implicit and the unconscious level:

> *I've made sense of it…the staff…..the staff (...) they're suffering enormously, because of the power differential, because of the displacement, because they suffer more than anyone else.* (888, 27: 1075-1079)

There was this lengthy process of de-selving me, not because I wasn't worthwhile, but because they'd been de-selved and they never saw themselves as worthwhile (888, 25: 879-985)

Valerie's hurtful experience of the ward, on the other hand, seems to have resulted in harbouring resentment and possibly anger. She noted that she has a need to process her ordeal in order to reach exoneration and sense of peace that would allow her to heal from its negative impact. She, therefore, identified a need to '*forgive the system to move forward'* (24: 958-962). However, Valerie also described how the experience allowed her to recognise her inner strength and prompted her to own her ability to endure life's adversities and pain. It seems that her experience is now used as a threshold for potential future challenges. However, Valerie's acknowledgement of her own psychological resilience enabled her to not only come to terms with the past but also to learn and grow from it. She elucidated how, with time, she was able to convert her sorrow, utilise her invaluable rich knowledge, which stems from her lived experience that she consequently channelled to instil a difference within mental health services. Thus, Valerie's journey portrays an experience that eventually transforms, once mute and helpless patient into an empowered individual and an influential advocate for those who represent, what she once too became – *a forgotten human being*. A spokeswoman drove by hope and newly constructed sense of meaning and purpose in life:

It's made me stronger in some ways…hmm…because I survived it…hmm…and it was horrific to go through so… (…) and it makes me think….whatever life throws at me now…..I could get through it. It made me feel I am a lot stronger than I thought I was (…); I can be a voice for the forgotten people (…) so I do a lot of service work now, and it's made me passionate in campaigning to make things improved… (…) I could start wallowing in self-pity about it, which I did when I came out at first, but that is very destructive for me, I know (…) I have to accept (…) what happened. (Valerie, 6: 210-224)

3.6 Summary

The above chapter presents the results of the interviews from a sample of six former patients that were involuntarily committed to an inpatient psychiatric ward as a result of a psychotic distress. The research question '*How do individuals experience, understand and make sense of their treatment and its outcome on a closed psychiatric*

ward under section?' was posed to and answered by the participants. The interviews explored the experiences and perceptions of these participants, in the light of the impact that their hospitalisation might have had on their well-being and recovery process. The following chapter provides further analysis of the data presented in this chapter by outlining its relationship to the existing literature on the subject, as well as includes an attempt to identify the limitations of the current project and the potential recommendations for future research.

Chapter 4: Discussion

4.1 Overview

The IPA analysis presented above (Chapter 3) aimed to provide insight into former patients' lived experience by generating an in-depth understanding of the impact of their involuntary admission to a psychiatric inpatient ward due to a psychotic episode. The data consists of the interviews with six individuals and the analytic process revealed four master themes (*A Struggle for Recognition; Terrifyingly Out of Control – Striving for a Sense of Agency; Transformation and Loss; The Comforting and The Sanguine*) that served as a primary conclusion of the accounts representing individuals' experiences, perceptions and challenges that participants described being confronted with during their involuntary hospitalisation.

The current chapter consists of a presentation and a discussion of the analysis in accordance with the central themes that emerged in the study and in relation to the literature review. The section offers some comparative reflections based on the existing research on the subject and also further explores the implications of some of the identified interconnecting issues, centred on *re-traumatisation, powerlessness as suffering, loss of self, parallel processes* and *the staff/nurse-patient relationships.* Conclusive remarks regarding the research question and the significance of this project are also made. Subsequently, limitations of the study, as well as recommendations for the future research and practice are outlined, before concluding the chapter with a brief summary.

4.2 Summary of the Results in the Light of Existing Literature

4.2.1 Discussion of Super-ordinate Theme One: Struggle for Recognition

Findings of the current study reveal that as patients, individuals mostly found themselves trapped in a place, where their wishes and opinions remained overridden and needs' unacknowledged or dismissed. In addition, human contact was not perceived to be a priority on the ward and individuals often noted that the nurses did not seem to have (or were unwilling to make) time for them, which often left the patients feeling frustrated, as well as isolated, estranged or abandoned. Such evoked the feelings of being unvalued or of being a burden which meant that the patients, at times, felt neglected or were left to their own devices to deal with the thoughts and painful feelings, which often led them to seek refuge in fellow patients. Other studies

also report that patients felt that their 'lifeworld' (problems and issues that were meaningful to them) was being discarded in favour of the services being pre-concerned with the demands of the 'system world'. Research also suggests that patients are often perceived that the system was more interested in paperwork and box ticking, as well as risk management and reduction (Godin et al., 2005). Foucault (1977) depicted psychiatric in-patient ward as a context in which otherness and uniqueness are constrained and dialogue arrested. In fact, research indicates that the common characteristic components of staff-patient interactions on acute wards often consist of rule enforcement, custodialism and lack of intimacy, empathy or caring (Muller and Poggenpoel, 1996). Previous research states the insufficient availability of nurses' (Cleary et al., 1999) and some observational studies discuss the absence of nurse–patient contact (Lepola and Vanhanen, 1997, Bray 1999). Individuals in this study also reflected upon their fruitless endeavours to communicate their distress to the staff in the ward. Literature suggests that the content of individuals' psychotic crisis is likely to be overlooked or negatively valued altogether (Martin, 2000; Mccabe et al., 2002). This practice by professionals can lead to explicit confrontation and disagreement about the reasons for treatment and may reinforce patient's disengagement with the services (Mccabe et al., 2002; Cruz and Pincus, 2002).

It is also apparent that overall patients experienced their time on the ward as passive and isolating, which hinders one's opportunity for recovery. Importantly, all participants in this study reported that their recovery and well-being was not facilitated and in fact, hindered by their hospitalisation, and was achieved after the discharge. Moreover, all participants highlighted that they felt abandoned after discharge, having to deal with the impact of the events that led the sectioning in the first place, in addition to acknowledging the effect of the hospitalisation itself, which often resulted in depression or even acute distress. In fact, literature highlights that objectives of recovery approach have been frustrated by the factors like enforced inactivity, boredom and loneliness on the wards (Radcliffe and Smith, 2007), lack of time for complex interventions, minimal psychosocial input and lack of clarity in relation to the goals of admission and suitable treatments (Richards et al., 2005).

4.2.2 Discussion of Super-ordinate Theme Two: Terrifyingly Out of Control – Striving for a Sense of Agency

Findings of the present study also indicate that involuntary hospitalisation can be experienced as frightening and chaotic, with the ward itself being perceived as an absurd-laden environment in which patients' vulnerability can be further pronounced. Thus, the individuals in the current study described in detail about being confronted with an overwhelming sense of powerlessness and at times an infuriating and futile

struggle for freedom and agency. Thus on one hand, and in accordance with Foucault's view, patients can experience themselves as helpless victims of the powerful structures of the mental health system (Fendler, 2004; Giddens, 1991); however, on the other hand, powerlessness can give rise to the feelings of anger (Johnson et al., 1998) and as Chambers (2005) argues, patients can exercise some control through resistance and non-compliance and such endeavours have been described by the participants of the present study. Nevertheless, Chambers (2005) suggests that any form of coercion may trigger unintended consequences, as non-compliance, in one way or the other, would be an understandable response to such measures. However, this may form a vicious cycle of further distress and even necessitate subsequent involuntary admissions, generating and reinforcing the feelings of coercion and powerlessness (Chambers, 2005). These occurrences are also portrayed in the accounts of the participants of this study. Thus, it seems that the ward frequently provokes profound feelings of impotence and worthlessness.

Patients often experienced staff members, who exerted their power over them and adopted a patronising attitude. Most individuals also felt that there was a distance or a battle between them and the professionals and felt attacked by the staff. Thus, patients often felt fragile and unprotected at the whim of an omnipotent and totalitarian system and in the hands of uncaring or even abusive staff members. Individuals often viewed themselves as having no credibility and being defenceless and alone in their predicament. The ward was often depicted as reminiscent of the prison and nurses resembling the jailers, the police or referees, rather than carers. Individuals experienced their treatment as degrading in many ways. Not being approached with respect and being coerced, stripped of one's rights and privileges often seemed unjust and humiliating. However, in some cases, it was also perceived as a confirmation of one's inner *evilness,* and therefore experienced as punishment, violation and oppression. Notably, it has been previously accentuated that patients can experience their involuntary treatment not only as imprisonment but also as punishment (Roberts et al., 2008; Katsakou and Priebe, 2007). Individuals often described how staff members did not allow much room for manoeuvre, and flexibility in their approach might have offered the much-needed opportunity to rebuild and reinstate one's sense of efficacy. Such reports seem in line with the classic debate concerning psychiatry and its institution, which has been viewed as patriarchal in culture by exalting mastery and domination. Foucalt (2004) coined this phenomenon 'power by normalisation,' which threatens the patient identity (Thesen, 2001). Reciprocity, collaboration or interplay and empowering opportunities seem to have formed rare instances. However, they constitute a powerful reparative and healing component. Such non-involvement of patients in their own care has also been long noted in the literature (Deacon and Fairhurst, 2008).

In line with existing literature (Sainsbury Centre for Mental Health, 1998; McGeorge et al., 2000; MILMIS, 1995; Barker, 2000), patients' time on the ward is also characterised by a sense of insecurity, as they described being exposed to various threats, which they had to circumvent in order to 'survive'. For example, facing the prospect of being restrained or mistreated by the staff, bearing witness to fellow patients' struggles, as well as, being exposed to the violent behaviour of other patients. Physical restraint was particularly depicted in terms of assault, which often elicited the feelings of bewilderment and dismay to the necessity and reasons for its implementation. Participants also noted how medication seemed to be the main concern of the staff in the ward, constituting to a bigger priority than their well-being. Medication was associated with the unpleasant side effects, which often contributed to the feelings of being out of control or not being able to rely on anything that was previously familiar and safe. Medication, however, is also noted to have alleviated the psychotic elements in the end. Forced medication and particularly injections represented the coercive, invasive and intrusive elements of the treatment. Patients' difficult relationship with medication during psychiatric treatment is also highlighted in the literature as being largely counter-therapeutic (Hagen et al., 2010; Rogers et al., 1993; Rettenbacher et al., 2004; Mancini et al., 2005; Flynn and Bartholomew, 2003). Present findings, therefore, mirror previously demonstrated the possibility of distress being retriggered in a vicious cycle by interactions on the ward that may seem punitive and resulting in a profound state of disempowerment and hopelessness (Hart, 2004; May 2004).

4.2.3 Discussion of Super-ordinate Theme Three: Transformation and Loss

Participants described being stripped of individuality and identity, which often awakened feelings of being seen as *nobody* or just as a diagnosis. Thus, common experiences were related to the vicious cycle of being misunderstood or misjudged, as well as pathologised, objectified or even demonised. As a consequence, former patients reflected on their transitions from being a human to becoming a disease or even a worthless or an inadequate entity. Patients' identity seemed closely associated with their actions on the ward. Such could be conceptualised as a form of reductionism and nihilism that seemed to have induced further suffering in individuals. This common theme depicts a transition from a subject to an object (becoming part of the collective group or a symptom) and was often associated with a sense of being profoundly dehumanised, which results in changes of one's subjective experience of the self. Scheff and Retzinger (2001) proposed that psychiatric treatment often separates an individual from their identity. It seems, therefore that diminishment or a loss of *self* is tied to the deprivation of key aspect of one's existence (such as freedom). As Dinos et al. (2004) highlighted, a patient no longer possesses

liberty to form or develop their identity in their own chosen direction, which was termed as 'psychiatric socialisation'. Individuals also described how professionals' ideas felt imposed, which consequently forced them to comply or mould to the staff perceptions by adopting a false persona, which often meant discarding their true self and identity. It was experienced as losing oneself or parts of self. In addition, an imposition of staff views, in conjunction with one's psychotic state led to the development of profound self-doubts and an inability to validate one's subjective state. At times, this meant that one's authenticity is compromised and one's ability for self-expression impaired, as freely voicing one's opinions is associated with various threats on the ward, which only compounded one's distress and further deteriorated one's relationship with staff and oneself. The treatment on the ward was often experienced as profoundly repressive in many ways. Current findings are, therefore in line with some existing evidence suggesting that coercion, in the context of involuntary inpatient care, can be experienced as extremely distressing and impede one's sense of self-worth and efficacy, as well as perpetuate a wheel of conflict (Flynn and Bartholomew, 2003).

Thus, themes that dominate the findings centred on loss of self, loss of liberty, rights, and power often result in feelings of failure and inadequacy, which consequently impedes recovery, competence and agency and in fact, even shake belief in one's ability to influence one's fate or live a fulfilling life again. The sense of hopelessness was often experienced as patients were confronted with the uncertainty regarding their discharge date. Evidence also exists that over exposure to acute ward environments may lead to dependency and the belief that functioning and recovery prospects are beyond one's reach (Priebe and Turner, 2003). In some cases, one's position in the world felt altered, as individuals often reflected upon their sense of disillusionment with the helping services. It seems that involuntary hospitalisation can instil fear of services and future coercion affects one's openness to seek help or in fact transform one's relationship with the world, which points to the relevance of the concept of trust in mental health services (Brown et al., 2006 and 2008; Vassilev and Pilgrim, 2007). The absence of which, as argued, can be a detrimental and obscure path to recovery (Hall et al., 2001; Mollering, 2006; Elliot, 2004; Calnan and Rowe, 2008; Fenton et al., 1997).

Furthermore, shame and stigmatisation are also impacts of sectioning and often lead to isolation and disconnection from the world, which according to some authors has been referred as *a loss of status,* at which the core humiliation lies (Torres and Bergner, 2012; Svindseth et al., 2013). It also seems that the experience of involuntary commitment has a potential of crashing one's sense of safety in the world and frequently leads to a collapse of faith in justice. In particular, the belief in the integral and unshakable nature of one's human rights and freedom is violently

compromised. It almost seems that sectioning for some warrants almost an existential crisis that forces the individuals to re-evaluate the formerly perceived reality.

4.2.4 Discussion of Super-ordinate Theme Four: The Comforting and the Sanguine

Findings indicate that hospitalisation can grant the much-needed time for reflection, and shelter one from the struggles and pressures of responsibility of the outside world. It is also important to note that paradoxically and especially in retrospection, for some individuals their involuntary hospitalisation offered them a place of safety that warrants protection from the potential danger that the individuals might have been subjected to if not hospitalised. Thus, in some cases hospitalisation, although construed as an adversary, can be simultaneously perceived as life preserving as it may help avert suicidal crisis and provide therapeutic opportunities for care and support. In addition, being stripped of power can also be deemed understandable and necessary for some individuals and even be associated with a sense of freedom and break from the strain of day to day life. Thus, in this respect participants' ambivalent and conflicting views and experiences regarding the necessity and function of their hospitalisation highlights the multiplicity of the issues involved, and perhaps also mirror the existing debates on the topic, and the dilemmas professionals are confronted with themselves (Seale et al., 2006).

Although negative themes emerging from the current study seem to reflect the dominant experiences reported by other qualitative studies on the subject (Katsakou and Priebe, 2007; Gault, 2009), Overall a complex picture is revealed, which emphasises a contradictory nature of the phenomenon. It appears that the individuals told the story of great losses; however, at the same time realised the potential gains retrospectively. Similarly, a study by Olofsoon (2000) uncovers the core themes that correspond to *being respected as a human being* and *not being respected as a human being.* For some individuals in the present study, involuntary hospitalisation was construed as the most traumatic time of their life. Most of them expressed a need to construct meaning around their hospitalisation that enabled them to come to terms with their experience, as well as incorporate it constructively into their lives. On the other hand, some formed a 'psychiatric survivor' identity through which they extracted their strength. Andrew Salomon during his TED talk (2014) on *'*How the worst moments in our lives make us who we are' stressed that '*we don't seek the painful experiences that hew our identities, but we seek our identities in the wake of painful experiences'*. Thus, the present study also highlights how individuals are able to draw strength from the major challenges in their lives and as Andrew Salomon concluded: '*forge meaning and build identity'.*

4.3 Synthesis of Interconnecting Issues: Re-traumatisation, Powerlessness as Suffering, Loss of Self, Parallel Processes and the Nurse-Patient Relationship

4.3.1 Re-traumatisation

Some authors have expressed concern regarding the impact of coercive environment on the patients' well-being (Vassilev and Pilgrim, 2007). Some participants in the current study have also noted a need to engage in trauma therapy, which brings to attention the existing research, which indicates that 'sectioning' can even lead to PTSD (Morrison et al., 2003). Literature has highlighted the traumatic potential of involuntary treatments. Studies that focus on the experience of restraint also reveal that such an ordeal can bring back memories of previous violent attacks, including experiences of being raped and being abused as a child (Bonner et al., 2002; Fish and Culshaw, 2005; Gallop et al., 1999; Sequeira and Halstead, 2002; Wynn, 2004). These findings have been replicated in the current study and carry poignant implications for nursing practice, in terms of considering more proactive responses to the crisis as opposed to coercive interventions, including restraint procedures (Strout, 2010). It seems that as compared to other studies, current project has more poignantly illustrated how psychiatric involuntary admission can warrant a scenario, where trust is again betrayed by the caregivers, leading to a re-traumatising experience. More specifically, it emerged that non-benign aspects of involuntary detention may replay and re-assemble early childhood traumas that are characterised by a lack of safety or an overwhelming sense of powerlessness.

4.3.2 Powerlessness as Suffering

Powerlessness is induced by being imprisoned by one's situation due to the limited choices and ability, the self-image of worthlessness (which appears to have been influenced by prevalent societal norms and human models) and emotional suffering. Such situation can lead to apathy and destructive states of alienation, anguish and shame. In addition, it seems that powerlessness evoked by involuntary hospitalisation may threaten not only individuals' sense of autonomy but also their very existence, and the combination of such factors can also result in stigmatisation. Phenomenology has offered some relevant accounts related to the everyday power to be oneself. According to such perspectives, identified features of the experience of powerlessness include a loss of familiarity with oneself and one's environment; an increased sense of insecurity; and existential loneliness. Thus it has been pointed put that the very

experience of powerlessness entails not only a conscious feeling of having lost the ability to do things or the power to control the future events, but it is experienced as a loss of power to *be* - it underlies the existential function that allows us to maintain a grip on our habitual world. Corresponding to the findings that emerge from this research, it is, therefore, a breakdown of the ability to be *'yourself'* (Batho, 2015).

4.3.3 Loss of Self

Studies exploring the impact of involuntary hospitalisation on the sense of self-seem very limited, although the existing research reveals that effects may constitute a loss of self-esteem, self–efficacy as well as identity, especially due to stigmatisation (Hughes et al., 2009). The findings of the current study, however, appear to provide a more detailed description of how perceived quality of care and treatment received can potentially impact the patients' sense of self. Current findings are therefore in line with postulations that compulsory detention to a psychiatric ward can result in a crisis of self-identity (Beveridge, 1998). It has been argued that involuntary hospitalisation is an experience that is ultimately linked to being judged insane and publically certified as an unfit entity, incapable of functioning in society, which leads to the re-evaluation of one's image and relations with others and often ends with depression, denial or anger. Hence, the process is similar to the course of bereavement as it involves dealing with a loss (Beveridge, 1998).

Furthermore, awry staff-patient relationship patterns on the ward, especially ones that were experienced as mistreatment can become internalised by patients and result in an annihilation of self. Current findings also suggest that something of value might be permanently altered and dispossessed as a result of one's involuntary commitment. This could be a part of one's inner structure (for instance, a sense of dignity), which leaves one with a void or some degree of incompleteness. No single broadly accepted definition of sense of self currently exists. However apparent consensus is centred on a loss of *conceptualised self* and a conscious awareness of 'not being the same person' (Estroff, 1989; Burke, 1999; Dubois and Persinger, 1996; Bennet, 1987). These feelings of differentness and estrangement are related to total disconnection from the past identity (Pollack, 1994; Dixon and Durrheim, 2000). As evident from current findings, loss of sense of self is often associated with negative self-evaluations (Parker, 1998). This seems pertinent as literature also suggests that loss of self is associated with changes in aspects of physical, cognitive, emotional and social functioning (Nochi, 1997; Bennet, 1987; Schell-Word, 1999), which is typically accompanied by emotional distress, often resulting in an array of extreme emotional

states, such as anger, depression, anxiety or grief (Miller, 1993; Lewis and Rosenberg, 1990; Judd and Wilson, 1999).

4.3.4 Parallel Processes

The current research points to the existence of parallel processes that seem to be implicated in the explored phenomenon. Psychosis itself has been described as a state of terror and fear and in terms of being out of control (Koivisto et al., 2003). This seems poignant in the light of the current results indicating that an in-patient ward does not always foster the sense of safety. It has been postulated that powerlessness often lies at the very core of trauma; trauma being a subjective experience (Herman, 1994). Similarly, psychosis is viewed as a state of confusion (Koivisto et al., 2003; Jenson, 2000) which the ward operations can subsequently mirror, and contribute to the experience of uncertainty and entanglement. Since the experience of trauma, in general, has been documented to induce distress, including psychotic breakdown, it is hence disquieting to consider that coercive treatment can reawaken the affects that are redolent of past afflictions. It can also create a totally new traumatic experience and negatively alter one's inter and the intrapersonal world. Finally, taking into account suggestions that psychosis itself can be experienced as a diminished sense of self (Nixon et al., 2010), it is also pertinent that the very impact of involuntary hospitalisation can also lead to the feelings of dehumanisation and loss of self and identity and, therefore a battle for their very preservation.

4.3.5 Staff-Patient Relationship: As We Relate We Create Ourselves, We are Relational (Gergen, 2009).

In the light of the above, the current study re-highlights the significance of the relationship with the ward staff. In fact, the nurse-patient relationship has been widely described as pivotal in the literature (Morrison and Burnard, 1991). It has been noted that nurses tend to hold a negative attitude towards patients, with some authors arguing that no major changes in this arena have been identified since the 1960s (Corrigan, 2002). Research also suggests that nurses are often characterised with a strong inclination to use categories in relation to patients, and often did not did see them as unique individuals. Such created more distant relations (Lilja et al., 2004). In fact, it has been previously outlined that involuntary in-patient settings can produce an atmosphere wrapped in a relational context that is antithetical to patients' recovery process (Jacobson and Greenley, 2001). Thus, the current study confirms that the relationship with mental health professionals lies perhaps at the core, as

perception and experience of *self* depends on its very quality and nature and therefore directly shapes patients' recovery path. This link between negative interpersonal relations and increased levels of distress has been well documented (Bertera and Hendrick, 2005). Thus, results emerging from the current study suggest that when individuals are approached with dignity and respect and when they are listened to and validated, they feel like 'normal' human beings – worthy of value. On the contrary, when they feel ignored and disrespected or deprived of an opportunity to have influence, their self-worth automatically suffers, and patients end up feeling inferior, insignificant or robbed of their humanity. Some like Tilley (1999) argued that every comment made to a patient or within their hearing can potentially be laden with therapeutic or non-therapeutic qualities and values. Thus, it can either enhance patients' emotional growth or increase their distress. In this respect, a nurse is conceptualised as a therapeutic agent that can be a vehicle for change.

4.4 Study Implications

The present research project aimed to draw attention to the experience of involuntary in-patient treatment as a result of a psychotic episode. Qualitative research on the subject remains scarce, while quantitative studies seem to be methodologically flawed or produce inconclusive results (Aranda and Street, 2001; Ridley and Hunter, 2013; Greenwood et al., 1999).

Thus, findings from the current study carry significant implications for involuntary in-patient care as it is crucial to understand how vulnerable individuals exposed to coercive treatment feel. The richness of the information available from the participants' accounts permitted a deeper understanding of the phenomenon, which can enlighten mental health professionals about the very nature and essence of such an experience and more importantly how it can potentially impact the patients' sense of self and recovery process.

Recovery has been described as comprising both internal and external conditions. Internal factors refer to the presence of hope, healing, empowerment and connection; while external conditions facilitating recovery include implementation of the principle of human rights, a positive culture of healing, and recovery-oriented services (Jacobson and Greenley, 2001). The present study suggests that an experience of involuntary hospitalisation not only provides a very limited opportunity for recovery, but it can be iatrogenic in nature. However, further research is required to generalise these findings. Moreover, it seems pivotal to be aware how involuntary commitment, or more precisely the ward and its operations, including staff approach to patients

may perpetuate and communicate renewed feelings of powerlessness and therefore cause vulnerable individuals to relive their abuse, contributing to the re-victimisation of patients with psychosis. Taking into consideration such a possibility and addressing the adverse experiences of patients may pose a challenge to professionals. However, it is essential to do so and may lead to improved outcomes. More importantly, current findings also indicate that even though individuals are treated against their will and some violation of autonomy is an inevitable part of involuntary hospitalisation, but still if patients' views are taken into account they may feel less coerced and feel more positive about their treatment. It is, therefore pertinent that supportive relationships are fostered in the in-patient ward between patients and the staff in order to ensure that the treatment offered is experienced by the patients as therapeutic (as opposed to distancing or oppressive) and provides relief in a crisis.

As well as paying tribute to counselling psychology as a profession, current research findings are of great importance in highlighting the crucial role interpersonal dynamics play in our lives, providing yet another powerful demonstration of how *it is all about the relationship. After all,* relatedness and relationship lie at the very core of counselling psychology as a profession. This is also of particular relevance to counselling psychologists, whose roles within mental-health settings entail organisational development and service management, where there may be less emphasis on mere symptom reduction but where instead the entire context, in which an individual is embedded, is taken into consideration. A prevalent tendency may be to locate fault at an individual level by overlooking the issue of *relatedness* that is also mirrored in a mutually-constitutive relationship between people and their context. This is of particular relevance in terms of the impact designed and built environments and human systems, in general, have in interacting with, influencing and shaping our health and well-being. Furthermore, it could be concluded that 'sectioning' is, not infrequently, viewed as a mere procedure, one that an individual with psychosis subsequently is expected to further 'split off' from their awareness. This can be construed as mirroring and replicating the psychotic defensive constellation itself, and therefore constituting yet another paradox as well as a concern.

Perhaps such an approach forms a part of a collective denial and resistance that allows us to distance ourselves from facing, and ultimately 'sitting with' and bearing, the painful facets of powerlessness that involuntary commitment tends to evoke. This include the impact that powerless states can have on one's sense of self and identity. The current study, therefore, has great potential for enhancing knowledge amongst professionals, including counselling psychologists, as it highlights that 'sectioning' should most of all be treated as an *experience* and a potentially traumatic one that can, in fact, be redolent of past inflictions. In such respects, current findings carry important implications for counselling psychologists and other practitioners, as they

provide therapeutic suggestions or a guide to a model for practice, when working with individuals who have been treated on a psychiatric ward on an involuntary basis. The current study can remind professionals to be mindful of potential issues and dynamics that can be implicated in such phenomenon. It is therfore pivotal to be aware that sectioning can lead to debilitating consequences and it may be a responsibility of a clinicial not only to have knowledge on the subject but also to facilitate a discussion and exploration of the ordeal that could help a client to process and make sense of the experience . It could also help them ponder the impact it might have had on their well-being and sense of self, enabling them to do so with an open mind and free of asssumptions.

4.5 Suggestions for Future Research and Practice

More research is required to address how patients in psychotic crisis experience the treatment they receive on a psychiatric ward. The aim of these questions would be to make psychiatric nursing more person-centred and make the interaction between professionals and patients more collaborative and susceptive to patients' subjectivity (Koivisto et al., 2004). In addition, more data is needed with respect to the psychological effects of coercion on individuals' well-being and sense of self in particular. As Barker (2001) postulated, psychiatric nursing is a process of re-empowering the disempowered; it is a continuous endeavour that aims to understand the individuals and their changing needs (Gastmans, 1998, Barker et al., 1999).

Furthermore, it is recommended that in order to fully make sense of the issues that are related to compulsory detention and in order to address individualising issues of emotion, resistance and control, both individual and structural arrangements must be taken into consideration (Gault, 2009). Thus, it is argued that the relations of power and powerlessness triangulation and projection should be acknowledged, along with the recognition that dysfunctionality is infrequently normalised on an organisational level (Kersten, 2001; Ashforth, 1989). In this respect, perhaps more attention could be drawn to an appropriate training of the hospital staff (e.g. interpersonal and therapeutic skills), in addition to stress management and general level of support and supervision of mental health staff. It is argued that *containment* and *holding* not only relates to the therapeutic consulting room, but also to wider organisational settings and its implementation would aim to restore human subject in its contexts (Yakeley, 2010; Kersten, 2001). This carries important implications for practitioners, such as counselling psychologists, whose role on an in-patient ward may be invaluable in terms of ensuring the development of psychological atmosphere and reflective forum

for mental health staff. Such is pertinent as staff well-being would directly determine the quality of care provided to the patients.

Finally, the current form of psychiatric care and its effectiveness have been critically re-evaluated and present notions regarding 'psychopathology' deconstructed (Parker et al., 1995). Studies such as this one seem to be of great importance in terms of knowledge enhancement on the subject. However, the problem seems to be that most suitable regulations regarding involuntary psychiatric admissions and treatment have been governed by very little research (Priebe et al. 2010). Such a significant omission may require rectification. Appeal for a paradigm shift within psychiatry has recently been made by British Psychological Society (2013) and some researchers like Richard Bentall (2009; 2004) or Robert Whitaker (2005; 2011) have illustrated how dominant treatment model offered by psychiatry hinders, rather than helps the patient. Thus, passionate arguments for a new type of patient care have been made. In fact, an alternative approach to the treatment of psychosis called an *Open Dialogue* has been developed that is characterised by de-emphasising pharmaceutical intervention and instead providing an immediate psychotherapeutic response. Open Dialogue Research indicates that in the 1980s psychiatric services in Western Lapland were poor and had one of the worst incidents of psychosis. Nowadays, they are regarded as having the best-documented outcomes in the western world (Seikkula et al., 2000; Seikkula et al., 2006; Whitaker, 2011).

4.6 Study Limitations

The findings of the current project are inevitably bound to the intrinsic limitations of any qualitative inquiry. However, these have already been discussed in some detail in the 'Method Chapter'. The analysis is specific to the particular individuals that took part in the project, a specific researcher and at a certain point in time. Self-selective sampling method means that the study might have attracted participants who were particularly impacted by their hospitalisation. Participants' accounts and results of the study may also have been constructed and to some degree influenced by the methodology and interview questions. Furthermore, other interpretations of the same materials are undoubtedly possible. However, it is important to highlight that subjectivity, interpretivism and a small sample lie at the heart of qualitative methods, including IPA and it can be treated as a strength rather than a limitation. In addition, it is relevant to note that themes that are emergent in the current project are also reported in other studies on the subject. Thus findings from IPA study can often be utilised to contextualise existing knowledge, including quantitative research.

However, it seems relevant to contemplate upon the fact that female participants constitute a majority of the sample, as researcher received a minimal response interest from male individuals. In addition, all participants who volunteered for the study are of white ethnicity.

Some research focusing on volunteering for psychological research suggests that females are somewhat more likely to volunteer than males (Cowles & Davis, 1987). Similarly, volunteer-related problems have become identified in behavioural studies where there seem to be a tendency for female subjects to be overrepresented, although this may vary depending on factors such as the research topic and task involved (Rosenthal & Ronsow, 2009) thus providing an indication that the issue may be far more complicated and therefore certainly beyond the scope of this project to focus on in more depth. However, a brief outline of the main issues possibly playing a role may be necessary. Thus it seems that, research concerning mental health difficulties and mental health awareness, in general, has, particularly in the past, focused predominantly on women which historically may have been intertwined with medicalization of women's experiences (Turner, 1987). It also appears that men with mental health problems, when compared to women, may still be facing more stigma and negativity from society (Farina, 1998). As a result, it is commonly believed that men may find it more difficult to acknowledge their problems, express their feelings and seek help which can be experienced and perceived as a sign of weakness (Stewart, 2000). However, it seems relevant to critically examine the above-mentioned discourse and how it positions each gender in our society, and ponder whether such assumptions reflect the differential experiences of men and women or merely represent a dominant perception of our culture at a particular point in time (Parker et al. 1995).

Furthermore, research seems to indicate that although women are more likely to be diagnosed with mental illness men are more likely to be admitted to a psychiatric hospital and detained formally under section (Office for National Statistics, 2006/2008; Department of Health, 2004). Parker and colleagues (1995) highlight that psychiatric statistics expose the occurrence of institutional racism. Ethnic inequalities and racial bias seem to be evident within the mental health system as black and minority groups seem to be treated differently, and are more likely to be diagnosed with mental illness or detained under the Mental Health Act when compared with their white counterparts (Mukherjee et al. 1983; Strakowski et al. 1993; Whaley, 2004. Research also suggests that Black men may have a high level of distrust which may prevent them from seeking services or engaging in research (Whaley, 2004 & 2001). Such a response has often been viewed as a symptom of psychopathology (paranoid schizophrenia was a common diagnosis given to Black men) but it could more appropriately be referred to as 'healthy cultural paranoia' or 'cultural mistrust' and therefore an overall distrust of White society indicating a defence against threats of

racism and discrimination (Terrel & Terrell, 1981; Ridley, 1984; Fernando, 2002). This points to an argument of dualism whereby racism and discrimination account for both misdiagnosis and existence of distress in the first place (Parker et al. 1995).

Furthermore, the majority of participants in this research sample reported having a diagnosis of bipolar disorder, and only one reported being previously diagnosed with schizophrenia. It seems that poverty, unemployment and social isolation links diagnosis of schizophrenia to ethnicity in particular, as studies indicate that black people are more likely to be given this diagnosis than their white counterparts with the same symptoms (Strakowski, 1995). It is also argued that schizophrenia is not only the most misunderstood but also the most stigmatised mental illness of all (Cromby et al. 2013; SANE, 2009).

Collier and Mahoney (1996) acknowledge that although literature on selection bias has its roots in quantitative research, the issue can still apply to qualitative review or at least pose a dilemma. On the other hand, it is important to bear in mind that a small homogenous sample is a central ingredient in discovering the quality of participants' unique experiences. Thus, qualitative studies are not concerned with generalisation and do not attempt to remove so-called self-section bias either. Nevertheless, it has been suggested that if qualitative inquiries repeatedly rely on the same population, there is a danger that access to a diversity of human experience remains compromised (Cannon et al., 1988). Cannon and others (1988) state that exploratory research is particularly vulnerable to race and class bias and that an integration of race, especially into qualitative research may require more labour intensive strategies.

4.7 Summary

The current study has contributed to the existing knowledge in terms of the importance of balancing patient care and suggesting that involuntary hospitalisation to a psychiatric in-patient ward has a potential of being experienced as traumatic and a violation of individuals' integrity. Although, simultaneously it appears that this does not necessarily be the case. To conclude, research including this study seems to call for the routine provision of alternative and improved forms of support and interventions, during involuntary in-patient treatment.

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SECTION D: THEORETICAL PAPER

Towards Inner Change and Empowerment: The Role of Therapeutic Interventions in Affect – Regulation Deficits

Abstract

'To speak about affects is to speak about relationships' (Spezzano, 1993, p.250). Early life experiences can shape the organisation of our emotions, with affect-regulation difficulties manifesting themselves as a reversible neuropsychological breakdown or a failure in the development of the function of the self (Schore, 2003; 2005). Focusing on and working with emotions in the context of a therapeutic relationship is one of the core techniques in modalities such as psychodynamic (Maroda, 2012) or Emotion Focused Therapy (Greenberg, 2004). The current paper aims to draw attention to the possibility of improving psychological therapies by making emotion regulation skills a target intervention, regardless of the therapeutic orientation, in order to facilitate change (Coombs, Coleman, and Jones, 2002**;** Berking et al., 2008). It is argued that the process through which feelings are brought to the surface and experienced leads to the mobilisation of a healing force (Davanloo, 2000). However, current trends in emotion research highlight the pertinence of not only emotional expression but also its regulation and management (Greenberg and Safran, 1987; Greenberg, 2002) as handling feelings appear to be pivotal to well-being (Gross and Munoz, 1995). It can be concluded that one's style of affective regulation, as well as emotional resilience and flexibility, is a measure of social interactions and can, therefore, be observed in the intensity and intimacy of the therapeutic relationship (Cozolino, 2010). The article presents a critical review of the relevant theory as well as research on the affect and its connection to intra and interpersonal functioning and changes through promotion of therapeutic adaptability, which may allow for the problems of emotion regulation to be more effectively addressed.

Keywords: affect-regulation, emotion, attachment, psychotherapeutic interventions, empowerment

1.1 Emotion, Feeling and Affect Conceptualisations

It seems pertinent to begin the paper by pointing out that some debate and controversy exists around the very definitions ascribed to concepts such as emotion, feeling and affect, as these terms are often used interchangeably (Tomkins, 1962; 1963; Westen, 1994; Shouse, 2005). Thus, significant confusion has clouded the use of emotion-linked constructs, with various investigators employing their own idiosyncratic *operalizations* (Rottenberg and Gross, 2007). It is highlighted that affect should not be equated with feelings and emotions (Shouse, 2005; Damasio, 2000 and Brennan, 2004). Massumi (1987) states that feelings are *personal* and *biographical*, emotions are *social*, and affects are *pre-personal*. Feeling is, therefore a sensation that is a result of language and previous experiences. Thus technically, the infant does not experience any feelings but affect. Emotion is conceptualised as the projection and display of a feeling. Emotion, unlike feeling, can, therefore, be feigned (Shouse, 2005). Affect, in turn, has been defined as a moment of unformed and unstructured potential, a neurophysiological state with an unconscious experience of intensity (Demos, 1995). Similarly, Nathason (1992) states that emotions are affects modified by experiences, with affects forming biological and emotional biographical structures and being superordinate to emotion regulation, coping and ego-defensive processes. Furthermore, Rottenberg and Gross (2007; 2003), as well as Scherer (1984), view emotion as a special case of affect, in its relatively short and referential mode. It also seems that some discrepancies exist with regards to the very definition of emotion regulation (Rottenberg and Gross, 2007). It appears that emotion regulation refers to an ability to influence which emotions to have, when and how these are experienced and expressed, down or up-regulated, either automatically or deliberately (Mauss, Cook, and Gross, 2007). In this context, emotion regulation is conceptualised to be only one of the many forms of affect regulation (Gross, 1998). It is essential to decide what exactly the construct of interest in research is, and what is the potential target of the treatment intervention - affect, emotion, feeling or perhaps mood? Undoubtedly, this is an extremely rich domain, with each or all aspects of potential interest within psychotherapeutic practice (Rottenberg and Gross, 2007). Nevertheless, the consensus seems to be that affect-regulation, as distinguished from emotion or feeling, is considered to be largely an unconscious skill. It refers to the capacity of tolerating intense feelings and impulses, both 'positive' and 'negative', without having to rely on a wide array of avoidance and distraction-based strategies or behaviours, which may take the form of substance misuse or form defence mechanisms, such as dissociation, suppression and repression, displacement, denial or intellectualisation (Carver et al., 1989; Folkman and Lazarus, 1980) - to name a few, as the list here can never be exhaustive (Selva, 2004). However, using value judgements, and therefore categorising emotions into 'good' or 'bad' polarities may not be helpful after all, as it is practically impossible to keep one and get rid of the other. Perhaps, emotions should

instead be integrated and those that are viewed as 'negative' may, in fact, be the most valuable as they often direct us to the areas that need to be processed, allowing the expression of denied or locked pain.

1.2 Affect-regulation Deficits as a Root Cause of Psychopathology

Several theorists argue that the problems with affect-regulation appear to be present to a greater or lesser extent in most, if not all, forms of relationships and complaints associated with common forms of distress.. It often represents the core of the maintaining issue and potentially manifests itself in resistance and difficulty to engage in therapy (Mennin and Farach, 2007). Awry attachments and/or trauma can result in a chronic imbalance of an autonomic nervous system. Many clients suffer as they feel they are not in charge of their bodies or their emotions (Schore and Schore, 2008). When encountering therapeutic practice, many individuals seem overwhelmed by specific feelings, or are frightened to experience any emotion at all. For some, even remotely touching upon painful underlying states can create marked discomfort and even a desire to withdraw from therapy. This could probably be because these individuals struggle with guilt and shame for being out of control for so long. Clinical experience reveals that while some clients are able to talk about their feelings, they are nevertheless unable to connect to them, indicating defence mechanisms at play. Psychological defences are also considered to be a type of affect – regulation strategies (Rottengberg and Gross, 2007). Therapy with more vulnerable clients who are unable to risk existing without their defences is one of the factors that may make the process less successful or more lengthy (Bradley, 2000; Whelton, 2004). However, the word 'successful' is in itself debatable. Nevertheless, the very concept of affect-intolerance seems crucial, when it comes to achieving a more efficient and deeper level of exploratory work or change in the therapeutic context (Nightingale, 2002).

1.3 Unconscious and Implicit Interpersonal Processes

Integration of findings, gathered predominantly from empirical research on cognitive science and neuropsychology, and informed and inspired by psychoanalytic theory and developmental psychology, suggests that affect-regulation is communicated through the non-verbal, sensory-perceptual-motor dimension. During the initial stages of human life development (the beginnings of affect-regulation seem to occur in the earliest foetal stages), emotions are managed by others as affective bodily-based attachment processes that are unconsciously regulated within the primary object and

infant dyad (Schore and Schore, 2008). Such non-conscious relational transactions shape the development of psychic structure, and internal working models, and critically impact the development of right brain neurobiological systems (which are regarded as the core of human unconscious). These systems are responsible for processing and modulation of emotion and stress, self-regulation and self-soothing capabilities of mind/body (Prodan et al., 2001; Schore, 2000; 2003; 2005; Applegate and Shapiro, 2005). It is argued that modern attachment theory is, in fact, a regulation theory consonant with the psychodynamic literature on inter-subjective dynamics (Schore and Schore, 2008).

Besides conscious and explicit attendance to client's linguistics, implicit communication at levels beneath awareness, is also embedded in the therapist-client relationship of transference and countertransference phenomena and is characterised by right brain transactions and interceptive, somatically-based, affective relational exchanges (Lyons-Ruth, 2000; Scaer, 2005; Schore, 2003; Decety and Chaminade, 2003). It, therefore, seems that as individuals we are not self-contained in terms of our energies, as affect has potential transmitting properties whereby one individual can have an impact on another (Brennan, 2004). It has therefore been demonstrated that the therapeutic encounter allows for the unconscious transmission of self-regulation transactions, which in turn provides an opportunity for remediation of client's early acquired ruptures in this domain (Jacobs, 1994; Schore and Schore, 2008). It is the role of an intuitive clinician, acting as an interactive regulator to be attuned psycho-biologically to the client's non-verbal internal structure. This work, however, requires profound engagement and commitment from both the therapist and the client (Tutte, 2004). It is argued that effective treatment, particularly related to early self-pathologies, is ultimately connected to changes in the unconscious system of the right hemisphere (Cohen and Shaver, 2004). Importantly, neuroimaging evidence has demonstrated that psychotherapy itself can reverse the effects of trauma and alter both functions and structures of the brain (Fuchs, 2004). Thus, the depth of therapeutic contact is enhanced significantly and carries transformative effects during *moments of meeting* (Stern et al., 1998), when emotions are deepened in intensity and are shared inter-subjectively (Whitehead, 2006). It appears that the key is how to *be* with the client during emotionally charged moments, rather than what to do or say to the client (which would be represented through left brain focus). The relationship, empathy and emotional responses of the therapist form cornerstones for a healing process. However, this idea is certainly not a novel one, corresponding as it does to Winnicott's (1960) *Holding Environment*, Kohut's (1978) *Mirroring* and Bion's (1962) theory of *Containment.*

Interestingly, it has been proposed that implicit transmission of affective processes, as linked to affect-regulation, may be facilitated in a more active, direct and effective manner. In other words, this process of emotional communication may be extracted

out of the intuitive realm and placed explicitly into the focus of conscious awareness. Fonagy and Target (1998), argue that the implicit dimension of therapeutic encounter falls under the rubric of 'non-specific factors,' and that previously-mentioned 'moment of meeting' should be authentic and spontaneous in occurrence. Following this line of thinking, it could be implied that the therapist may not be able to intentionally impact the *non-specific* elements as any theory and technique represent explicit and declarative knowledge. However, others have suggested that the therapist can be responsive, like the responsive mother. Therefore some degree of self-awareness of thetherapist's own behaviour and therapeutic intervention, in relation to affective states, can be developed (Kiersky et al., 1994; Knoblauch, 1997).

1.4 The Mechanism of Change

The concept of change may produce various definitions. In fact, the very idea of change is probably as problematic as staying the same. Nevertheless, in the context of affect regulation difficulties change can be defined as an enhanced ability to respond adaptively, flexibly and creatively to the circumstances of life. The aim is hence, focused on achieving greater fluidity and ability to use the full range of emotional repertoire, which ultimately entails a way in which one expresses oneself in life or how one relates to life. Therefore, establishing the occurrence and format of client's affect-regulation evokes questions regarding therapeutic action. McCullough et al. (2003) raised the subject of the importance of helping the client experience affect, rather than merely talking about it. Indeed, it has been identified that three components of the feeling must be present that would regard the client as truly 'in touch with' the experience of the emotion. These elements represent cognitive (labelling feelings), physiological (physical/visceral sensations) and motoric (mobilisation of an impulse) dimensions (Laikin, Winston and McCullough, 1991; Selva, 2004). Also when painful feelings are de-repressed, fully experienced and owned they can also be integrated as valid and healthy elements of the self (Jacobs, 2010). Moreover, affect–regulation or the nature of regulated interactions between the therapist and the client are associated with emotional communication and therefore better therapeutic alliance (Nightingale, 2002). Thus, when it comes to psychic change, a classic psychoanalytic method of interpenetration may be limited when used in isolation (Andrade, 2005). The premise that insight on its own is sufficient has become ingrained in talking therapy, and although of great importance (as it can form a foundation for change) it may not be the same as an actual change. The power and role of affect in human functioning and its connection to rationality has long been overlooked. Damasio's (2006) revolutionary work on emotion, *'I feel therefore I am*' corrects Descartes's '*I think therefore I am'* proclamation and points to the possibility that emotions may constitute the source of one's core being. Hence, if we are unable

to process and express our emotions, development of our true self and our authenticity is impaired; in other words, we are unable to *be* (Miller, 2008). Following this line of thinking one may wonder to what extent is it truly helpful to prioritise cognition and give precedence to logic by emphasising and fostering thought-orientated components, while downplaying the role of emotions. Thus, one may reflect upon the fact that some of the main philosophical, as well theoretical and scientific underpinnings of Cognitive Therapy have been questioned; including its key presumption that cognitive disturbance causes an emotional disturbance (Moloney and Kelly, 2004). In fact, even the long-term effectiveness of this approach is now doubted (Shedler, 2010; Huber et al., 2012). It may be concluded that the current preoccupation with 'quick fixes' undermines the importance of delivering interventions that would address the root cause of the problem and produce long-lasting and broadly-based benefits. Critique of affect theory, on the other hand, frequently concentrates on the argument that cognitions and meanings are not necessarily separate from emotion or affect (Leys, 2011). However, the counterargument stresses that affect proceeds language-based cognition (Stern, 1994 and Stern et al., 1998). Hence, it is claimed that cognitive re-appraisal or insight may provide a deeper understanding but cognitive change alone is unlikely to reconfigure the emotion schematic network in the brain (Bechera et al., 1997; Forgas, 1995). Holistically, it is highlighted that successful intervention requires attendance to both cognition and affective experience – with the latter being a fundamental motivator for behaviour and therefore change (McCullough et al., 2003).

1.5 Therapeutic Action and Empowerment

Berking et al. (2008) argue that although research seems to indicate that deficits in emotion regulation lie at the core of development, maintenance and treatment of a wide range of psychological problems (Gross and Munoz, 1995; Thoits, 1985), there are several limitations in current, albeit extensive, data on the subject. This makes it difficult to utilise the knowledge possessed for improving the psychological therapies by making emotion regulation skills a target intervention. Mindfulness, for instance, teaches us to *acknowledge* and *accept* experiences, rather than modifying or suppressing them, and this practice seems indirectly to increase the capacity for emotional regulation (Kavat-Zinn, 2003). Recent modifications to mindfulness-based approaches developed specifically for substance abusing populations (for whom affect regulation difficulties may be more pronounced) seem compelling and include Mindfulness-Based Relapse Prevention (MBRP). Research indicates that mindfulness practice is associated with decreased cravings, greater acceptance and acting with awareness (Marcus and Zgierska, 2009). Emotion regulation is also a core skill taught

in DBT, ACT, MBCBT etc,. and the research supports treatments that aim to improve emotional self-efficacy (e.g., Hoffart, 1995; Williams and Zane, 1989) or acceptance and resilience (e.g., Hayes et al., 1999; 2006; Kabat-Zinn, 2003). However, the strongest intervention is the one that combines all these approaches and focuses, not only on emotional awareness or acceptance but also on its modification, regulation and resilience (Greenberg, 2002; Linehan, 1993). Nevertheless, it appears that perhaps further research on the subject is needed in order to determine what works best and/or for whom (Berking et al., 2008). Furthermore, there is Emotion-Focused Therapy (EFT) which is an empirically- supported treatment intervention that targets emotion. Although it is regarded as humanistic in approach, it is nevertheless firmly established in attachment theory and affective neuroscience (however it also draws from Gestalt and systemic therapy). The emphasis is placed on enhancing emotional awareness in the first instance, followed by emotional regulation and finally leading to emotional transformation. EFT is also experiential as it utilises psychodrama, diaphragmatic breathing, physiological relaxation, self-empathy and compassionate self-talk as self-soothing techniques. For aiding emotional expression, EFT uses expressive enactment that focuses on body postures. EFT is also promising with regards to the treatment of psychosis and substance misuse (Elliott, 2013; Greenberg, 2004).

Affective model of change has, in fact, shaped some recent forms of Short-Term Dynamic Psychotherapy (STDP) that have been designed to focus more explicitly on emotional experiences. For instance, Intensive Short-Term Dynamic Psychotherapy (ISTDP), developed by Davanloo (1980), has been designed to focus on clients' intolerable and conflicting underlying feelings by breaking through their defence barriers and resistance (Abbass and Bechard, 2007; Selva, 2004). The aim of ISTDP is to expose (de-sensitize) the client to 'toxic' affects and reduce anxiety and need for defences that are accompanied by the rise of such concealed states (Davanloo, 1995; Bliski-Piotrowski, 2011). Although such work, because of its considerable brevity, is undoubtedly attractive in an economic sense, contraindications exist, as it is argued that not every client would be suitable for such intense treatment, characterised as it is by pressure and challenge from the therapist in order to 'unlock the unconscious' in the context of therapeutic transference. Abbass et al.'s (2012) meta-analysis study on ISTDP seems to support its effectiveness across a broad range of populations. However, it remains uncertain whether it can be applied to all client populations. Additionally, as the authors themselves note, some studies were characterised by methodological shortcomings. Contraindications seem to exist and include clients with psychosis or active substance misuse. Clients with fragile ego may not be able to withstand rapid and overwhelming affective states that are aimed to be evoked and brought to the surface in an almost flooding effect. It also has to be said that such a model and intervention would not appeal to all therapists as personality, therapeutic

style and ego strength also plays a key role and must not be underestimated (Selva, 2004).

The STDP model of Fosha (2000) and McCullough (2003) is based on the works of Davenloo (1980) and Malan (1976). The STDP model of McCullough and his colleagues (Kuhn, Andrews, Kaplan, Wolf, and Hurley) (2003) is built on the premise that psychopathology is rooted in *Affect Phobia,* which is viewed as central to core intrapsychic conflicts. It is therefore argued that *Affect Phobia* can be treated through the same method as other phobias – with systemic desensitisation, hence the analogy. Both Fosha's (2000) and McCullough's (2003) models are unique in the sense that they not only draw from previous psychoanalytic tradition but also incorporate elements of experiential approach. Existing research evidence indicates the efficacy of STDP approach, which is perhaps slightly superior for long term follow-up as compared to other forms of psychotherapy (Anderson and Lambert, 1995).

These interventions, especially when implemented gradually, can also help prepare the client for more intense work related to the previous trauma (*trauma* here *as* subjective experience) and to confront and own the most 'dangerous' and unbearable affective states, which are ultimately *contained* by the therapist. However, even though the above models utilise graded exposure (when compared to ISTDP, for instance), it is assumed that for some clients (such as those for whom marked inability to contain affects makes it impossible for them to control addiction or aggressive impulses), these interventions may compound existing impairment or lead to destructive acting out. It is, therefore recommended that behaviour linked to substance misuse should be under control for at least 1-3 years, before beginning the STDP treatment (McCullough et al., 2003) is a requirement that may be too unrealistic for many clients to achieve.

Berking et al. (2008) go further to propose that the efficacy of current evidence-based treatment approaches could be improved by developing 'non-disorder' specific interventions that could be incorporated into existing treatment packages and that would focus on enhancing emotion regulation skills for a wide range of distress forms (Berking et al. 2008; Moses and Barlow, 2006). This idea is also supported by the fact that many clients are diagnosed with more than one 'mental disorder' (Krueger and Markon, 2006), which as they argue, may represent the underlying emotion regulation deficits (Berking et al., 2008). However, it has to be noted that the authors here speak of *emotion* regulation and it seems uncertain whether the term is used with reference to affect constructs, or both. As mentioned previously, they are at times used as synonyms, which results in considerable confusion in the field (Shouse, 2005). Nevertheless, an alternative intervention, such as those mentioned by Berking et al. (2008), is provided by Anca Ramsden, a clinical psychologist with over 27 years of

experience in training, neuropsychology research and client consultation in Affect Regulation Therapy (here *affect* not emotion). Affect Regulation Therapy (ART) is considered to be compatible with, and complementary, to many therapeutic approaches, including psychodynamic therapy. ART operates on the principle that regulation of fight, flight or freeze arousal states are associated with developmental stages of socio-emotional and sensorimotor neural integration. Fear conditioning, affect regulation, bonding and attachment are closely connected with the body and sensory-based systems that operate outside the conscious awareness (that may be at the heart of clients' problems), which means that they are beyond grasp within symbolic thought or linguistic mode (Cozolino, 2010; Rothschild, 2000; Schore, 2003). ART, therefore, works by placing focus on the developmental milestones, raising regulation and having an impact on the implicit and unconscious memory (hippocampal/amygdala affect regulation systems) through the relationship that replicates mother and infant bonding. The efficacy of ART seems to be supported by observations in clinical practice over eighteen years, as well as a small quantitative pilot study that has yielded positive results. The Ramsden website states that this training is being endorsed by the British Psychological Society. Nevertheless, the research surrounding ART is very limited. Thus, unfortunately, as Berking et al. (2008) highlight, it seems that no significant empirical data exists that evaluates the effectiveness of such interventions.

John Omaha developed Affect Centred Therapy (ACT) (Omaha, 2006) and Affect Management Skills Training (AMST), which entails the Phase 1 of Affect Centred Therapy (Omaha, 2000). AMST can also be a precursor to any therapy, meant for clients facing substance misuse, personality and eating 'disorders,' and Crohn's disease (amongst others) by aiming to remediate affect-regulation impairments, acquired through childhood deficit experiences (Omaha, 2000). Omaha (2000) argues that without developing affect regulation skills, clients with substance misuse are at a risk of disorganisation, decompensation and relapse, as therapy would elicit affects that the client group is not equipped to manage. Therefore, he also argues that affect-regulation skills could be taught and transmitted to the client, leading to the formation of secure self-structure (Omaga, 2004). Thus, AMST operates by communicating with the client's right brain, through the utilisation of imagery, felt body sense and by connecting the two with cognitions. The method also draws on Attachment Remediating Visualisations (Safe Place Skill Visualization), as inspired by the works of Wesselmann (2000) and Schore (1994), which stresses the pertinence of the caregiver's facial cues in affect-regulation development. Finally, the work is focused on relapse prevention , and enhancement of clients' self-worth and self-efficacy. Omaha (2000) asserts that such work builds a strong therapeutic alliance, which also remediates issues associated with childhood attachment. Thus, using techniques such as imagery and visualisation, is the key, as affect regulation involves

sub symbolic-cognitive processes. Self-generated imagery has also been shown to replace unwanted and automatically-generated emotions (Derryberry and Reed, 1996). Imagery can also have a positive impact on the therapeutic relationship by allowing a more experientially-profound bonding with the client. Using symbolism promotes emotion assimilation into consciousness and increases reflection and aids to create new meanings (Holmes and Mathews, 2010). Furthermore, AMST employs eye movements (the EM of EMDR, Eye Movement Desensitization and Reprocessing), a specific type of Bilateral Stimulation (BLS), and draws from the CBT approach. Although empirical evidence exists to support CBT or EMDR, it seems that AMST is not currently an evidence-based treatment intervention, as only existing clinical impressions and limited single case design studies support it (Omaha, 2006). It is also argued that the model itself, and its theoretical underpinnings, are supported by a large body of empirical evidence (Sroufe, 1997). Although Omaha (2000) identifies potential obstacles that the client may face and suitable interventions to tackle them, there is also evidence that suggests some individuals may find it difficult to use specific strategies related to emotion regulation when instructed to do so (Demaree et al., 2006). Nevertheless, in a journal of chemical dependency treatment, Omaha's Affect Centred Therapy (2006, p.83) is stated as *''holding the promise of providing lasting treatment for many forms of substance abuse disorders, because it appears to effectively address the true causes''.*

1.6 Conclusion

It is important to note that no single theory can fully and adequately account for all clients' problems and explain or predict distress, personality or behavioural change. It is also highlighted that curative qualities of a given psychological therapy, may, in fact, lie in common components shared by all models, relationships and alliances, constituting its very essence or foundation (Wampold, 2015). The common factors approach also identifies desensitisation and confrontation of difficult emotions, as elements that are crucial for successful therapy. This approach influences the tendency of practitioners' towards psychotherapeutic integration and incorporation of various techniques (Norcross and Arkowitz, 1992). Such a pluralistic stance is characteristic of Counselling Psychology as a discipline mirroring and adapting to the complexity of human nature itself (Kasket, 2012).

Nevertheless, the relationship seems to be a vehicle for change. In the Analytic Press, Spezzano (1993, p.250) asserts that '*to speak about affects is to speak about relationships'*. It is argued that Bowlby's work on attachment itself constitutes a theory of powerlessness and therefore, broaching the very concept of affect regulation deficits is equated with embracing the psychology of powerlessness (Grotstein, 1986). Thus, drawing on richer and appropriately-tailored interventions

addresses affect regulation difficulties and can aid clients in discovering the inner sources, leading to empowerment. Well-developed affect - regulation skills appear to be related to the enhancement of psychological adaptability, which can lead to a greater sense of control, accountability and resilience to stress. Furthermore, acquiring effective affect-regulation strategies may lead to improvements associated with mood modulation, awareness, flexibility and personality, including cognitive functioning, learning capacity, self-expression and socialisation (Rossi, 1992; Schore, 2003). Issues around affect-regulation deficits, seen as an underlying and/or maintaining factor for psychopathology, seem to identify the gap in therapeutic practice that may call for its further development.

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APPENDIX 1 A: Information Sheet for Participants (Pilot Study)

PILOT STUDY RESEARCH

INFORMATION SHEET FOR PARTICIPANTS

Investigating experiences of a psychiatric treatment under section

The title of the Project*: To be heard: a Qualitative exploration of individuals' experiences, views and meanings of psychiatric in-patient treatment under section and its impact on the recovery process.*

Thank you for reading this information

INTRODUCTION

You are being invited to take part in the PILOT STUDY for the research exploring peoples' experiences of a psychiatric in-patient treatment under section. If you wish to consider giving consent to take part, please take the time to read the following information. Below, I have included details about the research that I hope will help you understand why the research is being carried out and what it involves.

WHO AM I?

My name is Anna Wachowska, and I will be conducting the study. I am a Trainee Counselling Psychologist and the research forms part of the requirements for my counselling psychology training at City University London. The research is supervised by Dr Sören Nils Petter who is a Chartered Counselling Psychologist, and a Lecturer at City University London. This study has been ethically approved by City University Research Ethics Committee.

WHAT IS PILOT STUDY?

A pilot study is a smaller version of the larger scale study. It is conducted to prepare for that larger, full-scale research. The pilot study essentially aims to ensure that ideas and all the methods behind the research are sound.

WHAT IS THE RESEARCH ABOUT?

This study is interested in finding out about individuals' experiences and views of their treatment on a closed psychiatric ward under section. It aims to gain a better understanding of the impact psychiatric treatment has on individuals with psychosis and their recovery process through exploring how individuals make sense of themselves, their experience and the world around them.

The research hopes to enhance knowledge on the subject and fill in gaps in existing research. Its objective is to promote the views of people with mental illness as well as provide guidance and inspiration towards the quality improvement of in - patient psychiatric care.

WHO CAN BE INVITED TO TAKE PART?

You are being approached to participate in the study because you might have experienced symptoms of **psychosis** in the past or are currently experiencing symptoms of psychosis and you have been in the past treated on the **NHS in-patient** psychiatric ward (on a **non-voluntary** basis). It is required that at least **six months** period must have passed since individuals' last admission. However, individuals who experienced drug-induced psychosis, have suffered brain injury or have an organic brain disease or diagnosis of learning disability will be excluded from the study. It is assumed that 1 to 2 participants would be invited to take part in the PILOT STUDY and a total number of 6 to 8 participants would be recruited for a full-scale research.

WHAT DOES IT MEAN TO TAKE PART?

Participation in the research is voluntary – it is entirely up to you whether you wish to take part or not. If you decide to participate, you will be given a copy of this *Information Sheet,* and you will be asked to sign a *Consent Form*.

WHAT IF CHANGE MY MIND DURING THE PROCESS?

Even after giving written consent you will have **the right to withdraw** from the study **at any time** without a need to explain why and without any adverse consequences. If you decide to withdraw any information that was collected from you as part of the research would be erased. A decision not to take part or to withdrawal from the study will not affect your current or future access or involvement in services in any way. You will also have the right to decline to offer any particular information requested from you during the research.

WHAT IS INVOLVED?

If you meet the criteria for the study and should you consider taking part I will be happy to answer any questions or concerns you might have. Should you decide to participate, I would ask you to sign a *Consent Form*. It is important that face to face interview is arranged for the purpose of this study. During the meeting we would discuss details of the study by going through this *Information Sheet* again, answering any remaining questions or concerns you might have. Should you decide to participate, I would ask you to sign a *Consent Form*. The interview will be informal and carried out in a conversational style. It is suggested that the interviews are conducted at City University premises in London (private room hired) however it may be possible to arrange for an alternative location. It would be possible for your commuting expenses to be partly reimbursed if required. The length of the whole process is likely to vary from person to person. However it estimated it might last from an hour to two hours, this can be shorter or longer than that. Before the interview begins, I will also ask you some basic background information about yourself. You will also be asked about symptoms of psychosis that you may have experienced. In the interview, you will be asked about your experiences of being on a psychiatric ward and the impact such treatment had on your recovery process. You will be asked to think about yourself and your relationship to others as related to your experiences on a closed ward. You will also be asked about your views and evaluation of psychiatric treatment.

WILL TAKING PART BE CONFIDENTIAL?

All information about you in this study will be kept **strictly confidential** and unidentifiable in written or published material. Your names and details will not be linked with the research materials in any way. Interviews will be recorded using voice recorder.

Pilot study may or may not form part of the final research sample. However the confidentiality, in either case, will be guarded and treated as a priority. If the pilot study does not lead to any significant modifications of the study materials or

procedures, its data might be incorporated into the main study. Otherwise, the data from the pilot study will not be included in the main study findings (and the recording will be erased) however the process and outcome of the pilot interview will be utilised for important reflection purposes. You will be informed whether your interview is to be incorporated into a larger scale study.

If the data from the pilot study is to be analysed and incorporated into a large-scale study – recordings will be subjected to transcription process. The recording will be kept in a safe storage system (locked memory) for up to 5 years providing audit trail evidence of the study being conducted. You will have the right to review the recordings and edit the transcripts at any time during the process. The interview transcripts would be stored in electronic versions, in an anonymous format.

Your information, including consent forms, will be stored in a secure location accessible only by the researchers. In order to preserve anonymity, you will be given a participant number so that you will not be recognisable in any way. You can choose your own pseudonyms which would be used in writing up stage of the data.

However, if during the process you disclose any criminal activity or information indicating that you may be at risk to yourself or others the confidentiality will be broken and your GP or other appropriate authorities informed. Before the interview begins, you will be asked to consent to confidentiality being broken in the situation where such disclosure is made.

WHAT WILL HAPPEN WITH THE RESULTS OF THE STUDY?

If the data from the pilot interview is decided to be incorporated in the main study, the audio-recordings will be transcribed and analysed. The results will be written up, and anonymous quotes from interviews used to support the data interpretation. In such case, it is also important that the findings are meaningful and credible to participants themselves. I, therefore, would like to share the interpretation of interview answers with you, and I would welcome any comments and suggestions including criticism on the subject. You would only receive findings from your own interview process. Your involvement would be greatly appreciated however it is entirely up to you whether you wish to engage in that part of the process or not.
Finally, it is hoped that the main study results will be published in a psychological or psychiatry allied research journal.

ARE THERE ANY POTENTIAL BENEFITS TO TAKING PART?

A pilot study is an initial run through the research tools and procedures. It can help to spot ambiguities and flaws. It, therefore, plays a crucial role in ensuring that the full-scale research is conducted to its best standard when investigating relevant topics such as this one.

Thus overall, little research has focused on direct experiences of patients on acute psychiatric wards. The experiences and insights of participants in this research are therefore of great value and will help to enrich our understanding of how psychiatric treatment is experienced, how it affects person's sense of self and how it can be improved.

Research also indicates that reflecting and talking about significant life experiences such as mental health or recovery can be beneficial and bring about a therapeutic effect. This may be an opportunity for you to contemplate and think about the meaning of your experiences and how they impacted on your own identity and others in your life.

ARE THERE ANY POTENTIAL RISKS TO TAKING PART?

It is possible that thinking and talking about your experiences and your mental health which includes answering questions about your feelings may be upsetting. If you become distressed during the interview, appropriate support will be offered to you by myself, Anna Wachowska. The interview can be terminated and postponed if you feel unable to continue and further help offered to you by your support group/organisation team member, case coordinator, case manager or your GP. For this reason, you would be asked to consent for appropriate persons to be contacted if you do become distressed during the process.

MORE ABOUT RESEARCH DESIGN and METHOD

This will be a qualitative study, conducted from a phenomenological perspective. Phenomenology is the study that is concerned with nature and meaning of phenomena. It places emphasis on how the world is perceived through experience or in our consciousness. Phenomenology is associated with narratives, subjectivity and lived experiences. It seeks to understand meanings in human interactions and events, affirming the importance of the perspective of individuals, their experiences and their view of the world.

WHAT IF I HAVE FURTHER QUESTIONS OR CONCERNS?

Please contact myself, Anna Wachowska (tel. [redacted]) for further questions or concerns related to any aspect of the research. I will do my best to answer your queries and clarify misunderstandings. If you remain unhappy and wish to make a formal complaint about the research, you can contact the Secretary to the University's Senate Research Ethics Committee on 020 7040 3040 or via email: [redacted]

Thank you for your time and consideration

Researcher's Contact Details:

Name: Anna Wachowska, Trainee Counselling Psychologist, City University London
Email: [redacted]
Telephone Number: [redacted]
Address: Department of Psychology, School of Arts and Social Sciences, City University London, Northampton Square, London EC1V 0HB
City University Telephone Number: (0)20 7040 0167; Website: http://www.city.ac.uk

Research Supervisor Contact Details:

Name: Nils Sören Petter
Email: [redacted]
Telephone number: [redacted]
Address: Department of Psychology, School of Arts and Social Sciences, City University London, Northampton Square, London EC1V 0HB

APPENDIX 1 B: Information Sheet for Participants (Main Study)

RESEARCH

INFORMATION SHEET FOR PARTICIPANTS

Investigating experiences of a psychiatric treatment under section

The title of the Project*: To be heard: a Qualitative exploration of individuals' experiences, views and meanings of psychiatric in-patient treatment under the section and its impact on the recovery process.*

Thank you for reading this information

INTRODUCTION

You are being invited to take part in the research study exploring peoples' experiences of a psychiatric in-patient treatment under section. If you wish to consider giving consent to take part, please take the time to read the following information. Below, I have included details about the research that I hope will help you understand why the research is being carried out and what it involves.

WHO AM I?

My name is Anna Wachowska, and I will be conducting the study. I am a trainee counselling psychologist and the research forms part of the requirements for my counselling psychology training at City University London. The research is supervised by Dr Sören Nils Petter who is a Chartered Counselling Psychologist, and a Lecturer at City University London. This study has been ethically approved by City University Research Ethics Committee.

WHAT IS THE RESEARCH ABOUT?

This study is interested in finding out about individuals' experiences and views of their treatment on a closed psychiatric ward under section. It aims to gain a better understanding of the impact psychiatric treatment has on individuals with psychosis and their recovery process through exploring how individuals make sense of themselves, their experience and the world around them.

The research hopes to enhance knowledge on the subject and fill in gaps in existing research. Its objective is to promote the views of people in distress as well as provide guidance and inspiration towards the quality improvement of an in - patient psychiatric care.

WHO CAN BE INVITED TO TAKE PART?

You are being approached to participate in the study because you might have experienced symptoms of **psychosis** in the past or are currently experiencing symptoms of psychosis and you have been in the past treated on the **NHS in-patient** psychiatric ward (on a **non-voluntary** basis). It is required that at least **six months** period must have passed since individuals' last admission. However, individuals who experienced drug-induced psychosis, have suffered brain injury or have an organic brain disease or diagnosis of learning disability will be excluded from the study. A total of 6 to 8 participants would be invited to take part in the study.

WHAT DOES IT MEAN TO TAKE PART?

Participation in the research is **voluntary** – it is entirely up to you whether you wish to take part or not. If you decide to participate, you will be given a copy of this *Information Sheet,* and you will be asked to sign a *Consent Form*.

WHAT IF I CHANGE MY MIND DURING THE PROCESS?

Even after giving written consent you will have **the right to withdraw** from the study **at any time** without a need to explain why and without any adverse consequences. If you decide to withdraw any information that was collected from you as part of the research would be erased. You will also have the right to decline to offer any particular information requested from you during the study.

WHAT IS INVOLVED?

If you meet the criteria for the study and should you consider taking part I will be happy to answer any questions or concerns you might have. Should you decide to participate, I would ask you to sign a *Consent Form*. It is important that face to face interview is arranged for the purpose of this study. During the meeting we would discuss details of the study by going through this *Information Sheet* again, answering any remaining questions or concerns you might have. Should you decide to participate, I would ask you to sign a *Consent Form*. The interview will be informal and carried out in a conversational style. It is suggested that the interviews are conducted at City University premises in London (private room hired) however it may be possible to arrange for an alternative location. It would be possible for your commuting expenses to be partly reimbursed if required. The length of the whole process is likely to vary from person to person. However it estimated it might last from an hour to two hours, this can be shorter or longer than that. Before the interview begins, I will ask you some basic background information about yourself. You will also be asked about symptoms of psychosis that you may have. In the interview, you will be asked about your experiences of being on a psychiatric ward and the impact such treatment had on your recovery process. You will be asked to think about yourself and your relationship to others as related to your experiences on a closed ward. You will also be asked about your views and evaluation of psychiatric treatment.

WILL TAKING PART BE CONFIDENTIAL?

All information about you in this study will be kept **strictly confidential** and unidentifiable in written or published material. Your names and details will not be linked with the research materials in any way. Interviews will be recorded using the voice recorder, and recordings will be kept in a safe storage system (locked memory) for up to 5 years providing audit trail evidence of the study being conducted. You will have the right to review the recordings and edit the transcripts at any time during the process. The interview transcripts would be stored in electronic versions, in an anonymous format. Your information, including consent forms, will be stored in a secure location accessible only by the researchers. In order to preserve anonymity, you will be given a participant number so that you will not be recognisable in any way. You can choose your own pseudonyms which would be used in writing up stage of the data.

However, if during the process you disclose any criminal activity or information indicating that you may be at risk to yourself or others the confidentiality will be broken and your GP or other appropriate authorities informed. Before the interview

begins, you will be asked to consent to confidentiality being broken in the situation where such disclosure is made.

WHAT WILL HAPPEN WITH THE RESULTS OF THE STUDY?

Once the interviews are completed, the audio-recordings will be transcribed and analysed. The results will be written up, and anonymous quotes from interviews used to support the data interpretation. It is also important that the findings are meaningful and credible to participants themselves. I, therefore, would like to share the interpretation of interview answers with you, and I would welcome any comments and suggestions including criticism on the subject. You would only receive findings from your own interview process. Your involvement would be greatly appreciated however it is entirely up to you whether you wish to engage in that part of the process or not.

Finally, it is hoped that the study results will be published in a psychological or psychiatry allied research journal.

ARE THERE ANY POTENTIAL BENEFITS TO TAKING PART?

Overall, little research has focused on direct experiences of patients on acute psychiatric wards. Your experiences and insights are therefore of great value and will help to enrich our understanding of how psychiatric treatment is experienced, how it affects person's sense of self and how it can be improved.

Research also indicates that reflecting and talking about significant life experiences such as mental health or recovery can be beneficial and bring about a therapeutic effect. This may be an opportunity for you to contemplate and think about the meaning of your experiences and how they impacted on your own identity and others in your life.

ARE THERE ANY POTENTIAL RISKS TO TAKING PART?

It is possible that thinking and talking about your experiences and your mental health which includes answering questions about your feelings may be upsetting. If you become distressed during the interview appropriate support will be offered to you by myself, Anna Wachowska in the first instance. The interview can be terminated and postponed if you feel unable to continue and further help offered to you by identified/chosen support network/group, case coordinator, case manager or your GP. For this reason, you would be asked to consent for appropriate persons to be contacted if you do become distressed during the process.

MORE ABOUT RESEARCH DESIGN and METHOD

This will be a qualitative study, conducted from a phenomenological perspective. Phenomenology is the study that is concerned with nature and meaning of phenomena. It places emphasis on how the world is perceived through experience or in our consciousness. Phenomenology is associated with narratives, subjectivity and lived experiences. It seeks to understand meanings in human interactions and events, affirming the importance of the perspective of individuals, their experiences and their view of the world.

WHAT IF I HAVE FURTHER QUESTIONS OR CONCERNS?

Please contact myself, Anna Wachowska (tel. [redacted]) for further questions or concerns related to any aspect of the research. I will do my best to answer your queries and clarify misunderstandings. If you remain unhappy and wish to make a formal complaint about the research, you can contact the Secretary to the University's Senate Research Ethics Committee on 020 7040 3040 or via email: [redacted]

Thank you for your time and consideration

Researcher's Contact Details:

Name: Anna Wachowska, Trainee Counselling Psychologist, City University London
Email: [redacted]
Telephone Number: [redacted]
Address: Department of Psychology, School of Arts and Social Sciences, City University London, Northampton Square, London EC1V 0HB
City University Telephone Number: (0)20 7040 0167; Website: http://www.city.ac.uk

Research Supervisor Contact Details:

Name: Nils Sören Petter
Email: [redacted]
Telephone number: [redacted]
Address: Department of Psychology, School of Arts and Social Sciences, City University London, Northampton Square, London EC1V 0HB

APPENDIX 2 A: The Consent Form (Pilot Study)

PARTICIPANT
PILOT STUDY CONSENT FORM

Name of the researcher: ANNA WACHOWSKA, City University London Email: [redacted]
Tel: [redacted]

The title of the study: *To be heard - a Qualitative exploration of individuals' experiences, views and meanings of psychiatric in-patient treatment under section and its impact on the recovery process.*

Please tick box to confirm

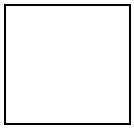
1. I have read The Study Information Sheet provided for the above research. I had an opportunity to consider all the information and I understand what the study is about. I had a chance to ask questions and have had these answered satisfactorily.

☐

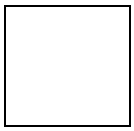
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my care, involvement in services or legal rights being affected. I understand that I have the right to decline to offer any particular information requested from me during the research.

☐

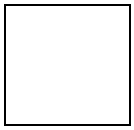
3. I agree to my interview being audio-recorded.



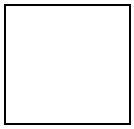
4. I understand that personal information about myself and all the information I provide during the process will be kept anonymous and confidential. However, I understand that if the researcher is concerned about my well-being or well-being of others they are obligated to inform appropriate persons/authorities.



5. I give permission to my care-coordinator/key worker Name: _____or GP Name: _____to be contacted if I become distressed during the interview or if I make a disclosure of criminal activity or risk of harm to myself or others.



5. I consent to the data from my pilot study interview being incorporated in the larger scale study if required.



A) In the above case:
   - I consent to the audio recordings being kept in a safe storage system (locked memory) for up to 5 years providing audio trail evidence of the study being conducted,
   - I consent to the anonymous quotes from the interview to be used in the write-up section of the study and for these to be published in a psychological journal.

B). OPTIONAL: If my data is incorporated in the main study, I wish to obtain findings of the study and have an opportunity to share comments on the interpretation process with the researcher. Please send the information to:

_____
__

☐

7. I agree to take part in the above research study.

☐

If you <u>do</u> want to take part in this study please print and sign your name below:

_____ _____ _____
Name of Participant (PRINT) Signature Date

Thank you for your help and participation:

_____ _____ _____
Researcher (PRINT) Signature Date

(Once copy to be retained by participant, original to be kept safely by the researcher)

APPENDIX 2B: The Consent Form (Main Study)

PARTICIPANT
RESEARCH CONSENT FORM

Name of the researcher: ANNA WACHOWSKA, City University London Email: [redacted]
Tel: [redacted]

The title of the study: *To be heard - a Qualitative exploration of individuals' experiences, views and meanings of psychiatric in-patient treatment under section and its impact on the recovery process.*

Please tick box to confirm

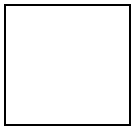
1. I have read The Study Information Sheet provided for the above research. I had an opportunity to consider all the information and I understand what the study is about. I had a chance to ask questions and have had these answered satisfactorily.

☐

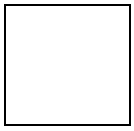
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my care, involvement in services or legal rights being affected. I understand that I have the right to decline to offer any particular information requested from me during the research.

☐

3. I agree to my interview being audio-recorded and for the recordings to be kept in a safe storage system (locked memory) for up to 5 years providing audit trail evidence of the study being conducted.



4. I understand that personal information about myself and all the information I provide during the process will be kept anonymous and confidential. However, I understand that if the researcher is concerned about my well-being or well-being of others they are obligated to inform appropriate persons/authorities.

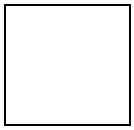


5. I give permission to my care-coordinator/key worker Name: _____or GP Name: _____to be contacted if I become distressed during the interview or if I make a disclosure of criminal activity or risk of harm to myself or others.

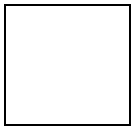
Contact details:

_____
_____

_____
___



6. I consent to the anonymous quotes from the interview to be used in the write-up section of the study and for these to be published in a psychological journal.



7. OPTIONAL: I wish to receive findings of my interview data and have an opportunity to share comments on the interpretation process with the researcher. Please send the information to:

_____
__

8. OPTIONAL: I wish to receive findings of the study and have an opportunity to share comments on the interpretation process with the researcher. Please send the information to:

_____
__

☐

9. I agree to take part in the above research study.

☐

If you <u>do</u> want to take part in this study please print and sign your name below:

_____ _____ _____
Name of Participant (PRINT) Signature Date

Thank you for your help and participation:

_____ _____ _____
Researcher (PRINT) Signature Date

(Once copy to be retained by participant, original to be kept safely by the researcher)

APPENDIX 3 A: Debrief Sheet (Pilot Study)

DEBRIEFING INFORMATION SHEET

I wish to sincerely **Thank You** for making this research project a reality.

This pilot study was designed to prepare for the larger, full-scale research on the relevant subject which aims to explore how you experienced and viewed your past treatment on a secure psychiatric ward under section. I was interested to find out what this experience meant to you and how it impacted on your recovery process, your sense of self and the world around you. The Pilot Study aimed to ensure that the ideas and methods behind the research are sound - it, therefore, makes a crucial contribution to the entire research process.

To date, there is little research that would focus on personal constructs and narratives of individuals experiencing/suffering from psychosis as directly related to their experience and evaluation of a compulsory psychiatric treatment as well as its implications.

It is hoped that the outcome of this research will help us better understand what aspects of psychiatric treatment are helpful and important from patients' perspectives, what possible limitations there are and finally how such factors are linked to individuals' recovery process. Its further goal is to inspire a quality improvement of psychiatric care as well as to promote patients' involvement in the services development and delivery.

SOURCES OF COMFORT AND HELP

Talking openly about your experiences may have left you to feel upset or low in mood. That is normal and is likely to pass after few days. However, if such emotions persist and continue to be overwhelming, there are sources of support you may reach out for. Some of them may be already familiar to you:

1. It is worth remembering that often the most immediate sources of comfort are likely to be your **friends** or **family.**

2. You can get in touch with **your local support group**/organisation that informed you about this study or your **key worker** if you have one.

3. If you continue experiencing distress, contact your **GP** or your **care coordinator to discuss it** – you then may be offered more specialised local support services.

4. Also, the following national **organisations offer support** in times of crisis:

- **Hearing Voices Network**

  Tel (Helpline): 0114 2718210

  Tel (Office): 0114 2718210 / 07714930740

  Web: www.hearing-voices.org

  Email: nhvn@hotmail.co.uk

  Hearing Voices Network is a voluntary organisation supporting people who hear voices and offering confidential telephone helpline.

- **Samaritans**

  Tel: 08457 90 90 90 (local rate), 24 hours a day

  Email: jo@samaritans.org, web: www.samaritans.org

  Available 24 hours a day to provide confidential emotional support for people who are experiencing feelings of distress, despair or suicidal thoughts.

- **SANE**

  Line: 0845 767 8000.

  Emotional support line for people in mental distress. The helpline is open from 6.00pm until 11.00pm every day. Or you can visit their website at www.sane.org.uk

- **Mind**

  InfoLine 0300 123 3393

  Open Monday to Friday 9 am to 6 pm

  E-mail: info@mind.org.uk

  Web: www.mind.org.uk

Offers callers confidential help on a range of mental health issues. Has a network of local associations in England and Wales to which people can turn for help and assistance.

- You can contact your **crisis team**. Even if it is out of hours, there will be an answer phone message advising you of whom to contact in an emergency, together with other useful telephone numbers. If it is an emergency crisis and you would like to see a professional urgently, your local hospital accident and emergency department might be worth visiting. There will be a duty psychiatrist available to assess people's needs and assist in finding the necessary support.

- You could also phone **NHS Direct on 0845 4647** or **111** (depending on the area). It will make it easier for you to access local health services when you have an urgent need

APPENDIX 3 B: Debrief Sheet (Main Study)

DEBRIEFING INFORMATION SHEET

I wish to sincerely **Thank You** for making this research project a reality.

This research was designed to explore how you experienced and viewed your past treatment on a secure psychiatric ward under section. I was interested to find out what this experience meant to you and how it impacted on your recovery process, your sense of self and the world around you.

To date, there is little research that would focus on personal constructs and narratives of individuals experiencing/suffering from psychosis as directly related to their experience and evaluation of compulsory psychiatric treatment as well as its implications.

It is hoped that the outcome of this research will help us better understand what aspects of psychiatric treatment are helpful and important from patients' perspectives, what possible limitations there are and finally how such factors are linked to individuals' recovery process. Its further goal is to inspire a quality improvement of psychiatric care as well as to promote patients' involvement in the services development and delivery.

SOURCES OF COMFORT AND HELP

Talking openly about your experiences may have left you to feel upset or low in mood. That is normal and is likely to pass after few days. However, if such emotions persist and continue to be overwhelming, there are sources of support you may reach out for. Some of them may be already familiar to you:

5. It is worth remembering that often the most immediate sources of comfort are likely to be your **friends** or **family.**

6. You can get in touch with **your local support group**/organisation that informed you about this study or your **key worker** if you have one.

7. If you continue experiencing distress, contact your **GP** or your **care coordinator to discuss it** – you then may be offered more specialised local support services.

8. Also, the following national **organisations offer support** in times of crisis:

- **Hearing Voices Network**

  Tel (Helpline): 0114 2718210

  Tel (Office): 0114 2718210 / 07714930740

  Web: www.hearing-voices.org

  Email: nhvn@hotmail.co.uk

  Hearing Voices Network is a voluntary organisation supporting people who hear voices and offering confidential telephone helpline.

- **Samaritans**

  Tel: 08457 90 90 90 (local rate), 24 hours a day

  Email: jo@samaritans.org, web: www.samaritans.org

  Available 24 hours a day to provide confidential emotional support for people who are experiencing feelings of distress, despair or suicidal thoughts.

- **SANE**

  Line: 0845 767 8000.

  Emotional support line for people in mental distress. The helpline is open from 6.00pm until 11.00pm every day. Or you can visit their website at www.sane.org.uk

- **Mind**

  InfoLine 0300 123 3393

  Open Monday to Friday 9 am to 6 pm

  E-mail: info@mind.org.uk

Web: www.mind.org.uk

Offers callers confidential help on a range of mental health issues. Has a network of local associations in England and Wales to which people can turn for help and assistance.

- You can contact your **crisis team**. Even if it is out of hours, there will be an answer phone message advising you of whom to contact in an emergency, together with other useful telephone numbers. If it is an emergency crisis and you would like to see a professional urgently, your local hospital accident and emergency department might be worth visiting. There will be a duty psychiatrist available to assess people's needs and assist in finding the necessary support.
- You could also phone **NHS Direct on 0845 4647** or **111** (depending on the area). It will make it easier for you to access local health services when you have an urgent need.

APPENDIX 4A: Study Advertisement (Pilot Study)

PILOT STUDY ADVERTISEMENT

TITLE: ***To be heard: Qualitative exploration of individuals' experiences, views and meanings of psychiatric in-patient treatment under section and its impact on the recovery process***

INTRODUCTION: You are being invited to take part in the pilot study of the research that is interested in finding out about individuals' experiences and views of their treatment on a closed psychiatric ward under section. The research aims to gain a better understanding of the impact psychiatric treatment has on individuals with psychosis and their recovery process through exploring how individuals make sense of themselves, their experience and the world around them.

PURPOSE: Pilot study is a smaller version of the larger scale study. The pilot study essentially aims to ensure that ideas and all the methods behind the research are sound. This research hopes to enhance knowledge on the subject and fill in gaps in existing research.

WHO CAN TAKE PART? Individuals (between age 18 to 65) who might have in the past or might be currently experiencing symptoms of psychosis and who have been in the past treated on the NHS in-patient psychiatric ward (on non-voluntary basis). It is required that at least six months period must have passed since individuals' last admission.

PARTICIPATION IS VOLUNTARY: You are free to withdraw at any time without giving any reason.

WHAT DOES THE STUDY INVOLVE? If you volunteer, you will be asked about your experiences and views related to being in a psychiatric ward. You will be asked to think about yourself and your relationship to others as related to your experiences on a closed ward. If the pilot study does not lead to significant modifications in the

research procedures, its data will be incorporated in the larger scale study. Otherwise, its outcome will be used for the important reflection purposes.

CONFIDENTIALITY: All information about you in this study will be kept anonymous, and it will be unidentifiable in written or published material. Interviews will be recorded using the voice recorder, and the recording will be kept in a safe storage system (locked memory).

QUESTIONS? For more details, please contact the researcher who is conducting this study - Anna Wachowska who is a Trainee Counselling Psychologist at City University London.

Email: [redacted] **Tel:** [redacted]

COMPLAINS?

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on 020 7040 3040 or via email: [redacted]

APPENDIX 4B: Study Advertisement (Main Study)

CITY UNIVERSITY LONDON

RESEARCH STUDY ADVERTISEMENT

TITLE: ***To be heard: Qualitative exploration of individuals' experiences, views and meanings of psychiatric in-patient treatment under section and its impact on the recovery process***

INTRODUCTION: You are being invited to take part in the study that is interested in finding out about individuals' experiences and views of their treatment on a closed psychiatric ward under section. The research aims to gain a better understanding of the impact psychiatric treatment has on individuals with psychosis and their recovery process through exploring how individuals make sense of themselves, their experience and the world around them.

PURPOSE: The research hopes to enhance knowledge on the subject and fill in gaps in existing research. Its objective is to promote the views of people in mental distress as well as provide guidance and inspiration towards the quality improvement of an in - patient psychiatric care.

WHO CAN TAKE PART? Individuals (between age 18 to 65) who might have in the past or might be currently experiencing symptoms of psychosis and who have been in the past treated on the NHS in-patient psychiatric ward (on a non-voluntary basis). It is required that at least six months period must have passed since individuals' last admission.

PARTICIPATION IS VOLUNTARY: You are free to withdraw at any time without giving any reason.

WHAT DOES THE STUDY INVOLVE? If you volunteer, you will be asked about your experiences and views in relation to being in a psychiatric ward. You will be asked to think about yourself and your relationship to others as related to your experiences on

a closed ward. Finally, if you wish you can receive findings of your interview data and have an opportunity to share comments on the interpretation process with the researcher.

CONFIDENTIALITY: All information about you in this study will be kept anonymous, and it will be unidentifiable in written or published material. Interviews will be recorded using the voice recorder, and recordings will be kept in a safe storage system (locked memory).

QUESTIONS? For more details, please contact the researcher who is conducting this study - Anna Wachowska who is a trainee counselling psychologist at City University London. **Email:** [redacted] **Tel:** [redacted]

COMPLAINS?

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on 020 7040 3040 or via email: [redacted]

APPENDIX 5: Recruitment Criteria Sheet

RESEARCH STUDY

To be heard: Qualitative exploration of individuals' experiences, views and meanings of psychiatric in-patient treatment under section and its impact on the recovery process

INCLUSION CRITERIA FOR PARTICIPATION:

1) Individuals between ages 18 to 65,

2) Who, **in the past**, were treated on an **in-patient** psychiatric ward (i.e. **former** patients),

3) Who received treatment through the **NHS,**

4) On a **non-voluntary** basis (thus were **sectioned** under Mental Health Act) as a result of experiencing/suffering from **psychosis;**

4) It is required that at least **six months** period must have passed since individuals' last admission.

EXCLUSION CRITERIA:

5) Individuals who experienced drug-induced psychosis, have suffered brain injury or have an organic brain disease or diagnosis of learning disability would be excluded from the study.

APPENDIX 6: Demographic Questionnaire

PARTICIPANT DEMOGRAPHIC QUESTIONNAIRE

1. **Pseudonym chosen for the research**_____
2. **Gender**_____
3. **Age**_____
4. **Ethnicity**_____
5. **Marital status**_____
6. **Do you have any children (if yes, how many?**_____
7. **How many years in total have you been in contact with mental health services?**_____
8. **How many in-patient admissions under section have you had?**_____
9. **What has been your longest stay in a hospital?**_____

10. **When was your last non-voluntary admission?**_____

11. **What is your current diagnosis?**_____

12. **Have you received a different diagnosis in the past? (if yes, what was it?**_____
_____

13. **Are you currently on medication, if yes please note whether anti-depressant and/or anti-psychotic etc.**_____
_____

14. **How long (in total) have you been on medication?**_____
___

THANK YOU FOR FILLING IN THIS FORM

APPENDIX 7: Interview Agenda

Interview Agenda

PHASE 1: Tell me about your experience of being on a closed ward under section.

The initial question was meant to be characterised by a non-leading and non-influential approach through lack of imposed agenda, encouraging participants to freely move in a direction desired and considered important, eliciting subjective experiences and facilitating the spontaneous and unrestricted flow of expression.

PHASE 2: Primary prompts

Designed to enable participants to generate further expressions, clarifications, more precise experiences and views as well as to extract specific meanings and elucidate impact it had on them.

Experience related prompts:

- What stood out for you the most and why?
- How would you describe your experience on the ward purely from an emotional vantage point, as an emotional journey? / What emotions were evoked in you by being on the ward, what were you experiencing on an emotional level?
- If you were to paint it, how would you depict the essence of your experience on the ward? What picture comes to mind? What metaphor/symbolism would represent what it was like for you?
- How would you summarise your entire experience on the ward, say in one sentence if possible?

Impact related prompts:

- What impact did this experience have on you?
- Has anything changed as a result of it and in what way?
- What impressions did it leave you with?

- What did you find helpful and why? /What facilitated your recovery process?

An *emphasis has been placed on this particular prompt and question was often asked repeatedly (Is there anything else you can think of that was helpful?) in order to access*

more remote experiences and memories particularly when participants focused predominantly on negative experiences; *such strategy also represented an attempt towards researcher's bias minimization and elimination.*

- What did find unhelpful and why? /What hindered your recovery process?
- If you could go back in time what would you have changed/wanted to be done differently? If you had a magic wand and could go back in time – what would you have used it for?

Meanings related prompts:

- What this entire experience meant to you? What consequences did it carry?
- How did you view yourself? / How did you feel about yourself? How did you feel about others? How did it affect your sense of self and your identity? / How did it impact the way you view yourself as well as others or the world in general?
- Is anything different now as you sitting here? What are you thinking and feeling right now?

Perceptions/views related prompts:

- Would you have changed anything about the treatment you received? What would you say needs improving and what does not? How would you have liked things to be?
- What components of the treatment experience do you consider to be relevant? What do you think of in – patient psychiatric treatment under section? / How would you evaluate psychiatric in-patient care?

PHASE 3: Final prompts

Implemented in order to ask participants about their experiences and views as related to particular themes, as emerging from literature, if not discussed or touched upon by them already in a phase one or two, such as:

- I wonder whether you could you tell me something about…..
- Your relationships (with staff and/or others) on the ward?
- Your level of influence in your care/treatment?
- The physical environment of the hospital?
- Activities and time spending?

- Therapeutic interventions or psycho-education?
- Your experience and view of medication while on the ward?
- Physical restraint?
- Being given a diagnosis on the ward?

PHASE 4: Closing safeguard question:

- Is there anything else you wish to mention/add in relation to your experiences, anything my questions have not addressed?

APPENDIX 8: Ethics Release Form

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor**, together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

~~BSc~~ ↑ ~~M.Phil~~ ↑ ~~M.Sc~~ ↑ **D.Psych** ↑ n/a ↑

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

To be heard: Qualitative exploration of individuals' experiences, views and meanings of psychiatric in-patient treatment under section and its impact on the recovery process

2. Name of student researcher (please include contact address and telephone number)

Name: ANNA WACHOWSKA, Trainee Counselling Psychologist, City University London
Email Address: [redacted] or [redacted]

3. Name of research supervisor

Dr Nils Sören Petter

4. Is a research proposal appended to this ethics release form?

Yes ~~No~~

5. Does the research involve the use of human subjects/participants? **Yes**
No

If **yes,**

a. Approximately how many are planned to be involved?

1 to 2 participants for a pilot study and 6 to 8 participants

b. How will you recruit them?

Participants for both pilot study and full scale study would be recruited through national voluntary/charitable or private organizations offering community based mental health services and support (residential/supported living settings, resource/day centres, psycho-educational/recreational and support groups) to individuals suffering from psychosis across London and surrounding areas. The organisations that would be approached include Hearing Voices Network, Together for Mental Wellbeing, Rethink Mental Illness, Richmond Fellowship, Mind, InterVoice, VoiceCollective, Voices Forum.

c. What are your recruitment criteria?
(*Please append your recruitment material/advertisement/flyer)*

* The study would look to recruit 1 to 2 individuals for the purpose of a pilot experiment and 6 to 8 participants for the final full scale phase of the research (of any gender, between age 18 and 65) who experience/d symptoms of psychosis and who in the past received compulsory treatment on the NHS closed psychiatric ward on that basis (former patients),

* Only individuals who were under compulsory treatment (detained and sectioned under Mental Health Act) would be recruited. In such context this research aims to investigate a unique experience that potentially differs from a voluntary in-patient treatment. Additionally, only individuals who were treated within NHS organisations would be included in the study, as research reveal that there may be differences in quality of care received in independent sector (Ryan et al. 2004)

* It is suggested that six months period must have passed since last admission in order to minimise risk to participants as well as enhance capacity for self-reflection,

* Exclusion standards would enclose individuals with prior history of head injury/evidence of organic brain disease, learning disability or previous diagnosis of alcohol or drug use/drug induced psychosis.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? ~~Yes~~ **No**

d1. If yes, will signed parental/carer consent be obtained? Yes **No**

d2. If yes, has a CRB check been obtained? ~~Yes~~ **No**
(*Please append a copy of your CRB check*)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

The initial meeting with a potential participant will be arranged for the purpose of discussing *The Study Information Sheet (Appendix 1A for pilot study and 1B for main study)* in detail with the emphasis being placed on the purpose of the study, confidentiality, risk and benefits involved, what participation would involve and its voluntary nature. Individuals would then be given time to consider participation in the study and following this, if still interested, *The Consent Form (Appendix 2A and 2B)* would be given and discussed. Should they decide to participate they would be asked to sign a consent form which will be followed by an interview. The interview will be informal and carried out in a conversational style and would be conducted at the location chosen by a participant (such as organisation's premises – private room, university or GP Surgery - if there is a room available). Participants' commuting expenses will be reimbursed. The length of the whole process is likely to vary from person to person, however it estimated it may last from 1 hour to 2 hours. Before the interview begins participants will be asked about some basic background and demographic information (Appendix 3). In the interview they will be asked about their experiences of being on a psychiatric ward and the impact such treatment had on their recovery process. Questions will require participants to reflect about themselves and about their relationship to others as related to their experiences on a closed ward. They will also be asked about their views and evaluation of a psychiatric treatment. Participants will also be given an opportunity to review and verify the accuracy of their interview findings.

Pilot study will be implemented in the first stage of the project primarily in order to pre-test the quality and objectives of the interview questions and style (such as their wording and order). Pilot study can also allow for some improvements on the study design and its outcome prior to conduction of the study on a full-scale basis. It is also hoped that it can help identify any practical issues in the research procedure.

7. Is there any risk of physical or psychological harm to the subjects/participants?
Yes No

If yes,

a. Please detail the possible harm?

It is recognized that any inquiry about participants' experiences of psychiatric treatment, mental health/recovery or self-concept can be of sensitive and upsetting nature and therefore evoke distressing feelings and states. Furthermore, there is some evidence suggesting that being sectioned can be a traumatic experience, for some people even leading to PTSD (Bentall, 2009; Morrison et al. 2003).

b. How can this be justified?

Research indicates that the dominant paradigm in psychiatry still demonstrates great resistance to seeing patients diagnosed with severe mental illness as experts and to their involvement as partners in helping to facilitate the treatment process or set a research agenda which is also evident in a dominance of clinical neuroscience in the psychiatric and allied journals (Faulkner et al. 2002 and Bental, 2009). Individuals suffering from psychosis are also most likely to report feelings and experiences of stigma and are most affected by them (Dinos and Stevens, 2004 and Gray, 2002). What is more, findings also suggest that psychiatrists themselves perpetuate many concepts that underlie biased and stigmatizing attitudes towards psychotic disorders (Rao et al. 2009). Thus, the implication of this study is to render and promote the views and experiences of people in severe mental distress as valid and having major implication for service and treatment. Additionally, since many individuals with mental health problems struggle with sense of powerlessness (Byrne, 2001; Gray, 2002), it is believed that this study may carry an empowering component as it aims to give voice to individuals and therefore convey the message that patients' experiences and insights are of great value, are respected and most of all taken into consideration. Research also indicates that reflecting and talking about significant life experiences such as mental health or recovery can be beneficial and bring about therapeutic effect (Hubble et al. 1999; Seligman). Reflecting about significant life experiences such as mental health/ill health or recovery may form a crucial healing element for individuals in mental distress – and since recent research highlights that self-expression is of particular relevance to the treatment of psychosis (Lysaker and Lysaker, 2001; Seikkula et al. 2006; Jaspers, 1959), this study may provide an opportunity for such individuals to contemplate upon the meaning of their experiences and reach a sense of being understood which can somewhat contribute to the rebuild of their communication processes both on internal and external level. The research is essentially concerned with key phenomenological constructs such as self and identity. Its relevance to counselling psychology as a field also relates to the study of mental distress in general (in this case psychotic phenomena), the role of relationships as well as recovery and appropriate treatment interventions. Finally, this research will hope to enhance knowledge on the subject and fill in previously recognised gaps in existing research. Further contribution may result in helping to identify components that could be measured to ensure the validity of patient satisfaction surveys and outcome studies - thus providing guidance or inspiration towards quality improvement of in - patient psychiatric care.

c. What precautions are you taking to address the risks posed?

The study aims to ensure that procedures would be in place that would aim to prevent, manage and contain potential distress. During the data collection process, particular attention and consideration would be given to identifying any signs of concern or distress that may arise and ensuring that any issues are addressed immediately. Participants would also be informed, both via information sheet and again verbally prior to the interview, that they have the right to pause at any time during the process, take breaks or reschedule the interview if they encounter difficulty to continue. Participants would also be reminded about their right to withdraw at any time without giving a reason. When obtaining informed consent, participants would also be required to consent to their GP/Key Worker/Care Coordinator being contacted should they become distressed during an interview (such information would also be provided on *The Study Information Sheet*). Before the interview begins participants would be reminded that should they become distressed the interview would be suspended and time spent to discuss their distress during which researcher would be available to offer support. In such case, researcher would draw on her therapeutic skills to listen and support an individual in a person centred manner, demonstrating empathic understanding and unconditional positive regard. If participants' distress appeared to be contained, the interview would resume. However, if participants did not seem to respond to researcher's interventions and continued to appear overwhelmed by the process, the interview would be terminated, to be resumed at later opportunity. Participants' GP/Key Worker/Care Coordinator could be immediately informed of the situation in order to gain further input aimed at helping participant to manage their distress. Post interview a Debrief Sheet (Appendix 4A and 4B) would be given to all participants containing information about sources of support and assistance should they experience distress as a result of participation in the study.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes ~~No~~

Information Sheet for Participants – Appendix 1A and1B

(*Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)*

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

~~Yes~~ **No**

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Consent Form – Appendix 2A and 2B

Yes ~~No~~

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Records to be kept include interview audio - recordings, transcripts (data), consent forms and demographic data of participants.

12. What provision will there be for the safe-keeping of these records?

Transcription process would take place shortly after each interview when audio-recordings would be transferred onto the computer and removed from the note recording device, next backed-up copies would be made and all files stored in an anonymous format. Following completion of the transcription process, audio files would be transferred into the safe storage system (locked up memory) and kept for the 5 year period thus providing evidence that the research has been conducted (audit trail). All the data would be stored in electronic versions - anonymisation and encryption measures will be use appropriately (back-up copies will be created in order to prevent any accidental destruction).The consent forms along with demographic data will be securely housed as hard-copies in clearly labelled and durable containers.

13. What will happen to the records at the end of the project?

Most scientific journals require original data such as transcripts to be kept for 5 years. It is hoped that this research will be published, however if this is not the case then all the data will be hold for up to a year and then destroyed.

14. How will you protect the anonymity of the subjects/participants?

Every effort will be made to ensure confidentiality of any identifying information that is obtained in connection with this study. Participants' names will not be linked with the research materials. All data will be treated with full confidentiality and even if published will not be identifiable as each participant would be assigned a number that would be used for identification purposes. Pseudonyms, chosen by participants after consenting to take part, will be used in writing up stage of the data.

15. **What provision for post research de-brief or psychological support will be available should subjects/participants require?** **(*Please append any de-brief information sheets or resource lists detailing possible support options)***

Post interview a *Debrief Sheet* (Appendix 4A and 4B) would be given to all participants containing information about sources of support and assistance should they experience distress as a result of participation in the study. The Debrief Sheet will include suggestions for possible sources of help and comfort including the list of national organisations offering support to individuals in crisis along with their contact details.

If you have circled an item in **<u>underlined bold</u>** print or wish to provide additional details of the research please provide further explanation here:

Since some evidence has been cited in support of the information included in the Ethics Release form– please refer to appended Research Proposal for the full reference list

Signature of student researcher
Anna Wachowska---------- Date **18/01/2014**

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal	↑
Recruitment Material	↑
Information Sheet	↑
Consent Form	↑
De-brief Information	↑

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself?
Yes (potentially) ~~No~~
If yes,

a. Please detail possible harm?

It could be argued that individuals with a history of being sectioned for a treatment of psychosis may pose a higher risk in general when compared to others with no such history.

b. How can this be justified?

It may as well be counter-argued that a diagnosis of psychotic disorder attracts stigma, prejudice and discrimination and that common negative attitudes of dangerousness and unpredictability attached to the diagnosis of schizophrenia in particular are more of a damaging stereotype than a fact (Read, 2007). Research indicates that the notion of dangerousness as linked to severe form of mental distress seems to be grossly exaggerated as for instance individuals diagnosed with psychotic disorder are ten times more likely to be the victim of a violent crime rather than to commit one (Brekke et al., 2001).

References

Brekke, J., Prindle, C., Bae, S., and Long, J. (2001). Risks for individuals with schizophrenia who are living in the community. *Psychiatric Services, 52(2), 1358-66.*

Read, J. (2007). Why promoting biological ideology increases prejudice against people labelled 'schizophrenic'. *Australian Psychologist, 42(2), 118-28.*

c. What precautions are to be taken to address the risks posed?

Following the above mentioned arguments, I have not identified any significant/elevated risks in relation to myself in this context however I am aware of maintaining precautions and safety in general when conducting a research therefore for instance I would only meet with participants in the community and conduct interviews in a hired room on university or organisation's premises ensuring that there is always someone else in the building (thus implementing standard safeguarding procedures).

Section C: To be completed by the research supervisor
(*Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.*)

Please mark the appropriate box below:

Ethical approval granted x

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature [redacted]

Date 16/05/2014

Section D: To be completed by the 2nd Departmental staff member

*(Please read this ethics release form fully and pay particular attention to any answers on the form where **underlined bold** items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

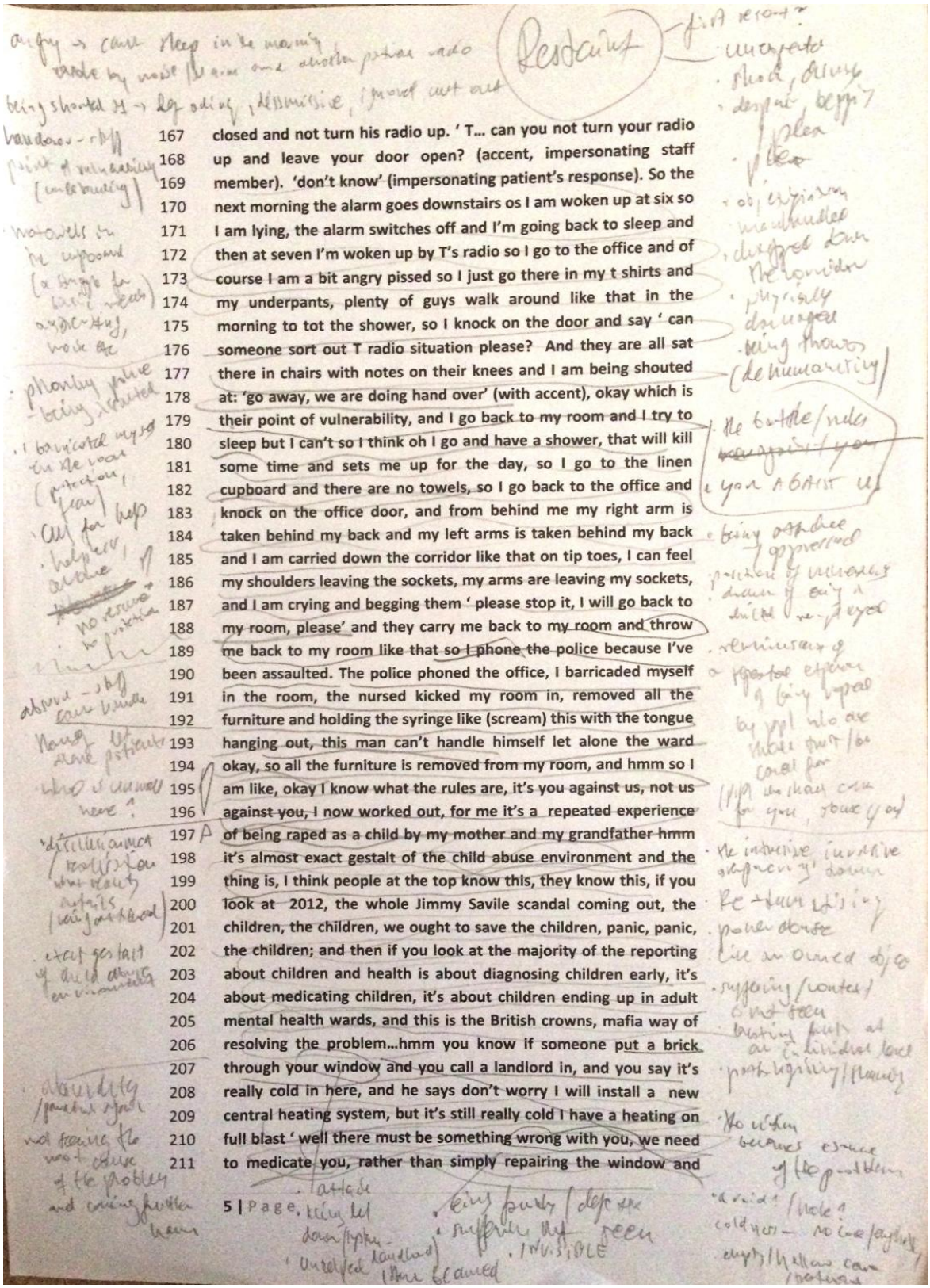
Signatu[redacted]

Date 23/5/14

APPENDIX 9: Extract from Interview Transcripts

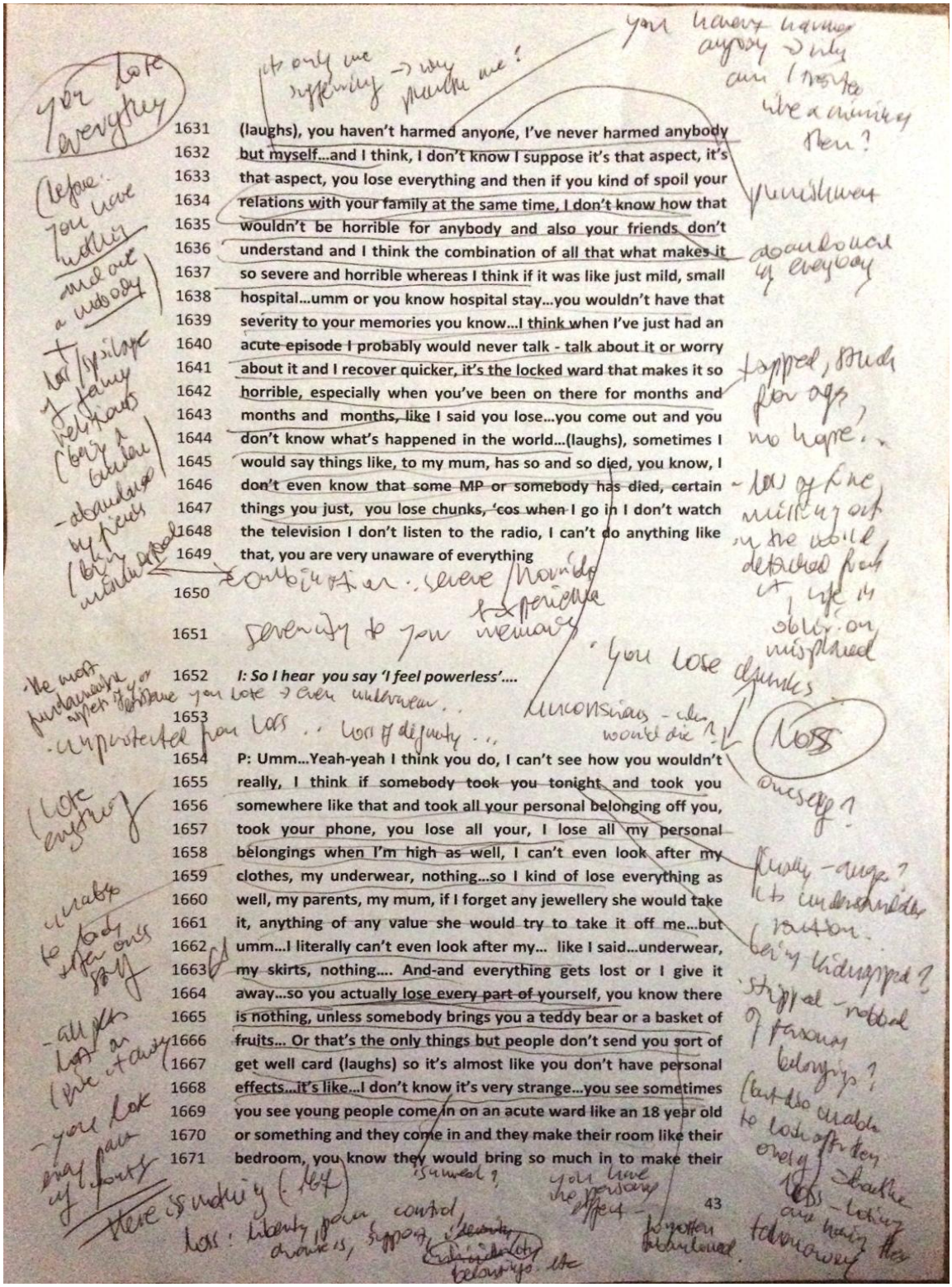
Examples from participants' transcripts illustrating initial notations in right hand margin and emergent themes in left hand margin

Interview Transcript: 888



closed and not turn his radio up. ' T... can you not turn your radio up and leave your door open? (accent, impersonating staff member). 'don't know' (impersonating patient's response). So the next morning the alarm goes downstairs os I am woken up at six so I am lying, the alarm switches off and I'm going back to sleep and then at seven I'm woken up by T's radio so I go to the office and of course I am a bit angry pissed so I just go there in my t shirts and my underpants, plenty of guys walk around like that in the morning to tot the shower, so I knock on the door and say ' can someone sort out T radio situation please? And they are all sat there in chairs with notes on their knees and I am being shouted at: 'go away, we are doing hand over' (with accent), okay which is their point of vulnerability, and I go back to my room and I try to sleep but I can't so I think oh I go and have a shower, that will kill some time and sets me up for the day, so I go to the linen cupboard and there are no towels, so I go back to the office and knock on the office door, and from behind me my right arm is taken behind my back and my left arms is taken behind my back and I am carried down the corridor like that on tip toes, I can feel my shoulders leaving the sockets, my arms are leaving my sockets, and I am crying and begging them ' please stop it, I will go back to my room, please' and they carry me back to my room and throw me back to my room like that so I phone the police because I've been assaulted. The police phoned the office, I barricaded myself in the room, the nursed kicked my room in, removed all the furniture and holding the syringe like (scream) this with the tongue hanging out, this man can't handle himself let alone the ward okay, so all the furniture is removed from my room, and hmm so I am like, okay I know what the rules are, it's you against us, not us against you, I now worked out, for me it's a repeated experience of being raped as a child by my mother and my grandfather hmm it's almost exact gestalt of the child abuse environment and the thing is, I think people at the top know this, they know this, if you look at 2012, the whole Jimmy Savile scandal coming out, the children, the children, we ought to save the children, panic, panic, the children; and then if you look at the majority of the reporting about children and health is about diagnosing children early, it's about medicating children, it's about children ending up in adult mental health wards, and this is the British crowns, mafia way of resolving the problem...hmm you know if someone put a brick through your window and you call a landlord in, and you say it's really cold in here, and he says don't worry I will install a new central heating system, but it's still really cold I have a heating on full blast ' well there must be something wrong with you, we need to medicate you, rather than simply repairing the window and

Interview Transcript: Buster

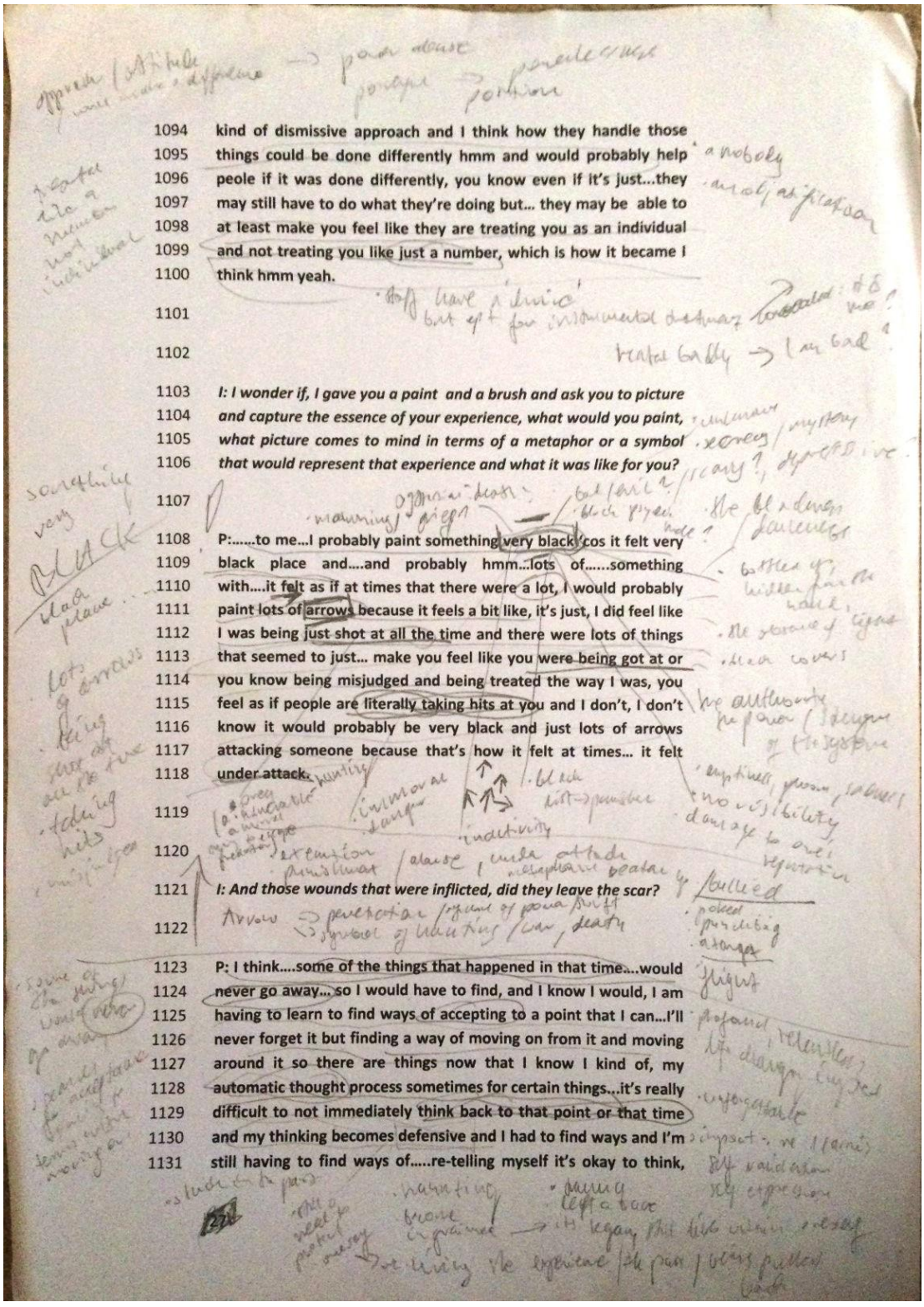


(laughs), you haven't harmed anyone, I've never harmed anybody but myself…and I think, I don't know I suppose it's that aspect, it's that aspect, you lose everything and then if you kind of spoil your relations with your family at the same time, I don't know how that wouldn't be horrible for anybody and also your friends don't understand and I think the combination of all that what makes it so severe and horrible whereas I think if it was like just mild, small hospital…umm or you know hospital stay…you wouldn't have that severity to your memories you know…I think when I've just had an acute episode I probably would never talk - talk about it or worry about it and I recover quicker, it's the locked ward that makes it so horrible, especially when you've been on there for months and months and months, like I said you lose…you come out and you don't know what's happened in the world…(laughs), sometimes I would say things like, to my mum, has so and so died, you know, I don't even know that some MP or somebody has died, certain things you just, you lose chunks, 'cos when I go in I don't watch the television I don't listen to the radio, I can't do anything like that, you are very unaware of everything

I: So I hear you say 'I feel powerless'….

P: Umm…Yeah-yeah I think you do, I can't see how you wouldn't really, I think if somebody took you tonight and took you somewhere like that and took all your personal belonging off you, took your phone, you lose all your, I lose all my personal belongings when I'm high as well, I can't even look after my clothes, my underwear, nothing…so I kind of lose everything as well, my parents, my mum, if I forget any jewellery she would take it, anything of any value she would try to take it off me…but umm…I literally can't even look after my… like I said…underwear, my skirts, nothing…. And-and everything gets lost or I give it away…so you actually lose every part of yourself, you know there is nothing, unless somebody brings you a teddy bear or a basket of fruits… Or that's the only things but people don't send you sort of get well card (laughs) so it's almost like you don't have personal effects…it's like…I don't know it's very strange…you see sometimes you see young people come in on an acute ward like an 18 year old or something and they come in and they make their room like their bedroom, you know they would bring so much in to make their

Interview Transcript: Cait



kind of dismissive approach and I think how they handle those things could be done differently hmm and would probably help peole if it was done differently, you know even if it's just...they may still have to do what they're doing but... they may be able to at least make you feel like they are treating you as an individual and not treating you like just a number, which is how it became I think hmm yeah.

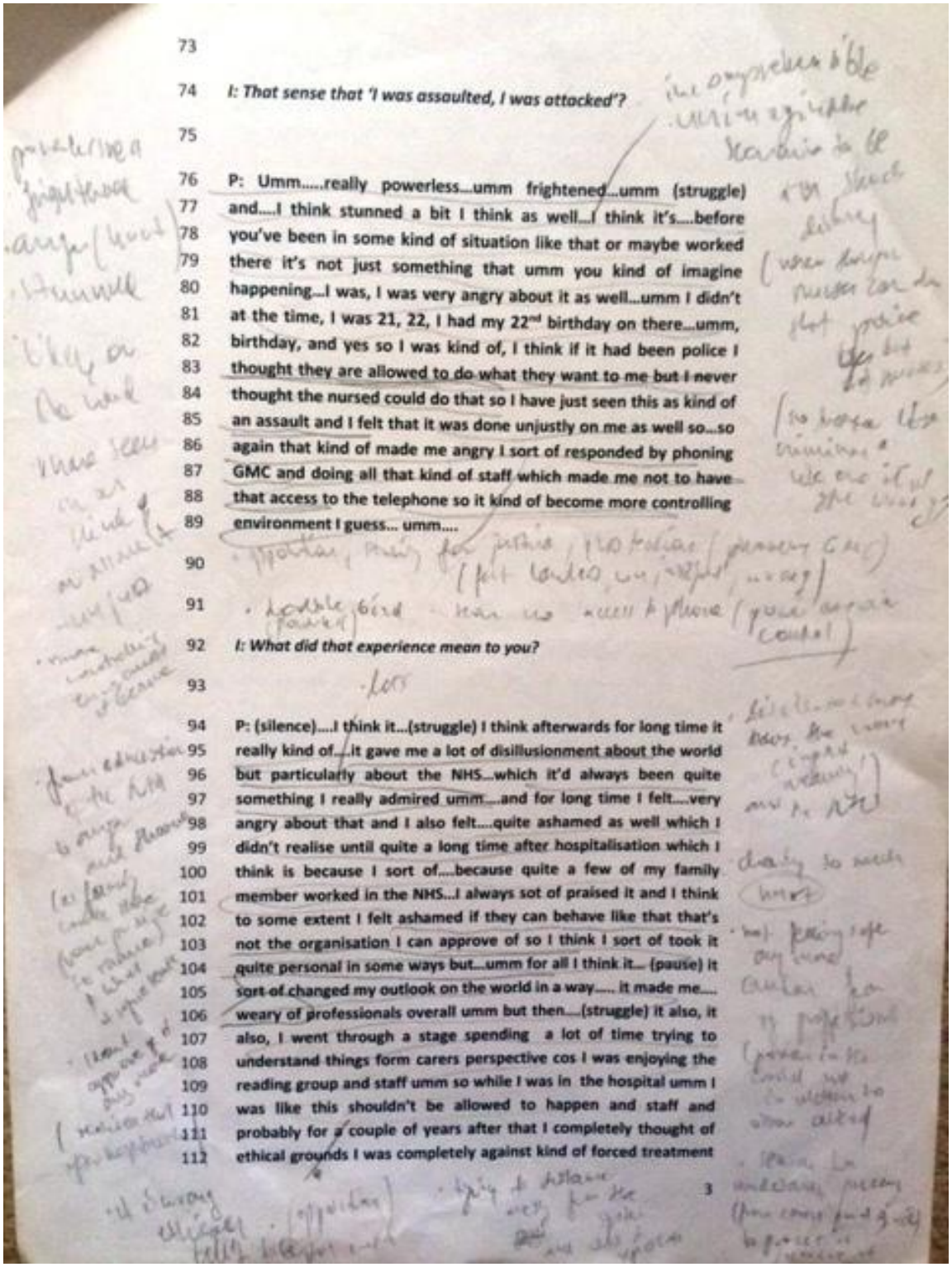
I: I wonder if, I gave you a paint and a brush and ask you to picture and capture the essence of your experience, what would you paint, what picture comes to mind in terms of a metaphor or a symbol that would represent that experience and what it was like for you?

P:.....to me...I probably paint something very black cos it felt very black place and....and probably hmm...lots of.....something with....it felt as if at times that there were a lot, I would probably paint lots of arrows because it feels a bit like, it's just, I did feel like I was being just shot at all the time and there were lots of things that seemed to just... make you feel like you were being got at or you know being misjudged and being treated the way I was, you feel as if people are literally taking hits at you and I don't, I don't know it would probably be very black and just lots of arrows attacking someone because that's how it felt at times... it felt under attack.

I: And those wounds that were inflicted, did they leave the scar?

P: I think....some of the things that happened in that time...would never go away... so I would have to find, and I know I would, I am having to learn to find ways of accepting to a point that I can...I'll never forget it but finding a way of moving on from it and moving around it so there are things now that I know I kind of, my automatic thought process sometimes for certain things...it's really difficult to not immediately think back to that point or that time and my thinking becomes defensive and I had to find ways and I'm still having to find ways of.....re-telling myself it's okay to think,

Interview Transcript: Sally



I: That sense that 'I was assaulted, I was attacked'?

P: Umm.....really powerless...umm frightened...umm (struggle) and.....I think stunned a bit I think as well...I think it's....before you've been in some kind of situation like that or maybe worked there it's not just something that umm you kind of imagine happening...I was, I was very angry about it as well...umm I didn't at the time, I was 21, 22, I had my 22nd birthday on there...umm, birthday, and yes so I was kind of, I think if it had been police I thought they are allowed to do what they want to me but I never thought the nursed could do that so I have just seen this as kind of an assault and I felt that it was done unjustly on me as well so...so again that kind of made me angry I sort of responded by phoning GMC and doing all that kind of staff which made me not to have that access to the telephone so it kind of become more controlling environment I guess... umm....

I: What did that experience mean to you?

P: (silence)....I think it...(struggle) I think afterwards for long time it really kind of....it gave me a lot of disillusionment about the world but particularly about the NHS...which it'd always been quite something I really admired umm....and for long time I felt.....very angry about that and I also felt....quite ashamed as well which I didn't realise until quite a long time after hospitalisation which I think is because I sort of....because quite a few of my family member worked in the NHS...I always sot of praised it and I think to some extent I felt ashamed if they can behave like that that's not the organisation I can approve of so I think I sort of took it quite personal in some ways but...umm for all I think it... (pause) it sort of changed my outlook on the world in a way..... it made me.... weary of professionals overall umm but then....(struggle) it also, it also, I went through a stage spending a lot of time trying to understand things form carers perspective cos I was enjoying the reading group and staff umm so while I was in the hospital umm I was like this shouldn't be allowed to happen and staff and probably for a couple of years after that I completely thought of ethical grounds I was completely against kind of forced treatment

APPENDIX 10: Example of Emergent Themes and Subthemes from Sally's Interview

The Unsafe

Feeling unsafe (after restraint) 3:76-89
Living in fear, being frightened of staff and what they are capable of 9:316
'Staff could do anything they wanted to me' 10:360-362
Comfort and safety need/wanting to escape?: Wanting to go home 3:1674-1677
Despair, wanting to escape, adapting false persona 20:758-759
The Island Fantasy: 'I wanted to go to island' (greenery, hills to walk on and space); island: need for insularity (detachment of self from others/need for isolation/separation/being cut off?), island as safe haven/seeking refuge, escape from world/people & solitude; island: inhabitant defined as against those who are not islanders? / going to island and going to sleep (escape from reality, exhaustion) 43:1672-1682
PICU ward: injections and restraints 16:580-586
Main ward & negative interactions with staff but one felt safer as less threat of injections or restraint; compliance and fear of repercussions ('at that point I was taking drugs because I knew I would be injected'), 'I didn't feel like I was gonna be attacked at any point' 17:644-650
Them against US: Less violence from the staff on the main ward however division was more pronounced 18:679-682
Distrust, acquired fear of unpredictability and mistreatment, long term impact- No longer feeling safe when under care of professionals/system 19:722-732
Scarred; Fear of asking for help in the future 20:743-766 & 21:804-812
Defenceless, alone and vulnerable: 'No one to protect you from staff' 25:948-950 & 957
Under threat, being /feeling hurt and mistreated by staff, helplessness ('When you know the person can hurt you or is hurting you and there is no one to help you;') 25:967-970
Paradox of safety: 'Kept me save but hospital guaranteed bad experience' 29:1110-1111
On egg shells, threat, neglect, omissions, vicarious trauma, bearing witness and mirroring (death of another patient, health complications), 'I am safe now, but who knows what's gonna happen next' 36:1405-1421
I am not safe; sense of terror (witnessing others being treated badly or neglectfully too) 36:1415-1421& 37:1452-1457
Safety paradox: protection from self ? 29:1095-1121
The Noah Arc Image (safe and unsafe paradox) 40:1583-1590
Lack of safety and pronounced vulnerability impeding recovery; 'made one more vulnerable and less able to deal with symptoms of mental health' 37:1422-1425

The Abandonment

Trauma, danger & having flashbacks: Medication became' a daily remainder of the worst experience of my life' 23:866-867 (symbolic not only of powerlessness and coercion which were top feelings but underneath there was a sense profound abandonment – being utterly alone and without protection, 'I am in a dangerous situation and I can be harmed')= traumatic memory of medication incidents 23:873-897

Isolation/abandonment/ powerlessness: 'Completely on my own with all these people saying they want to help when they are hurting you and being cruel and you are the mercy of their whim' 24:937-938 & 25:939-940 & 26:985

'Feeling that there is no one there to help and they can do whatever they want to you' 25:948-950

Feeling completely abandoned (the essence) 25:957-962

Illusion of help, inverted mountain/warped, abandonment as the essence: Complete and frightening isolation, profoundly alone, left with no devices or resources to draw on, 'nothing I can do myself, no one to turn to as everybody says they're trying to help but you know that's not the case' 25:967-976 & 26:979

Re-traumatising, triggering: The abandonment seems to be a feeling that one felt to a degree before being sectioned 26:994-9

The Absurdities & The Unnecessary

Inconsistent rules 1:28

Obstacles and aggravations, basic matters becoming huge 1:28-34

Picking the hole? / Staff being petty – feels ridiculous 6:224-226

The absurd: Good staff being told off for being too soft with patients, demonstrated the ethos of the ward (harshness, distance keeping, punitive) 9:321-325

The main ward even though had some positive aspects not useful in terms of mental health care 18:659-661

Playing the game, Pretence the only way out: 'If you want to get out, tell them what they need to hear' (which is what one did) 18:660-663

Absurd: agreeing and submitting meant insight and respect from staff and progress while in truth meant dishonesty and compromising one's subjectivity and true needs 18:668-685

Caring profession not always caring: Feels weird having to 'interview' your key worker/professional involved in your care (long term impact of the ward= fear/distrust), thus it is not 'right' as they should all be caring etc 20:773 & 21:774-775

The incomprehensible and unacceptable: Care coordinators are known not be very good – hard to accept that care professionals are not caring (it's wrong) 21:782-787

The absurd of staff being experienced as redundant and useless: Staff interventions- not useful to have them around ('I suppose they had to run the place though') 22:830-834

Façade: Presence of an advocate made a difference in how one was treated by staff ('if you treated me like that all the time we would not have a problem') 28:1061-1065

Petty rules of the ward that everybody had to fit into, rigid structure 28:1088-1094

Box ticking, illusions, inadequacy: Activities – most of them did not happen that much, TV and books not helpful when one is manic 29:1122-1128; Activities that barely occurred (box ticking; facade); informing commissions that all activities were taking place when in reality they were not 45:1747-1757

The staff-patient chasm: Staff not understanding why one would not like to be in hospital, no empathy 33:1281-1290

The absurd: Criticised and told off for bringing staff attention to another patients need for help as the wardrobe had fallen on him and obs were not being run ('you are interfering with another patient's care') 37:1446-1452

Boredom/meaninglessness/nihilism: 'Your entire life was to wait for next meal or doctor visit' 45:1754-1757
Stigma and the absurd: Staff advice- 'do not become friends with fellow patients, you don't want to get involved with those who are mentally ill' 45:1761-1770
The unacceptable: All the negative experiences that one was faced with – it's difficult to accept that they occur ('it should not be happening anyway'); they need to recruit/train better staff that treat you with respect 46:1790-1798
Needing protection from oneself but then also from staff: 25:948-957
Having people around was reassuring yet also one felt completely alone page 25

- Aggravations: The discomfort and coldness & need for comfort and warmth (The symbolic nature of physical environment)

Hot and staffy, discomfort exacerbating one's struggles 2:40-41
Too hot, AC not working 7:250-251
PICU: confined, no smoking ban, no AC (having asthma) aggravating/difficult/suffocating 17:639-641
Too hot or too cold 24:901-904
Bearing the coldness of the room (no heating, no curtains, clammy/plastic sheets as bedding) lack of comfort etc, sitting on the verge of the door to get some warmth denoting harshness of the experiences 24:901-914
The Noah Arc: crowded and confined 40:1583-1590
Magic wand: would use it to make the environment more homey and pleasant (ban smoking as well, create a swimming pool – more freedom and relax) 42:1636-1646
The importance of physical environment is underestimated 49:1926-1930

Coercion & Powerlessness

Restraint, forced medication/sedation 2: 44-48
Restraint: felt like an assault 2:58-61
An attack that happened several times: 2:64-67
Shock: Waking up and being covered in bruises 2:58-59
PICU: 'horrific and not helpful at all' 2:53-54
Restraint: evoked powerlessness and terror 3:76-85
Double bind, hitting the brick wall, powerlessness (Phoning GMC and having access to telephone denied) 3:85-89
Aggressive treatment 4:117-119
To have ideas imposed on, one's life is another's hands ('what THEY think should happen to me') 4:127-129
Forced to take drugs 4:133-134
'I could have been an animal': an analogy denoting sense of helplessness, vulnerability and no voice 5:167
Paradox: mostly not a caring and therapeutic environment but place where staff exert power over you ('most staff were abusive, selfish and horrible') 8:297-301
Difference between authority and power: 'they had the power that I did not respect' 19:700-702

'To be fair there were staff on main ward that had time to talk to me but I could not talk to them because of level of coercion I had experienced on PICU' 22:834-838
Being overridden, overpowered, intimidated (traumatic memory: medication incident) 23:882-892
Moments of terror: My life/fate is in someone else's hands, at total mercy of the other, position of total powerlessness and vulnerability (traumatic memory of medication/IM incident) 'WHEN HE DECIDES….' 23:882-897 & 24:898-900
No curtains/bare room representing – coldness of one's relation with the ward/staff (although safety precaution) 24:901-903
Out of control, unpredictability: memory of 'once they just come in and say we'll give you an injection with all these people around and you have to take your trousers down'…24:920-926
If you didn't take your trousers down you would be pinned down/manhandled (traumatic memory and what the drug represents) 24:921-926
Trauma: Looking into psychiatrist eyes and see him weighing up the decision whether to inject me or not/ clinical judgment feels like a whim that can go either way (he could have a cup of tea earlier and make a different decision) and you are the one who bears the consequences 25:943-948
Medication hindered the recovery in larger scale of things as added to the feeling of powerlessness 30:1139-1144
Psychiatrist: an authority and in position of power/power exertion, 'walked off with a little nurse on his side' as he dismissed her request (anger?) 33:1262-1269
Authoritarian/old school stance of psychiatrist was not helpful 38:1483-1487
'Psychiatrist was very brutal to me in the hospital' (after discharge it continued to upset me that he was responsible for care of other people = identification & powerlessness) 38:1505-1510
Staff being in a position where they could exert and misuse their power (withholding things, creating aggravations) 41:1600-1605
Hard to come to terms with the fact that one can be coerced into treatment 44:1696-1740
Coercion might have been avoided: Perhaps admission would not have been needed to keep me safe if I had family around me 49:1912-1919
Magic wand (what you could do with it/if you could do anything): 'apart from the obvious -just get the door open and leave!' (Humour yet may be denoting how negative the experience was and how powerless one felt?) 42:2624-1629
Magic wand: would go to the river (river symbolises creative power of nature but also irreversible passage of time and therefore a sense of loss and oblivion; current as struggles to overcome; also water in movement eventually merges intact and triumphant for union with the sea out of which it rose to begin with ?) and then go home 42:1653-1654
An Island Fantasy: Metaphor of the heart? - representing a need for independence, self-sustenance, existing according to one's own terms 43:1672-1682
Trauma of being hospitalised: if that happens to me again I don't want to be treated and that should be respected 47:1840-1842

- The restricted/constraint self

Couldn't go out at all, no freedom of movement, entrapped & shut off 1:21
Like a prison cell? Unable to leave the room 24:900-901

Difficult and Frustrating 1:22-23
Intense environment 1:33
Restrictions (e.g. no bath plugs) 1:28
Stuckness and powerlessness 1:33-34
Controlling environment, repressed 3:88-89
Boredom: paradox here staff busy and patients spending hours with absolutely nothing to do 6:203-204
No freedom of movement, irritation growing 7:249
PICU: segregated & confined to the room for a month, not allowed to leave 16:600-601
Trapped & confined: PICU ward/tiny room, secluded & isolated for a month 18:653-655
Being constrained/confined/havingwithheld opportunities: one could have gone out a lot more (frustration and irritation, psychiatrist could still say one can go out on section 17 leave); going out was positive for me but it was not being implemented (lack of resources) which hindered me getting better (not getting help a lot) 37:1461-1466 & 38:1467-1471
Positive glimpses however elusive, impermanence and losses: Having more sense of control on the main ward for a short while, (although a lot of patients felt out of control) however then losing it 17:610-618
Main ward less restrictive compared to PICU, more freedom to come and go, having bath when one wanted it, going out to the grounds 17:623-628 & 217641-643 & 17:651 - 18:652

- The impactless self

Deprived of agency, control, power, no longer author one's life 4:127-134
Things that you normally do, how you behave normally have no effect 5:181-184
Sense of self altered: the ward challenged the sense that one is effective in anything being accomplished/done, challenged one's an ability to influence anything or anything that happens, one's sense of agency is diminished, one becomes passive as is no longer an author of one's actions and life; loss of confidence (sense of being inadequate and ineffective, not in charge, terrifying out of control, total and utter powerlessness) 6:191-198
Giving up, sense that one cannot win, there is nothing I can do about it, becoming passive 6:195-198
Relations with staff represent having no power at all (not able to get through to them, have what one needs, hitting the brick wall) 6:224-228
Even out of control in relation to cream for eczema, pleading, degrading 7: 251-263
Overwhelmingly painful: No control over anything being reinforced. What happened to me, my body and my whereabouts 8:269-274
Self with no rights: disowning/denying one's rights to question, complain and reason (it must be me as being constantly told one is misunderstanding) 13:487-492
MDT meeting were intimidating with psychiatrist talking the whole time and leaving me little time to speak 28:1059-1072

- Submission & compliance

Passiveness: no more reason to stand up for oneself 14:501-503
Submission: Journey from rebellion and fighting to passiveness 6:191-200
Long term impact: Unable to be assertive, to say no, loss of boundaries, becoming easy to control,

compromising one's needs, people's pleaser 14:508-523
Fear of having an injection resulted in compliance with drugs (resulted in enhanced level of safety) 17:645-650
Compliance and pretence/compromising one's congruence, concealing oneself to survive and be discharged 18:660-663
Doing what they wanted, agreeing with what they said 'cos then you showed 'insight' 18:668-671
Compliance meant one's life was easier, enabled survival 18:668-685
Showed respect only when compliant/ one has no value when one is herself ? 18:668-685
Moulding oneself: Giving staff impressions that I was behaving within their expectations as to how 'mentally healthy person behaves' so I would get out quicker 22:839-841
I will take it orally (as no choice) and then collapsing 23:875-897
Demanding compliance (staff nagging and not understanding why she did not want to be there or take meds, focusing on lack of insight) 33:1282-1290

The Resistance (Quest to Regain what's lost)

Refusal to comply (backfiring) 2:45-48
Seeking justice, striving to protect oneself 3: 82-87
Trying to challenge, put the point across, be understood/communicate distress 4:118-120
Trying to protest, put point across, communicate distress (not understood, dismissed) 10:373
There can be power imbalance but this does not need to entail lack of respect – therefore protesting against lack of respect, wanting to have an equal relationship, let's work together 19:704709
The injustice: Not accepting or respecting the power staff possessed 19:700-707
Attempts to get through and establish dialogue & connection with staff (failed in the end though) 19:703-711
Standing one's ground, demanding respect from psychiatrist (the appointments) 32:1252-1261
Feeling out of control (requesting an appointment to be arranged by psychiatrist to see her and wiping names off the board) trying to regain sense of power 32:1249-1257
Decorating/transforming one's room: personalising it, being creative/making an impact/producing something, creating sense of familiarity, comfort, making it homey and cosy/safe and colourful/positive /hopeful /vitality, creating a distraction from reality/safe haven, one's own space/ having inspirational quotes around 42:1653-1660 & 43:1661-1667
Trying to engage in a debate with staff, question the ethical underpinning of the system and the coercion it relies on –expressing a sense of injustice 44:1696-1740
Physical and mental health law regarding capacity should be the same 49:1932-1935

- The battle – me/us and them

'This what SHE thinks, this what WE think' 4:131-132
Working against them rather than with them 7:231-232
Desperate attempt to regain some sense of power (acting 'silly' – wiping names off the board) 7:242-246

Tit for tat – revenge seeing, acting out, making the unbearable bearable (anger= hurt) 7:246-248
Anger/hurt: 'They are not respecting me I am not gonna respect them' (blow for blow) 9: 312-316
Them and us (become more of a distinct feeling) 18:679-682
Felt like it was a battle against them (staff) 28:1055-1057
Perhaps fantasy of being on an island: representing one to be against those who are not islanders? 43:1672-1674

- Survival

Mania helped to make the ward experience more bearable at one point 20:743-745
'Some of the things, you just became so used to them' (things not being implemented properly etc); unhelpful things became a routine that one didn't even think much about them 37: 1458-1466 & 38:1467-1474
Scarred: Not wanting to go through the experience again/Conclusions reached: 'If I ever become ill again I don't want to be treated against my will and that should be respected' 47:1840-1843

The Unrecognised

One's opinion does not matter, no credibility, not taken seriously 4: 130-132
Plea/concern dismissed, not taken seriously (drug test incident) and that having serious consequences (collapsing) 4:140-148 & (the memory of that evokes painful emotions and is associated with medication taking) 23:873-882
'I could have been a rock or an animal' 5:167-168
Lack of mirroring, mutuality and receptivity: 'How people normally treat you and listen to you does not happen here' 5:177-184
Misjudged: 'They thought I irritated them for no reason', one's attempt at communicating distress not recognised/dismissed , being misunderstood 7:242-248
Eczema – body communicating unexpressed distress (pain & anger erupting?) 7: 251-255
Invalidated 9:325-334
MDT meeting: left with one min to speak then cut off 28:1070-1074
Unable to be open about one's mental health/distress (impact on recovery?), it was a coercive one was not listened to, all communication being cut off 19:714-721
No honest / meaningful interactions with staff about what one felt or thought 20:745-747
Unheard/misheard/striving to get through and be heard & not being taken seriously/ seen as untrustworthy and manipulative & unpredictable 23:884-892
Valid points and argument dismissed/ not being understood (debate on coercive treatments; believing that locking people against their will is unethical even though they have no insight) ; 'if I think I have bipolar I still do not think I should be there' (emphasis on independence and freedom) – staff unable to engage in the conversation on the issue, staff lack of openness to such concerns and lack of acknowledgment was key 44:1696-1740

- Suffering in isolation/unrecognised/invisible

‘ They didn’t understand’ 8:301
‘Everything I was saying was being misinterpreted’ (they thought I had malignant motivations) but I was being in pain 9:302-307
Unable to show distress / be honest with staff (as it backfired) 18:668-685
Main ward – suffered in isolation (as not expressing her true feelings) however this was not experienced as poignant while on the ward until discharge as then one fell into severe depression and suicidal ideation that lasted two years and included serious suicide attempts (impact of the ward thus being unable to then ask for help out of fear of professionals and another hospital admission which reinforced emotional suppression) 20:741-760
Imposed on/ Manipulated/Misunderstood/misjudged/judged/words twisted– ‘another example of putting words into my mouth’ (traumatic memory) 23:883-888
Talking to fellow patients valuable however not necessarily about how one felt (thus suppression, suffering in isolation?) 27:1045-1048
Misunderstood and annoyed: staff was going on about her need to take meds, the fact she didn’t want to be there and her lack of ‘insight’ 33:1274-1286
Misunderstood and blamed: hyperventilating and placing hands over my mouth interpreted as an attempt to make it worse (being viewed as manipulative & devious) 37:1434-1439
Not valued or appreciated (incident with another patient – when a wardrobe had fallen over him and one informed staff of it) 37:1446-1452

- Unmet needs

Staff unavailable / unable to respond to one’s needs 1:30-34
Reaching out, needing help or support and not receiving it (being told off – infantalisation?) 6:201-208
Asking for help is not welcome or perceived / felt as wrong = equated with being a problem/ a burden for others 6:200-219
One is left feeling infuriated, upset in relation to staff attitude and them being petty (as above) 6:224-226
Left in oblivion/unknown/confusion when given diagnosis: no explanation given although asked for/psychiatrist’s arrogance and ignorance/dismissal of one’s request/plea/ left with the bombshell 33: 1262-1269
Let down as needed explanation and talk about diagnosis which was not facilitated instead staff focused on medication and the fact she did not want to be in hospital and had no insight (unmet needs and misunderstood), no consideration of the impact diagnosis can have 33:1274-1285
Neglected and misunderstood: Staff lack of knowledge of physical healthcare (neglect of physical needs), staff dismissive approach (seen as attention seeking) /reckless attitude/delayed responses leading to dangerous consequences (patient died, another ended up with serious problems) 36:1405-1421
Being misunderstood/misjudged (and again staff lack of knowledge of physical healthcare): panic attack/hyperventilating incident (sense of impending doom or threat/being overwhelmed?) when one was dragged around by staff to prevent her from ‘making it worse’ (i.e. putting her hands on her mouth which is an effective strategy) 37:1434-1439
A strong and understandable need to have one’s point of view acknowledged and respected (unmet need) 45:1741-1770

Positive: having one's needs more fully met at times/main ward (being taken to the grounds) 17:651 - 18:652

The Unreliable Self: world collapsing/turning upside down

- World turned upside down

'level of upheaval, it was EVERYTHING' (no longer able to rely on one's subjectivity, one's body and the world) 30:1162-1163

The whole world disintegrating (loss of inner cohesion and strength?), the foundation of it was also having psychotic breakdown and trying to come to terms with that (plus dealing with everything else that the ward brought on and therefore complicated the whole experience) 32:1197-1201

The Noah Arc Image (one's world drowning/disintegrating/one becomes estranged) 40:1583-1590

- Disorientated & Bewildered

Self in relation to others: Familiar and normal ways of relating to others or being in relationships are altered, how people behave and treat you, the usual template for interpersonal relating, the foundation, the implicit rules do not apply (all of the sudden I am not listened to, taken seriously, having no impact on others), things you take for granted do not happen (confusing), 5: 175-184

Alien, unnatural, no mirroring, no mutuality & responsiveness and receptivity 5: 175-184

Muddled and in turmoil: Intense & extreme confusion & shock a predominant feeling for a long time/ mental uncertainty/ not knowing how to be any more (loss of self) 15:542-557

Diagnosis: bomb shell: left in confusion, no explanation given for a long time, then some handout given out, that was it, no one sat down and talked to me about it 33:1274-1282

- Taken for granted

Realisation that one's can take so many things in life for granted (and lose it/have it snatched away)

Losing/having taken away integral, stable and reliable parts of oneself and one's life/ bewilderment and shock/the incomprehensible – something one would never predict could happen , all you are used to about yourself suddenly shifts sands (all it takes is to give you a pill) 30:1147-1156

Basic expectants overturned: most basic/natural things one relies on like the body (dealing with drastic unnatural changes medication brought upon) 30:1168-1178

World view and self-image deconstructed 30:1139-1178

Sense of injustice: one's conceptions of personality and human rights and ethics were challenged (being coerced into treatment) 44:1696-1722

- Twisted and Warped (abuse equated with care; brainwashed?)

Confusing and contradictory messages: being told one is cared for when one's experience is in contrast to that (feeling of being mistreated/abused and told he staff are trying to help) 9:325-335 & 10:358-363 &10:368-373

long term impact: being left vulnerable, unable to recognise when one is mistreated , allowing to be mistreated; being mistreated become one's normal reality = equated with care 10:373-380
losing ability to respond to red flags, becoming & maintaining a victim position in future relationships 12:431-438
internalisation of staff treatment: convincing oneself that one is demanding and wrong 13:479-487
Self with no rights: disowning/denying one's rights to question, complain and reason (it must be me as being constantly told one is misunderstanding) 13:487-492
Twisted& disturbing reality (the façade): everybody says they're trying to help but you know that's not the case, they are hurting you instead 25:972-976 & 26:977-979

- Alienated/misplaced/disintegrated

Admission & discharge: being taken away from the familiar and the world one was part of, interruption, the world changing, becoming unknown & alien, rug swept from underneath one's feet (loss of education, close friends contact, accommodation = discharge) 12:441-452 & 13:457-466
Misplacement & Isolation: hospital and discharge – dropped –becoming homeless, the familiar transformed into the alien world, facing upheavals /drastic changes 12:441-452 & 13:457-466
Trying to integrate oneself into the world – however forming unhealthy attachments as a result 13:465-467
Dislocated and misplaced (PICU): waking up and not knowing where one is in space is surprisingly distressing, unfamiliar surroundings yet in one's university town (unable to locate one's position when looking out the window) 16:599-608
The total loss/annihilation/ to sum up: one can no longer rely on myself or the world around me, my life is over and my future is bleak and I am traumatised by the whole experience and will probably be back in the hospital; loss of oneself and one's life, becoming a diagnosis….35:1345-1365

- Self-alienation (Self- doubt/loss of self-reliance, gradual loss of self)

Losing an ability to validate one's own subjective experiences (sense of self altered), not being able to trust one's perceptions, inferences and beliefs (long term profound/aversive impact of hospitalisation), being told she is wrong and it's all her illness (pathologised) 9: 325-336 & 10:344-347
Diagnosis: evoking self -doubt and confusion (can I trust what I see or hear?) 9:335-343
at peak: one's confidence was completely crashed, disconnection and dissociation from oneself, self becomes alien and surreal, what is real what isn't, can I believe anything I am feeling or seeing, are my boundaries realistic? (constantly feeling unsafe and abused yet told they trying to help, maybe it's your illness) 10:352-363
Discharge/falling into depression (serious suicide attempts), was the complete bleakness and understandable reaction to my experience, was it simply my bi-polar, ore chemical, was my recollection of the ward tainted by the serious depression I had – no definite answers, all meshed / tied up together (is there a self-doubt here again?) 35:1360-1376

Long term and aversive consequence: lack of trust one's feelings (forming friendships and not being treated nicely), unable to see people for who they are 10:373-380
Long term impact: being left vulnerable, unable to recognise when one is mistreated , allowing to be mistreated; being mistreated become one's normal reality = equated with care 10:373-380
Internalised: putting one's own view down, loss of self-belief ('convincing myself that I could not just believe myself any more'), losing credibility as a human being in other and then in one's eyes; if one does not own one's feelings and thoughts/loss of subjectivity – losing oneself? 11:381-382
Self with no rights: disowning/denying one's rights to question, complain and reason (it must be me as being constantly told one is misunderstanding) 13:487-492
Self- compromise, not attending to one's needs, sacrificing authenticity = loss of self 14:508-523
Upon discharge: becoming numb and depressed: discomposed /disconcerted/disconnected from oneself/loss of self & identity/ not knowing 'how to be' anymore 15:552-557
Loss of self-reliance and connection to oneself and others 15:542-557 & 14:508-514
Unable to be oneself (honest about ones feelings etc), telling them what they expected to hear 18:657-663
Diminished individuality: petty rules everyone had to fit into/being boxed 28:1088-1094

- The ego-dystonics and the betrayal of the body

The medication brought about unwelcome transformations/ body become unpredictable and unreliable as well/ drastic shifts (another aspect of lack of control, another layer of powerlessness); the familiar becomes alienated; ' no longer having anything about myself I can rely on' 30:1142-1148

- Self-estrangement

'no longer having anything about myself I can rely on' (betrayal of the body and unable to depend on one's subjective responses and the world around) 30:1147-1149
Estranged from oneself and the world/detachment/depersonalisation?: 'Everything I depended on was swept away from under me' (the body becoming unpredictable and extreme was a component that added to everything else, part of bigger picture, not knowing where I was, alien environment and not able to rely on my perceptions etc) 31:1183-1192
The issue of diagnosis and the context in which it was introduced complicated the process (diagnosis plus ward experience compounded self-doubt) 32:1238-1243
Diagnoses made her doubt herself, her beliefs etc which in conjunction with other experiences made it harder to manage 31:1200-1218
Diagnosis=pervasive self doubt had profound impact as made one less able to deal with things that now one knows was poor care from staff, that led to self-blame which hindered recovery 32:1220-1230
An Island Fantasy: being an island/being on an island perhaps denoting identity issues, transformations, displacement ? 43:1672-1674

Disillusionment & Distrust

Damaged Trust: 'I thought staff were angels', having different ideas/expectations that collapsed; world view challenged 2:62-78

Waking up form sedation/covered in bruises: shock, dismay, fear instilled 2:58-64

Position of self in relation to others transformed 2:53-67

Restraint: being stunned, incomprehensible, unimaginable, unexpected, unjust, lawless almost – how can this be allowed? 3:76-89

The police yes but the nurses? 3:82-85

The fall: from admiration to anger and shame/disgust towards NHS (stripped of illusions about the world; loss of faith and trust) 3:94-99

Shame and disgust (anger=hurt) and disapproval of what the service represents (as family members worked in the NHS), distancing oneself from what the system denotes 3: 94-105

Impact: becoming weary of professionals, caution and fear 3:105-106

From encouragement to coercion 4:137-140

One does not matter: 'Realisation that they don't care about me & my wellbeing', my feelings 4: 147-154

Realisation that one cannot expect familiar outcomes or no longer rely on what one knows is integral to human relationships 5:176-184

One week on main ward to begin with then being transferred to PICU (the two experiences are dissociated/separate), the latter become traumatic and stripped one's of illusions/ bubble bursting 17:611-618

PICU experience – upset with staff 17:636-638

Realisation that being honest with staff was pointless and adverse (not safe to be honest), giving up on efforts to have a proper and equal relationship with staff 18:671-685

Giving up on the prospect of having equal and respectful relationship with staff, no longer trying/protesting , no longer trying to have any relationship with staff, loss of hope 19:704-712

Broken trust/unsafe thus Long term impact: unable to trust professionals and the system/ weary and cautious (before I would have assumed them to be good/caring etc), expectations and feelings altered 19:722-732

Long term debilitating impact: depression and serious suicide attempts after discharge (2 year struggle) which was exacerbated by the fact that one left hospital being terrified of asking professionals for help, also fear of another admission, suffering alone (it would not have happened if my hospital experience was different) 20:743-758

Rude awaking – how much power they have over you 25:939-950

Perception of the world altered/one's position in the world: Up until hospital experience had positive relations with authority etc, ward experience disillusioned me about NHS, feeling that world is a good/safe place (that one is safe) went away and that there is justice (example of the mugging) 26:1000-1006

'There was an expectation that I would be safe'/looked after in hospital etc but it collapsed 26:1010-1014 & 27:1026-1033

Rude awaking/stripped of illusions/bitter reality/truth: All my expectations how I would be treated were dashed, my beliefs and what rights I have in society 30:1162-1166

Let down/disappointed: injustice, lawless world, it's like being put in a prison without a trial and repeatedly assaulted and no consequences 30:1166-1169

Let down by psychiatrist…not turning up/unreliable ('maybe he had good reasons but I was frustrated with it all') 32:1247-1250
Distrust increased by realisation that one's physical needs are not attended to/neglected (cannot rely on staff care) 37:1422-1423
Vicarious: Seeing other patients being restrained or not looked after etc (instilling fear and sense of distrust towards staff) 37:1447-1460
Magic wand: would give staff personality makeovers/transplants 42:1640-1642

- Let down

(Diagnosis): resentment and being let down about how it was introduced in the hospital, perhaps if it was introduced differently one would have a different perception of it altogether (it all had a devastating effect as when one left hospital reading on bi-polar on the internet further reinforced/ backed up existing sense of hopelessness); I could have feel more positive about my diagnosis (as in now I get the right treatment for example) 34:1300-1328
Realisation that one was let down/ 'I was not getting help a lot' but things like that just became a routine and one did not think about it 38: 1470-1474
Resentment and disappointment: Psychiatrist was the biggest hindrance to one's recovery acting as role model to other staff perhaps (prolonging one's stay in a hospital and made it more traumatic; he had a pretty unpleasant attitude towards me, one still is feeling animosity towards him), it all did not have to be such an aversive experience 38:1474-1492
Let down: Emergency admission, sudden/shocking/displacing/no awareness or preparation provided for such scenario 48:1868-1873
Again it all comes down to individual staff members (making a difference for better or worse; here making it more traumatic that it could have been otherwise 38:141474-1487
It can happen to anyone, anyone can end up in hospital against their will, there should be more awareness of those issues 47:1859-1862
People should consider long term impact of hospitalisation, one being affected by it years later (10 years thus perhaps also important to note that services might have changed significantly since then? Or have they?) 48:1887-1892

The punitive components

Nurses compared to the police? treated like a criminal (someone who did something wrong) in that sense? 3:82-85
'Your bi-polar is really bad need to be treated aggressively' 4:117-118
Taunted by staff: Punished by staff for irritating them: being locked in the rooms and staff paying games outside 7:263-266 & 8:267-268
Being an irritation/irritant to staff and having been made to pay for it 8:267-269
Becoming self condemning, shaming (criticising and deeming 'wrong' one's feelings) 14:498-501
Shame & self-blame, feeling guilty when others said it was my fault 15:542-546
'Just give her an injection as she will change her mind immediately' (traumatic memory of nurse trying to sway psychiatrist) 23:890-893
Guilty without trail analogy and then assaulted 30:1167
Internalised badness? ('it was my fault, I am wrong') 321225-1230

The context in which diagnosis was given experienced as punishment from psychiatrist for previous demand of respect from them (book and app if you want to see me), their authority questioned was not welcomed 32:1252-1261 &33:1287-1290
Being blamed for being physically unwell (accused of making it worse or being manipulative or attention seeing etc) 37:1435-1446
The Noah Arc Image: allusion to the punishment ? 40:1583-1590
Being an irritant?: Staff when annoyed with me deliberately were withholding things (power exertion), making it harder (say to get a bathplug) 41:1600-1605
Prison cell analogy 49:1921-1923

- Patronised & degraded

Knocking on staff doors: Being told off by staff, being seen as a nuisance/as making unreasonable demands, getting in trouble for it (like a child), staff getting annoyed/impatient 6:201-219
The trauma and result/impact beyond hospital admission: being nervous around doors (fear of being told off) 6:200-208
Traumatic memory: told to go back to bed by a nurse (pointing a finger at her), she could not stand me not being in bed, told off, shouted at/degraded (infantalisation) 24:905-920
Boarding school and prison analogy: reminiscent of being a child, staff becoming a bad teacher (not therapeutic, them against us) 7:229-232
Treated like a child, patronised: coming to the office and keep asking staff for eczema cream, being given only little each time and coming back for more (then staff becoming annoyed), 7:251-263
Patronising: one's expertise on oneself dismissed (eczema example, amount of cream needed) 7:251-263
'stop this messing around' scenario – feeling like a child? 25:942
MDT – staff being condescending, short and disrespectful ('held his hand up and said I am going now' while she was left with little time to talk) 28:1067-1074
Like one does not matter: psychiatrist appointments, visits, turning up whenever it suited them, no consideration for patients, chaotic and unpredictable, unreliable (saying he would come but he did not)/ feeling disrespected 32:1246-1257

Dehumanisation & Objectification

'I stopped being a human in a lot of ways' 4:120-121
Becoming an object to be done to or imposed on, for observation 4:127-132
Not engaged by staff as a subject 4: 130-131
'Not engaging with me as a person', no feeling nor understanding 5:164-166
Something to be observed/an object, could have been a rock or an animal, anything like that (rock: inferior, no value, no soul, no feeling?) 5:166-168
Not a human being having any equality with them (unrecognised, degraded, objectified) 4:154 & 5:155
Feeling angry, confused and powerless as a result 5:175-176
'they tried to manage me there, they took me to PICU ward' 17:629-630
MDT meeting: 'he was telling me whatever he was gonna do to me' 28:1070

Being an object for observation (reduction but also is there something about being a freak/peculiar?) 37:1428-1430
Being dragged around/manhandled (and for no reason) 37:1436-1444
Treated like a creature to observe (a monster?) 46:1796-1800

- 'That's all it meant to them'/ am I a nobody to you? 4:146-154

Instrumental treatment: No concern for her wellbeing, welfare and feelings, I am nothing to them? And object, a problem, a nuisance, a puppet/object to be done with as they please? (now it will be hard to make her take drugs preoccupation), an object to fit their agenda 4:146-154

- Pathologised self & self-pathologising

'I was completely equated with my illness' 4:120
Invisible/non-existent self, 'it's ME you treating aggressively not my bi-polar' 4:117-120
One becoming a diagnosis in other's eyes, reduced, objectified 4: 117-121
Deemed grandiose as kept asking eczema cream (as was given not enough) 7: 251-261
It's all your perception/'it's in your head, it's your illness' 10:368-373
It is me (my fault) locating fault/blame on individual level 13:488-492
De-normalising and shaming: 'I am wrong for feeling upset, wrong for not liking how I am being treated' 14:499-501
Loss of self-worth (shame), one becomes wrong, inaccurate, without credibility and therefore value & contribution, if one cannot believe in oneself one cannot accomplish anything 15:542-557
MDT meeting: left with short time at the end to speak thus had to rush to be heard then told she still has pressure of speech (double bind, no win situation) 28:1070-1075
Diagnosis compounded the issue of self-doubt (internalised stigma and pathologsing oneself) 31:1200-1218
Asking to be treated with respect (book an app with me, don't just turn up when you feel like it and expect me to drop everything) interpreted as being grandiose 32:1250-1258
Decorating and personalising one's bedroom interpreted as symptom of 'complete mania' 42:1657-1660
One's valid arguments regarding ethical grounds for sectioning seen merely as lack of insight 44:1696-1740
Demonised? Am I a 'leper'? (being seen/feeling like a disease, disturbed & to be avoided/the un-faceable?): don't get involved with others patients, you do not want to have too many friends who are mentally ill/disturbed; but I've got mental illness too, so what are you saying? How other view me? What am I then? 45:1762-1770; however then slight contradiction as this is interpreted a staff expression of care, they genuinely thought it's better for you not to socialise with patients, concerns of triggering one another or being too needy (perhaps intellectualising here)? ; however staff unknowingly promoting separation, isolation, & stigma through control exertion (keep distance for your own well-being, thus damaging attitude = as seen in 'leper' feeling above) 45:1776-1782 & but summing up: 'that is really wrong' 46:1783-1784 & 46:1783-1790

- Degradation/ disrespect

Disrespected by a psychiatrist while given diagnosis during lunch 33:1262-1269
Humiliating, shaming & degrading: having to take trousers down in front of many staff members for an IM 24:920-926

Hopelessness & Bleakness and The Falling

'My life is over': Diagnosis plus being sectioned and the experience of the hospital and its effects (they all cannot be disentangled) evoking sense of hopelessness and despair (recovery beyond one's reach), staff on the ward old school conveying the message that one's life is over (psychosis: as if one is now unable, incapable, inadequate and broken and should remain in the asylum/ belong to the hospital not out in the society messages, e.g. 'you should not study or work again' etc); others' comments 'oh we never though you come out again'; hopelessness evoked by hospital experience and the context in which diagnosis was given then backed by internet search/messages then all those memories and experiences were integrated and resulted in despair & depression hindering me getting back on track 34: 1322-1344
Getting diagnosis: numbing 34:1311-1312 and irritation with psychiatrist 34:1327-1331
Future gone: Having bi-polar means spending your b'day on the psychiatric ward; all that background, and internet saying my future is bleak and I just had the most horrific time in the hospital which means my life is already following such path 35:1345-1356
Discharge/falling into depression (serious suicide attempts), was the complete bleakness and understandable reaction to my experience, was it simply my bi-polar, ore chemical, was my recollection of the ward tainted by the serious depression I had – no definite answers, all meshed / tied up together (but also is there a self-doubt here again?) 35:1360-1376
World collapsing/Meshed in: hospital experience, discharge, self-estrangement continued, unable to ask for help and take medication, impact of diagnosis , no need to isolate it out 36:1384-1391
One flew over the cuckoo's nest: Again hospital representing having 22nd b'day there, old Victorian building, asylum, being confined, locked away, my life as mental health patient now (hard to come to terms with) 48:1880-1885

The journey: corrective experience, search for meaning and resolution; towards self-reinstatement and resilience

- The bright side:

'It was frightening but probably kept me safe' 1:23-24
'Kept me safe, I was very maniac, delusional, I don't know what I would have done' otherwise and 2nd admission was helpful 49:1912-1920
1st admission just kept me alive but was unhelpful overall 49:1922-1923
Time spent on trying to understand the carer perspectives (from NO stance on ethical grounds/being completely against forced treatment after hospitalisation/having strong feelings to becoming more lenient towards the issue: maybe if someone is very ill it's the

best thing); processing the trauma, transformation of beliefs and feelings towards one's experience 3:107-112 & 4:116 & 46:1807-1824

Acceptance: 'I now think it's needed (section), which I did not at the time for quite a few years' 43:1694-1695

Strive to make sense of the experience & come to terms with it, perhaps quest for forgiveness and understanding, changing view on coercive treatment, knowing how challenging it is for carers deciding that its needed as a last result and may need to overshadow one's right for freedom and independence to keep them safe (even medication now seen as reasonable if one needs to be brought back to themselves) 46:1807-1824 &47:1825-1832

However still in the process of constructing one's stance (I may change my mind again, that's what I reached now) 47:1842-1843

Perceptions altered over time: when I first came out of hospital (even from 2nd admission) there was nothing good about it – with time became ready to discern positives that came out of it 49:1924-1926

- Corrective experience:

2nd admission enabled recovery of self /corrective experience/ process of reinstating oneself (i.e. realisation that one was not wrong and that it was not all one's illness, I am not saying here staff are horrible), re-gaining self-confidence (took a while, 5 years after) 11:395-403 & 11:410

2nd admission: being supported, cared for, heard, feeling grateful to staff (staff creating mild frustrations but nothing unreasonable) 11:388395

Paradox/contrast: 2nd hospital admission provided a corrective experience: staff were respectful not doing things in degrading way/ same procedures yet staff attitude approach is a key 11:388-395

2nd admission was in contrast to 1st one as although nursing techniques were the same etc it was delivered differently through warmth, acceptance, empathy and it was supportive/ therapeutic (staff/nurse talking to me regularly, activities that were helpful) and such approach is key to making a difference 22:842-855

2nd admission: more activities 29:1131-1132

' now I know it was poor care from staff' 32:1227

2nd admission (2009): more positive, needing that level of input, being monitored, receiving help & support, more skilled staff not aggressive, becoming well faster 48:1901-1904 & 49:1905-1912

After discharge: The 'hindrance psychiatrist' was finally removed from one's care and one improved rapidly beyond any effect of medication, one had anew psychiatrist for several years after and it made a huge impact (the 'good' psychiatrist was in charge of the unit when I had a positive experience) thus feeling grateful 38:1474-1486

Long term changes/impact: Having a good relationship with the psychiatrist: experience of being involved in one's care (have a voice/being validated, having influence, being an equal partner, empowerment, increase of self-worth) collaboration rather than coercion, working together not against each other , mutual respect – all makes a difference as how one experienced being sectioned (as system procedures, legal side of things remains the same), being treated with empathy makes one more open and collaborative in terms of treatment (it didn't make me feel like I was unjustifiably put in hospital); being transparent/making efforts

to explain the rationale behind the decisions made (therefore one may not agree but will understand it, resulting in better compliance with treatment), being listened to and reassured, decisions made not based on assumptions but fully informed and in one's best interest; when one is mistreated one becomes oppositional and is judged as being more unwell mistakenly (two way street, conflicted encounter) 39:1522-1551 & 401552-1571
I now know this was all a stereotypical myth about mental illness that one internalised (my future is gone etc) 35:1348-1356

- The gain (bigger picture):

In the end becoming more assertive, self-assured, it's okay to be demanding & persevere in order to protect oneself, determination to receive adequate care (journey from losing confidence to becoming more assertive and resilient as a result of ward experience) 21:789-801
The Gain: Positive/Constructive as in the end caution and rigidness in choosing professionals resulted in better care (protecting oneself) 20:765-773

- The Noah Arc symbolism (the life journey) 40:1583-1590

The Arc: (house of god, an omnipotent, powerful object? Punitive? = psychiatry?); safety / provided vs confined and crowded
The flood/storm (frightening context/background,): crisis, disaster destruction/devastation, punishment by god; trip into the underworld, world dying/disintegrating/disappearing (one's world drowning) and being reborn ? vs washing away the old/cleansing/regenerating / hope = all in the end resulting in some positive outcomes such as being assertive etc)?= Journey/life/spiritual plan (stuckness, floating around, the unknown, estrangement but one is saved/purified?….)
Animals: vulnerability/ defenceless/conflict?

- The positives: Being Held/comforted/reassured /supported/feeling safe (through the building, 'bodies around' and other patients)

Clean physical environment (felt nice and supportive) such as clean linen (in contrast to feeling depressed and living in horrible place at home) 22:826-829
'The building, itself allowed me to feel held' 26:1007-1010
The space itself 28:1076-1077
Chapel room enabling more privacy (valuable) 37:1432-1434

- Connections and Identifications

Contact / support from fellow patients was helpful1:24 & 22:824-826
Shared experience with fellow patients 22:824-826
Some staff being supportive and nice 2:41-42
There were sort of 2 or 3 staff you desperately wanted to come on shift as they treated you with respect/feeling cared for 8:294-296
Bad vs good staff: comparisons instilled more respect for caring staff as they didn't have to be respectful as most were not 9: 317-322
Feeling fortunate: Keeping in touch with friends from university, they stuck with me but they moved away so contact was limited 12:439-446

Companionship with other patients 16:584-588
Main ward: more activities, more social experience, sometimes having fun with other patients, integration, a lot of people to talk to one's age (more positive experience that was welcomed and did not need to be dislocated and in need of disavowal) Main ward vs PICU (main ward less restrictive, less confined and more activities therefore more social experience) 16:581-598
Returning to main ward: more connected to the world/recognising where one is in space 16:604-607
Main ward: dancing, listening to the music, felt more friendly and warm, at times felt nice, reminiscent of school experience (one week on main ward to begin with then being moved to PICU) 17:611-616
Main ward: feeling more relaxed, meeting nice & interesting people 18:655-658 & having fun, chatting to people helped (combated loneliness as well) 27:1040-1048
Learning from fellow patients, how to work the system 18:657-661
Seeing refuge/focusing on patient relationships 19:720-721
Simply Human contact was helpful & reassuring, feeling people around me/their presence (not feeling utterly alone) 22:822-824
Valuing friendships with fellow patients: forming attachments, meeting a best friend in the hospital/ supporting each other is adversity/crisis 46:1783-1787

- Presence of others:

To an extent feeling of security, being held and feeling reassured (no longer alone in the flat while depressed), being surrounded by people even at night helped even though staff interactions were not good; able to talk to fellow patients when needed (surrounded by people reminiscent of childhood experiences = having big family around) 16:565-574 & hearing bodies / presence of others simply 26:1009-1010
Main ward: more staff around (positive/safety) 17:651
Bodies around, general kind of human feeling around me even though they were staff not important or helpful to me/human connection on a physical level 28:1077-1082
Having An advocate at one point (feeling supported & diminishing power imbalance which resulted in more respect from psychiatrist) 28:1062-1066, 'he was on my side whereas staff were not' 28:1054-1055
Having visitors Was helpful 28:1057-1058
Medication (olanzapine) at the time bringing down the mania eventually / getting me more well (mixed blessing in the end though) 28: 1082-1087
Structure of the ward/routine somewhat helpful however only to an extent (as also rigid / petty rules) 28:1087-1090
Music technology activity was fun (however little activities overall) 29:1128-1130
Chaplains coming around: Treating patients with respect (that was not felt from staff) no matter how ill you were (again staff – others contrast) 37:1425-1430

APPENDIX 11: Full Themes Table with Example Quotes

Superordinate and subordinate themes	**QUOTES**
Struggle for Recognition	*''(…) when I self-harmed I felt…the way staff reacted was….very, there was no 'why did you do this'…I was attention seeking (…) they would say that I was demanding (…) they would say that I liked the idea of self-harming hmm and it was an obsession and...(…) instead of seeing that as a 'she in distress' (….) so the pain I already felt had just been heaped upon…. (…)''* Cait; 24-25:1000-1023 *''I was assaulted by other patients too and nothing was done''* 888; P.9, 343-344 *''I was about 8 stone weight and not needed to be restrained, I could have been talked to, if somebody actually sat down with me and listen to me and try to find out why I was trying to escape or what I was so frightened of when I was there I think I would have reacted very differently''* Valerie; 3:104-108 *''there was no care, no compassion at all in there, I really didn't see an ounce of compassion while I was there''* Valerie;9: 337-339 *''(….) people didn't even care about my modesty you know…I wasn't respected'' Valerie; 11-12: 430-447* *''and if you complain about anything but…(...) what people kept saying to me oh this is part to your illness, that is how you get when you're not well so I didn't feel heard''* (Valerie;1: 35-38) *''normally in a conversation people sort of take what you say, like they, they listen to you umm and you realise that there wasn't any of that….umm and so it's quite disorientating (…)* Sally: 5;176-184 *''It's as if they don't give you the right...they are not willing to listen, they're not willing to treat you like an individual and that was the policy of their unit, and their ward and that's how they treat people (….) but they don't look at a person (…) I stopped, I felt as if in that environment I stopped being me, I stopped being a person (…) I wasn't an individual any more, I was part of this collective group of people (….) maybe they didn't have a choice- they couldn't trust what we were saying I don't know, but the things they did, they would search everybody and they didn't even show respect to… your possessions''* Cait; 26:1065-1083 *''so yeah I wouldn't really say me getting well was facilitated in any way which is yeah I thought I was more manageable so therefore I could leave and I wanted to leave, I really wanted to leave, when I was, I didn't need to be there, I wasn't dangerous''* Annabel Alexandra; 33:1219-1222
Abandonment and The Falling	*''They ignored the patient''* 888; 11: 443-444 *''I do feel I remember feeling abandoned (….).''* Buster; 32:1227-1238 *''And then I would be put in segregation and then when I was in segregation, I think legally they're supposed to sit and observe you (…)and they didn't, and I would just feel like I've been there forever and ever and ever so (…) I don't even know why I'm here, it feels like I've been here forever''* Buster;47:1811-1817 *''being kind of completely abandoned in a way umm like completely on your own…umm with these people who say they want to help you but actually just hurting you and being cruel and you just at the mercy of their whims''* Sally;24-25;937-940 *''I would have a lot more staff, a right sort of staff that could give, there is not point having bodies that lock themselves in the office''* Valerie; 18: 700-702 *''you know, thinking about it, it's like being human trafficked but you never going anywhere or you only go you know (laughs) down the road to hospital and then you transported back to your home environment and just left there and it's like what just happened? yeah it's like being a refugee in your own country''* 888;12-13: 496-501 *''I suppose the only thing I can hmm say as well….is this huge hmm shortage of beds has an impact on patients while you're in there, 'cos once you start to get well hmm and yea it's great to be discharged don't get me wrong, I've spent most of my time trying to escape, but the discharge has to*

	be planned and you have to…but the message you're getting all the time then is 'we want you out, we want you out of here, we have no more time for you' hmm you're not…(…) hmm but that's not good for recovery you know (…) again you feel… of no importance, my recovery doesn't really matter hmm… (…) *but I've seen a lot of patients in there badly affected by that, and actually going out and trying to kill themselves again and ending back in there''* Valerie; 29-30: 1141-1163 *''I mean I didn't ever speak to anyone (…) all they seem to do is give them pills until they feel better and then you leave, there is no like after care (…)''* Annabel Alexandra; 14:514-523
Terrifyingly Out of Control – Striving for a Sense of Agency	
Living in Fear	*''What was happening, the doctor was sort of saying 'well your bipolar is really bad and we need to treat it aggressively'…and I was like - well that's not my bipolar you're treating aggressively it is ME you're treating aggressively".* Sally; 4:116-119 *''In terms of there weren't at that point any kind of honest interaction about, about what I thought or that how I was feeling….and while….I don't think that mattered on the main ward but when I left and over the next couple of years when I got very depressed and staff, suicidal and that kind of thing, then I think it had real impact as I didn't feel safe to talk to professionals about that and it took a long time for that safety feeling to build up and I think as a result of that, it hadn't been for the hospital admission I don't think in the next couple of years I would have, I took two very, very serious attempts at my life that kind of left me in the coma for a weekish each time and….I don't think there would have happened if I could speak to staff or that I hadn't felt there was a risk of putting me up in hospital if my mental health was deteriorating (…)''* Sally;20:745-759 *''(…)…your life would have to be so crazy for you to think that was...even a…a safe or beneficial environment for you in any way (…)…''* Buster; 50:1904-1918 *''you know you, I think because you live there with others for 24 hours a day it's not like you go home at the end of the shift, you've got to sit there in your nighty at seven o'clock at night I don't know it's a funny experience...and also they're not great, on the locked ward years ago you didn't have a division between male and females I don't know, that wasn't particularly nice you never knew, you didn't feel safe, you didn't particularly feel safe anywhere that's quite frightening….they're horrible frightening places.. I wouldn't wish it on anybody''* Buster; 8:274-282 *''other horrible things one guy punched me there but he just punched me in the arm''* Annabel Alexandra 18;674-675 *''I would say my experience was the most traumatising horrific experience of my life''* Valerie; 24: 949-950 *''I would be terrified if it happened to me again though, if I thought I had to go in there''* Valerie; 7: 239-240 *''not all the staff are horrible but the majority are really…morally hideous people, ethically hideous people''* 888; 45:1762-1851 *''you know that expression home away from home….? Well, it's rape away from rape……that's what it was….I was physically violated, I was emotionally violated, I was psychologically violated…hmm so yeah home away from home, rape away from rape….umm…..it's an environment to create trauma''* 888;37:1452-1457
Deprivation & Re-attainment of Power	*''at times it was infuriating…at times it was…just really upsetting….and at times it felt ridiculous because you feel like staff are being quite petty….and umm I think it would just underpin that not having much power or not having really any power at all…and umm and it kind of almost sort like there is a boarding school, when they became a teacher but not in a nice way, so rather than working kind of in a therapeutic way it kind of became maybe prisoners is a better analogy….yeah so kind of working against them rather than with them I think…''* Sally; 6-7:224-232 *''for quite a long time umm on the main ward until I got a bit better umm sort of still protesting that I wasn't being treated with respect umm which in a way sort of…umm…umm lease open that opportunity to have the relationship, like it might be like I'm protesting but I'm, it's kind of me saying treat me as equal lets kind of work on it together, umm…so that had a lot of visible conflict on the*

	PICU, on the main ward it was more entrenched because I wasn't trying to do that after while…I almost, I was saying whatever they wanted to hear so was not trying to have any kind of relationship in a way, and kind of honest interaction with them and….even now looking back I really don't think there would have been…much point in me trying to be more open about what my mental health was like with me which I know it's a bit…'cos I often hear about carers saying that sort of staff but my personal opinion is that with good staff it might be useful but my experience of hospital was that it was really no point and it was pretty much a coercive situation where I wasn't listened to so any kind of communication was kind of cut'' Sally; 19:703-720 *''I think if I had a mild bipolar and I only went to an acute ward I wouldn't say it's a horrible experience, I would say it's something you have to live with, it's a condition bla bla but I think once you've had more than one experience on the locked ward THAT is the horrible experience, the locked ward...(…) I think once you've had your liberty taken away, basically you're not, you can't do anything you want, you can't say I've got a day on Friday, you can't say I want to see a film on Tuesday, you know you can't say anything, you have nothing, you have no control over the 28 days that you're sectioned and then it can be another 28 days or whatever, there is nothing you can do about it…''* Buster; 42:616-630 *''I don't think I've got any influence…when it comes to pills… you just told to take it'' Annabel Alexandra 57:2143-2144* *''you go onto a ward and it's like being held by a throat on the edge of the cliff and if you struggle, if you don't submit, the grip on your throat tightens until you do and then when they're happy when you are submissive and complaint they let go off your throat''* 888;3:120-124 *''he (staff) had lot of fun exerting the power so in terms of smoking protocol, he would just decide, there were set times when it was, but he would decide when he was ready it would happen and he would wander through the ward shouting 'smoking time' (accent) and if you didn't get into the line quick enough to go through the door, say like if you're having a shower or you were eating or you're sleeping in your room and you hear smoking time and you get up he would take a great pleasure in locking the door, locking you on the other side of the door so this is refused to you''* 888;2:69-78 *''you feel controlled all the time….you know it's more, the nurses in there seemed to be to me more like referees rather than somebody to support you, you know hmm when they were doing one to one, I was on one to one observations for a long term (…) there was this chap following me everywhere I went, my god, that's most horrendous thing and he wouldn't even give me personal space, you know, he was right up my back''* Valerie; 5: 182-189 *[being followed] ''(…) hmm you know he was in my face all the time, well at my back really, and you could feel this thing behind you, there was no need for that he could have left certain amount of space between us you know and it was almost…I might have been reading at that point, like you can't get away from me, I am more powerful than you, that sort of attitude, that's the feeling I got…you know if you think you going anywhere (evil laughs) not when I am around….other people would've followed me but he was particularly bad at it, other people were much more subtle at the way they did it….and were better…it makes you feel hmm… again powerless that you know, you can't even go anywhere…you know he's on your back, he's even waiting for you while you at the toilet…''.* Valerie; 11: 415-430 *''there is always a certain level of power imbalance but doesn't have to feel like in a way away, just because there is power imbalance doesn't, doesn't mean there has to be lack of respect going both ways umm I suppose, I think that's the difference I kind of suppose between sort of authority and power and I felt they had power''* Sally; 18-696-701 *''I don't know, it all just very patronising and - have you taken your medication, are you gonna be good tonight, are you gonna sleep tonight, you've done a nice painting, you're gonna come to art classes, you're gonna go for a walk..? oh okay (child's voice imitation) …(laughs) umm…. I suppose it's not… I don't know it just encourages you not take a responsibility for a while, and that's probably what it does, it's a bit indulgent in a way, that's what I say it's not actually that bad when you go in there 'cos you're like, a bit like oh great, I'm just gonna do what I want, and play around with my staff, have my special room and have visitors yeah but I don't know how good that is in terms of getting people better''* Annabel Alexandra; 14:503-513 *''hmm this feeling of being powerless hmm your freedom taken away, that's the worst thing, that you're not in control of any aspect of your life you can't even go out to the shop if you want, all your*

	personal belongings are checked and things taken away from you that mean a lot to you'' Valerie; 1: 21-26
The Battle & Resistance – Under attack & Refusal to submit	*''but at one point was tit for tat if they're gonna treat me with so little respect then I'm not gonna respect them so (…)''* Sally; 9:313-319 *(After restraint) "but I didn't, you know as I said I phoned the police I barricaded myself in the room, I was determined I was gonna fight it, I think any rational person would, any rational person would''* 888;26:1023-1026 *''I just had fun with it, I just had fun with them…..they were force feeding, they were giving me pills and I would just…. pushed them to the side of my mouth….and then…go back to my bedroom and out the window or down the toilet you know…and then at certain point – 'he is doing very well on the medication, he's being complaint with the medication' (laughs), it's just a joke, if people treated me well in these environments I treated them well, if they treated me badly I would be oppositional and treat them badly (…)''* 888:27:1059-1069 *''when you on the ward and you wake up at 3 every morning and kind of, all you want is a drink, you don't care if it's just water you just want a drink and the rule there is nothing to drink till the morning, and the machine is switched of and you like but the water machine is not working and I need something to drink, no that's it go back to your room, and you like I don't want to go back to my room I just want a drink, those kind of behaviours, really kind of treat you, that's the situation where the staff can either be good or bad, (…) and all they have to do is literally walk two paces to the kitchen tap and get you a glass of water and you would go back to bed (…) if they say no and they enforce you going back to bed so they insist and they become kind of, if you refuse and say 'I am not, I can't, I need a drink' and then …then and sometimes you would say 'I'm not going back to bed till I've had a drink'* Cait; 14: 548-566 *''I decided I wasn't gonna take my meds 'cos they weren't doing me any good….hmm so I refused to go to the meds counter for my meds and the nursing staff kept sending some the junior student nurses to tell me to go for my meds and I didn't go and I kept saying I am not going to go, can you please tell them I'm not going to go and eventually I got told I had to take my meds and I was getting agitated and I was like I don't feel agitated I've made a decision I don't wanna meds and I don't think I was agitated at that stage but then I was kind of told…hmm…by force I guess that I was gonna take my meds''* Cait;44: 1766-1776
The Absurd	*''this kind of attitude oh don't get to sort of involved with another patient, don't make friends with other patients but they may be so disturbed to be in hospital you don't wanna have too many friends who are mentally ill, these are the kind of things that staff were saying not just to me they said to other people and that's really bad because if they're saying it to me it's like I've got mental illness, what are you saying to me how other people are gonna view me and of course other people are like oh they said that to me, so that makes just feel like a leper…''* Sally; 45:1761-1770 *''so two plus two equals five, so this is an environment you're in''* 888;14: 571-572 *''and unfortunately my family wouldn't listen to me because the actual hospital environment was a beautiful environment, , it was a newly purposed build hospital and I need to praise that, the food was excellent, the on suite facilities in the room, it was as good as any hotel, so as far as my husband was concerned I was well looked after but anything but you know…''* Valerie; 4: 140-145 *''the hospital procedures were that any new patient who arrived had to use the spoon to eat with and plastic utensils because, till they knew you were safe to choose a knife and a fork and a plate was breakable and I had never ever harmed myself or anyone with a knife or a fork or a plate and suddenly and I was given plastic cup to drink from and a spoon to eat my dinner which would have been fine if it was something you could eat with a spoon but it wasn't so it as impossible''* Cait;25:1036-1043
Transformation & Loss	

Disillusionment & Distrust	*''I was fooled into believing that they were going to do it my way, what was best for me but it is not''* Valerie; 30: 1159-1161 *''I realised that (…) actually it isn't a good idea to go to government or a corporation for help with managing your own life''* 888;12:475-480 *''I think if it had been police I thought they are allowed to do what they want to me but I never thought the nursed could do that so I have just seen this as kind of an assault and I felt that it was done unjustly on me as well''* Sally;3:82-85 *''I think it…(struggle) I think afterwards for long time it really kind of….it gave me a lot of disillusionment about the world but particularly about the NHS…which it'd always been quite something I really admired umm….and for long time I felt….very angry about that and I also felt….quite ashamed as well which I didn't realise until quite a long time after hospitalisation which I think is because I sort of….because quite a few of my family member worked in the NHS…I always sort of praised it and I think to some extent I felt ashamed if they can behave like that that's not the organisation I can approve of so I think I sort of took it quite personal in some ways but…umm for all I think it… (pause) it sort of changed my outlook on the world in a way….. it made me…. weary of professionals overall'' Sally;3:94-106* *''I just think they really could have dealt with it in a different way, I think….it's unacceptable to take someone's clothes of, I don't think……yeah I think it's been out of character for them, normally they're nice, it was really shocking when I think about it, seems a bit, seems like quite… really humiliating I suppose umm…and they wouldn't probably have thought anything of it… (…) Yeah I suppose and you do put a lot of trust in them (…)''* Annabel Alexandra; 27-28:1033-1048 *''you would think people would have faith for people who are in mental hospital but support is very crap''* Annabel Alexandra 40;1481-1483
The Punishment – Attribution of Blame	*''it's not the bloody hmm policing they should be doing, it's caring really, not policing you know and that what it felt like -policing or referring….''* Valerie; 19:762-764 *''I also felt some of them were angry with me because I put them to an awful amount of trouble when I was trying to escape and that took a lot awful amount of their time''* Valerie; 23: 900-903 *''(...)...a picture comes to mind really of whole load of people….having hold of me and firing me into my room and then throwing…darts at me hmm…condemning me really that you're not worth saving, that's the overall feeling I had while I was in there…''* Valerie; 9:327-331 *''….(sigh/struggle) they basically pounce on you…(…) they were really not happy, they weren't calling me by my name, they were… I was, it felt like I was an object and I was being treated like a piece of meat and it really felt kind of oppressive and when I tried to say they were hurting me…it was as if they didn't, they didn't hear me because nothing seemed to get heard…''* Cait; 44:1783-1806 *''I think what I was referring to was with staff umm….(struggle) sort of when they were annoyed with me kind of deliberately withholding things (…) .so yeah when I would be difficult then umm sort of making it harder for, sort of getting the bath plug or something like that so yeah sort of feeling of being penalised if I irritated them…''* Sally; 41:1600-1605 *''there are there some staff who don't want you to establish boundaries, they want to move them because it's funny or because they have some kind of vicarious power game going on''* 888; 45:1765-1768 *''I've been put in a solitary confinement for hours…and years ago they used to have solitary when they had a room like that and six different chambers of it and I would be put in one of those and left...like a prison cell really just left with the mattress on the floor and really if you ever exhibiting behaviour that it's just too difficult to deal with and everybody does want a bit of peace you do, I have been put there, I have been restrained''* Buster; 9:324-330
Losing oneself: Self and Identity Redefined	*''but then I was like just like some nutter who's gone in the shower without clothes on, then I'm just… some bloody patient, so yeah it's quite dehumanising while you are just generic patient…'' Annabel Alexandra; 29:1080-1083* *''if they treated me like a normal person they would have asked me and spoken to me or said what you're doing or anything but what they did do but they didn't yeah so that was not a very nice feeling….''* Annabel Alexandra; 30:1105-1108 *''Turning the world upside down, this level of upheaval, it was everything, you know…(…) then just the most basic just things you didn't realise you rely on, what you naturally expect from your body(…) and so juts suddenly feeling like my body was completely unpredictable as well so it was*

	juts adding of everything was juts…everything I depended on was kind of swept away from under me….umm so, so in a kind of thing by itself that I wouldn't say it particularly hindered my recovery but it was part of kind of whole big picture I think, it kind of did, in a way I like said not quite knowing where I was…in relation to other places I knew when I was on the PICU in itself it wasn't that a big thing but it added to that disorientation feeling that I was completely taken out of the world I knew and put in a completely alien environment hmm, umm (…)Yeah so like my whole world just disintegrated'' Sally; 30-31:1162-1192 *''Yeah contradiction between what I was experiencing and I was told I experienced and how when I was trying to protest about it without being responded to it was kind of probably it's your perceptions constantly, I learnt new worlds like 'perception' and 'appropriate' which really never been in my vocabulary before and then when I left hospital…it was kind of like…I'd…if people weren't very nice to me I sort of almost, I sort of lost that ability to know that what kind of people they were, so I became very vulnerable for a while, nothing bad happen to me but I'd sort of had friendships where people were not very nice to me and staff, which wasn't a problem before I went to hospital and….so I had a lot of….lot of lack of trust in my own opinions my own experiences which kind of…on one hand I sort of would like constantly put my own view down, it was almost like I had to convince myself as I couldn't just believe myself any more…(…)''* Sally;10-11:368-399 *''I felt that I was being written off and that I was worthless and that there was no hope for me you know…I wasn't worth listened to…and… and that somehow I wasn't believed and what I was saying didn't matter because it wasn't true, the message I was getting was whatever I had to say was part of my illness, that it wasn't hmm wasn't worth listened to, they were too busy (…) but they never had time to talk to (…) you know I suppose hmm it….their behaviour really validated all the feeling I had about myself ...that I was worthless, hopeless human being that I was just causing a lot of hassle to people in this world and I'm better off out of it''* Valerie; 5: 159-176 *(Q: what's that like not to have a voice?) ''Terrible….you just want to die, you know you don't matter, you don't care, you…you….hmm (sigh/struggle) you are, you're the lowest of the lowest, something to be put in a scrappy….you have no value, it brings you right down hmm…''* Valerie; 10: 387-390 *''I was refusing the drugs and they were trying to encourage me but they weren't forcing me to but then that sort of changed umm….yeah so then when…they, there was this incident where I was basically given the option you can have the injection or you can….or take this drug now...umm and they kind of called the on duty psychiatrist or whatever but then they let me just take the liquid form umm and then I collapsed and I remember saying on the day I don't wanna take this until you test me for Neuroleptic Malignant Syndrome as my aunt died of that a year ago, so collapsed form that and had to go to the general hospital, and umm how they response to that was sort of, I heard them saying umm….oh now it will be even more difficult to get her to take the drugs and so it sort of felt like that was all that it meant to them, it just makes it more difficult to persuade her that drugs were good idea, not how that made me feel…yeah it was more like I was….kind of… (struggle) just an object around trying to get them to do what they wanted to do….umm rather than me being a human having any equality with them or anything like that''* Sally: 4-5;138-155 *''I guess the impact is that you just feel like you've lost everything, you feel like you've lost… your dignity is gone hmm nobody is listening umm and you've lost everything it's that ultimate feeling of helplessness hmm and the impact is long lasting I think 'cos I feel like it kind of re-traumatises you in the whole process''* Cait; 3:89-94 *''Anything you say other than 'yeas you're right doctor' is an attribution, an attribution of your alleged chemical imbalance''* 888; 13:530-532 *''I think the feeling overall is …I felt like a third class citizen I dint just feel like I was, I actually said at one point I felt worse than a prisoner because prisoners have rights and I did feel like I had any hmm and I felt like I was being treated worse than a prisoner because they had taken away, they taken away any right and they were judging me as if I was some kind of… I don't know… at the time I used to think well, they think I am this terrible person hmm… and yet in truth I was just a mum who had a few issues, I was a mum who had issues and they didn't look at the cause of my issues they just looked at the issues and.. I felt like being judged being in there and in that judgment…it felt wrong and I think it made me very angry and it made me very sad and there were lots of emotions kind that were felt because of it hmm and I used to get…I used to get annoyed at the fact that I was, they*

	were judging me this way I used to say I used to I guess that came out sometimes but I think overall it kind makes you feel like a lesser person…I think…overall I felt a lesser person at the time because it didn't matter what I said or what I did even if I played the system and sat there and did everything they asked me to do and behaved myself they still seemed to judge and that just felt so unfair'' Cait; 10-11:42-440 *''You feel nobody, you lose yourself, just feel……I don't matter really, you know….I think it reinforces the idea if you are suicidal that hmm…there is no place for you in this world, that's what it did to me''* Valerie; 16: 614-620 *''To a degree it amplifies the emotions but at the same time you're taught not to have that experience not to…you know it's a denial of that experience, you've got to cut off from yourself….that was the thing….''* 888; 20:817-820 *''There was a form of self-obliteration….umm but you know as I've known that from an early childhood''* 888; 26:1036-1037 *''The system that wants to care you to death''* 888;12: 492-493 *''I think judging and attitude of staff kind of can cause issues for patients that don't just last during the time you're sectioned they can last way beyond that and I've kind of experienced that I think hmm and I think….the staff who were, those kind of staff I've met them in different places and different wards and I kind of learnt to, over time, I learn to avoid them, I learnt that I just. ..I kind of had to set myself into a …you just go yes or no to them kind of response 'cos it was easier than engaging in a dialogue that ended up causing trouble, and I learnt to switch off my feelings and I kept that switched off and I think I still find that now, even there is certain things that I find with my, the person that I see now for help hmm we've had, there's been issues, he's had real trouble, difficulty I think in getting me to be able to express my feelings in a safe, I am in a safe therapy environment and yet he's real issue to persuade me that it is a safe place to actually express how I feel because my first thought is ' I express how I feel I'm gonna get into trouble' and that I something I learnt being sectioned and being in hospital which I probably wouldn't…hmm I wouldn't have realised it would happen''* Cait; 18-19:759-778
Hopelessness, Meaninglessness & Fatalism	*''I used to say I was a mum and a partner, I had a partner and I was a mum and I defined myself by my job and suddenly I wasn't any of those things anymore, I was this person with…with what, whatever the label was at the time and my identity changed and I no longer was a mum…I was… I had three children but I wasn't a mum and I was in fact, all I was…was this person who was constantly in and out of hospital and I was just, you know I was a psych patient and that's how I felt''* Cait;23-24:972-980 *''it's a shame I don't know why they think that nobody on the locked ward need any sort of stimulation (…)''* Buster;9:340-343 *''so we just had the enormous amount of time, 'so what you're gonna do?''* 888; 12:460-461 *''I mean there is that hopelessness feeling in there when you have no release date…you know if you're sent to prison you know that you have something to work towards, I think you need a goal when you're going to those places…. ''* Valerie; P.17, 649-652 *''The one thing I would try and…work with people in there with hope…I think it's…that's the first thing you need to start with…those places are completely hopeless environment…and I would have…what I needed really some sort of….hope sessions, group sessions whether maybe bring people back in who had recovered and then got out living their lives now, that would have made a huge difference in me to hear those stories…and I would have intensively for first week of me being in there, continuously drill hope into me, takes a lot of time but I bet you I wouldn't have been there fourteen weeks….''* Valerie;18: 690-699 *''I think in terms of what I was saying what hospital may represent so for me when I was 22 kind of getting diagnosis and kind of being in this old Victorian hospital it was quite… on the symbolic level for me to come to terms with diagnosis because I kind of had those images of you know one flew over the coco's nest sort of, that's gonna be my life as mental health patient…umm umm so-so I think things like crisis houses that perhaps don't have stigma of hospital are a good idea 'cos it's not just the short term treatment I think I think umm it, people also have to consider longer term effect of hospital of what hospital admission can have, so even though it might seemed to have-have been affected in the short term someone might still be affected by it like in some ways I am ten years later so that needs to be included in it''* Sally; 48:1879-1892

Facing Shame & Stigma	*''being officially sectioned that's more embarrassing and people get really like 'oh you were sectioned'! (laughs), sounds quite dramatic (laughs) isn't (…)''* Annabel Alexandra; 11;414-417 *''made me a statistic or someone who's been in mental institution and it's not really that different what you see in the films….and probably how it's been…hundreds of years - crazy people locked up together… yeah''* Annabel Alexandra; 66:2258-2261 *''I feel like I think people think when you're manic that you don't pick up on any social-social things, you know somebody raised their eyebrows oh she's you know…they think you don't pick up on anything and that's not true- you do, there are some, I know I don't pick on everything like I would normally, but-but you still can pick on oh I know that's nurse doesn't like me or that nurse is short tempered with me or she will make it quite clear that I'm irritating her, you do, you don't lose completely the ability, 'cos I think some people are just very blunt, they will say oh look you need to go, they tell you like you're a child you know they always you need to go and sit down, you're driving us mad or go back to the back of the queue so you can pretty easy tell that…but umm.. no it's right you can…and also I get that pretty much with my mum because I always feel with my mum I feel like when she comes up like she looks like she hates me and I say to her the reason I think I'm extremely aggressive with her is that I can sense hatred, I almost feel like she sees me in that state she can't hide her hatred towards me in that state''* Buster; 34:1294-1311 *''I could even remember when I was at school people would say umm oh you know things about…(name given) which was a mental hospital, so people would tease in a derogatory way, so it's always been somewhere that you know people would juts mock and you certainly would never think that I'm gonna spend a large quantity of my life there you know and when you go and you spent nine months you know''* Buster; 21-22:820-827 *''if you have a mental health record and there is a group people saying to you: 'he's mentally ill, he's mentally ill!' (accent)…you're gonna, you know you're gonna take the gang…''* 888;30:1207-1209 *''I was some freak of nature I would say that was born or developed all these difficulties and hmm not fit to be hmmm in the outside world really...only the only place really… I could be managed is inside of one of those places, that's how I felt, and that I had to be put away really hmmm…. I didn't fit in…to what was going on out in society and hmm my extremes of hmm aspects of my personality like sensitivity….wasn't just suited to the world out there and not even suited to being in there 'cos they didn't….they didn't or wouldn't be able to handle that either so a misfit really for society….and most of the people you look in those psychiatric units they all appear misfits you know…..''* Valerie; 14:534-544 *'' (…) I still feel that my sections are on my documents and my medical records and I know, I get the impression at least that some professional they automatically judge me because of that (…) it's kind of secret you want to keep(…)''* Cait; 6:214-248
The Confusion	*''you completely lose your structure of your day, I'm not aware of shift change, day and night, I just completely lose, it's just very weird, it's very weird environment''* Buster; 3:83-86 *''suddenly cope with everything after everything that's been taken care of for you really you know, medication, your food, everything it's been, you haven't had to make a decision for a long time to suddenly have to make all your decisions...I don't know...and your life…like before I got to hospital I trash my flat and staff like that you know...when I'm in manic state before I go in suddenly all the crazy things go on, you know like candles and all staff out of cupboard, it looks like it's been burgled and I have to come back, once I came back and I couldn't remember how to put the heating on so I had to sleep on the floor in the lunge without the heating on…you just don't know...you relay forget the things that are automatic to you''* Buster; 30:1170-1181 *''when I'm newly admitted to a closed ward I am actually very unaware of where I am anyway because I'm in such degree of distress and normally I become so hypomanic I don't actually I am even probably aware when I am, the routine, where my bed is, anything, I am not really aware of…I could be anywhere really...unfortunately I always get put on the locked ward so late that I deteriorated so much hmm (…) I just…I am in such a…strange state that I wouldn't even, you know, I can't even recognise members of staff, I wouldn't recognise my doctor, I wouldn't know who was trained who wasn't trained, you know I become very…fearful of everybody around 'cos I don't know…it's not like I can make an attachment because I'm in such a funny state''* Buster; 1:13-29 *''(…)…they think you don't pick up on anything and that's not true you do, there are some, I know I don't pick on everything like I would normally, but-but you still can pick on oh I know that's nurse*

	doesn't like me or that nurse is short tempered with me or she will make it quite clear that I'm irritating her, you do, you don't lose completely the ability'' Buster; 34:1294-1302 *''also I'm not always aware that they're staff because on the psychiatric ward obviously nobody wears a uniform…so sometimes I get confused 'cos I haven't worked out who is patient and sometimes people come in and go very quickly, the turnover is very high, and then sometimes you've got agency staff that you have never seen before so you really don't always know when you're not being particularly observant that somebody is you know staff (laughs) it's shocking really but you know, you don't become aware of it… ''* Buster; 18-19:701-709 *''so at the time because I was a bit, not in a right mind, I didn't really know what was going on, diagnosis, sectioning, just like that you're now going to be living here, I think I realised it was a mental institution… ''* Annabel Alexandra; 13:469-473 *''(…) I suppose that's what I remember, I would say it's quite scary how is big massive memories, that is weird for me, so I just sometimes I get odd thoughts, odd memories I can't pin point the time and I was being with someone last night, my friend whose is like must be like in her sixties, you can remember that? (laughs) that's a bit scary that is so patchy that you do wonder like what fills, I was on antipsychotic pills, so yeah…'' Annabel Alexandra; 17:641-651* *''… I sort if remember trying to remember it but because he didn't believe me again I'm like…did it happen? Sure it did happen. (…) I suppose anything that I do remember do seem to be visual, so yeah maybe I ought to doubt less and try to remember a bit better, yeah that makes sense. So yeah that did happen (laughs)''* Annabel Alexandra; 51-52:1924-1935 *''I don't know...that's all that going at the moment…(laughs) yeah… and it's. .got some sad bit and some okay bits but it's all very confusing (laughs) it seems hard trying to work out what I think about it now''* Annabel Alexandra; 60:2228-2231 *''personally I wouldn't go there if I was depressed, just like…when I came back to reality I don't wanna be there any more, oh my god I've been locked up with all these people who are really unwell…but yeah so it was probably better that I wasn't….conscious…(laughs)''* Annabel Alexandra; 62:2288-2292
The Comforting & The Sanguine	
Exhilaration & Fun	*''some of the patients were really funny we had a lot of fun, we really did bond''* 888;45:1783-1785 *''I don't know, it's quite funny (laughs) when you think about it, the leading up to it when you're not in hospital 'cos you're doing really stupid things and people who are not psychotic so they… (laughs) don't get this, when in there everyone's like on that level, it's just like being a little child really, just allowed to run around in this confined area, got your own room yeah but as soon as you start getting better or as soon as they give you enough drugs so you are like more like zombified then you start seeing everyone for what they are (…) whereas when I was in that state everyone was like me, we used to like wind people up and it was all sorts of naughty things….''* Annabel Alexandra; 1:45-58 *''I don't know umm maybe that it wasn't that bad….yeah I think sometimes…when I'm really pissed at things I'm like - I wish I could spend a week there, like do some art therapy, yeah it's not that bad….umm yeah I think people think it's really-really awful….like really awful, I think it's an illness that's awful and being psychotic and having manic episodes, I don't… I think they try to do what they can, and it's not that bad actually being in a psychiatric hospital if you get a nice one, I've had better and nice but there are some horrendous ones, but it's not that bad, they're like -oh my god how did you dadadaa…. but when I was ill it was fine, there is courtyard, there was, food was very nice (laughs) and some of the nurses, some of them were actually lovely, yeah it's kind of, on one side it's patronising and treated like child the other side wouldn't that be nice for everyone to do that, have a week to just be taken care of (laughs) and yeah not worry about anything in the outside world yeah I suppose that's what I remember''* Annabel Alexandra; 17;629-645 *''well it is having absolutely no responsibilities (…) and yeah like you just lining up for your food and have nice food and then go watch TV and people and have your friend's visit, yeah it's nice, can be, bits of it were….umm yeah it was (laughs)''* Annabel Alexandra; 21: 807-820

The Care & The Belonging	*''like I said I can remember even though there are small incidents I can remember, I can remember being in hospital at Easter and somebody got me and Easter egg, I had a birthday, I've had lots of birthdays in hospital and another patient made me cake, in occupational therapy we all had a piece of it…so I think you do remember all those people being nice to you.. I think staff or patients…it's very important you know, sometimes I had on the wards…because you sort of like umm you all the same even though you are all different, you all have different problems, it's a very umm you now you are all on the same boat sort of thing, but I don't find that so much on a locked ward 'cos it's more scary, on a an acute ward you find that, women will take care of each other so if there is like eight women, you sort of like… I remember doing some ladies nails for them, so you sort of take care of each other a little bit and if one person wouldn't sleep we would sit up together if we're allowed to and try and stay up together, I don't know I think you do get that sort of bond…with staff or patients you know...and it makes a massive difference you know''* Buster; 26:1027-1045 *''sometimes I found that students were very good you know sometimes you get from Anglian University, only on my last time in…(name of the hospital) and you get a lot of mature students that have gone back to study in their forties or whatever and I found that helpful 'cos they were similar age to me and they were, I don't know give you a bit more personal care and interest, you know they would try and help you either wash your hair or… I could remember some…I think because they haven't got the heavy case load, they're doing their notes, you know some, they can if they're just doing it as a placement, be more…supportive''* Buster; 54:2077-2087 *''I liked talking to the other patients umm I found them quite supportive''* Sally; 1:24-25 *''one of the people from the ward I am still friends with and it's ten years later and she is one of my best friends and I met her on the ward''* Sally; 46:1784-1786
Light in the Darkness	*''so there were bad nursed I guess, there were bad nurses and there were good nurses and I think….. I wouldn't, I don't wanna judge all mental health staff the same cos I don't think there are I think some people are really good at what they do but there were times when I sat , I used to sit and watch some of the mental health nursing staff and wondered why on earth they would come into nursing profession for because I kept thinking 'why do you do this?' because it doesn't seem like you are in the caring profession''* Cait; 17:672-680 *''I do think part of my recovery help was actually letting out some of that feeling through the art because it was an enabling process to feel like you were….kind of….allowed to express what was going on and also getting it out of my head and if I was frustrated I would go down to the OT department if something had happened and I was very frustrated rather than getting upset about it, I would go down there and draw frantically and probably manically really (laughs) hmm but it meant that I got it out of my head and….it was a way I think creative things allowed me''* Cait; 34:1415-1424 *''I think it's just safety, I think I don't know I would be contained in that state if I wasn't put…it's not an ideal place to be put in any way but I think it's just umm temporary solution to a you know''* Buster; 52:990-1993 *''were sort of maybe two or three that you do desperately wanted to come on shift because they treated you with respect and you felt cared for but the majority of them on that unit I just felt that they were just horrible''* Sally; 8:294-298 *''in terms of did I feel held when I was in the hospital, I felt kind of…like the building, the environment, the sort of having the other patients there juts hearing bodies that's sort of feels comforting umm….but in terms of my interactions with staff…[not good]''* Sally; 26:1007-101 *''obviously it was traumatic but also on one hand you can look at positive things as if although I haven't succeeded as much as I should do, it is completely contradictory so I just switch from one thing to the other, so sometimes I'm like completely held back other times I'm like actually I did go through that and I'm okay now, that's quite good as well''* Annabel Alexandra 21:781-787 *''during the couple of my admissions I got to see a therapist… and….they were able to listen and see me and while they still to a point, I think at least one of them, the admissions they were very….judging, they were….very medical, they were able in their role as a therapist to allow to see me with the whole, the whole, my whole baggage so they saw me with my baggage and I think unpacking some of my baggage''* Cait; 37;1508-1514 *''I was desperate to talk to someone and the only people I used to talk to in the end, well the patients… other patients in there I must say were a wonderful support to me and I'm still in touch*

	with some of them…there were the people who made the difference'' Valerie; p.4, 121-125 *''you know I do have memories of very compassionate moments when I was crying once, a young girl (fellow patient), she's young enough to be my daughter and just come in and put her hands around me so there are nice memories for me….''* Valerie; p.9, 346-350 *''the thing is…there would always be staff who realise this guys is all right, he just doesn't like being poked in the cage…so there were some members of staff that were just great, in the end I considered them friends, we had things in common, we knew people in common -some of the staff''* 888;23:920-924 *''you just feel horror…you just feel horror and you reach out to other colleagues, your peers, your client group umm do your best to ignore the staff…''* 888;20:808-810
Search for Meaning & Resolution	*''I went through a stage spending a lot of time trying to understand things form carers perspective 'cos I was enjoying the reading group and staff umm so while I was in the hospital umm I was like this shouldn't be allowed to happen and staff and probably for a couple of years after that I completely thought of ethical grounds I was completely against kind of forced treatment but I spent a lot of times talking to carers 'oh what would you do if someone is that ill' so my feelings about it sort of gradually became well if you think someone is very ill then maybe that's the best thing umm''* Sally; 3-4:107-116 *''even when, in the way sort of, nursing and the techniques can be the same umm it's the way it's done, that affected what made me feel good, so even though they sit in front of me and talk to me on the man(bad)ward, there wasn't that basis of respect , it didn't feel therapeutic in any way, which was in complete contrast to how perhaps similar umm things were delivered by people with different attitude in the other hospital so…yeah so I think in saying what helped sort of…the attitude and warmth and empathy was helpful that the sort of nursing care without that didn't really make much difference umm…''* Sally; 22:845-855 *''my kids had to come to terms with this as much as me as cos they had a mum for a while that wanted to die, they've had just kind of I guess they grew up quickly and they had to accept things, they've certainly got more empathy towards mental health than anyone I've ever, the other children I guess or adults''* Cait; 23:958-963 *''I guess that's what the staff are taught to do and I try and look at it in that way, that's what they taught to do, they're not taught to calm people down when they're a bit upset, they're not taught how to...calm people verbally, they taught to restrain people and inject them and I'm not saying it's right 'cos it isn't but I think…it can't be nice for them either….i try and look at it in the context through their eyes too and i don't imagine it's great for them either to go home and think that's what they'd done to someone, and I'm assuming they're finding it difficult but hmm (…)by doing that I've been able to sit down and think about the reasons maybe why they do it or why they use it which helped me to kind of not carry that kind of…that with me, that legacy with me long term maybe hmm yeah''* Cait; 46-47:1882-1901 *''so I kind of learnt that nurses were running around like headless chickens and basically I needed to, you know when I asked for 5min they were really busy or when they started demanding you do xy or z it's because they've got a hundred and one of the things to do and they really haven't got time for you to take 2min to do something, they've got one or two jobs to do with that afternoon or shift and they're struggling and so I learnt that the best way for them to see me as improving was to be helpful because if I was helpful and polite and not responding to their obnoxiousness I guess, it meant they saw me as a stable patient and I learnt….I think that helped me to then… find the way forward for myself as well 'cos I could….just define…(…) just define their behaviour and not blaming me I think really helped me ''* Cait; 32: 1304-1322 *''I do sympathise with staff 'cos now I do some work for the service, there are all these paper work they have and they can't do the job they're trained to do…''* Valerie;18: 702-704 *''It was - the unbearable. And I look back now and think, you know when sometimes I feel… when I get overwhelmed by emotions now I think, I look back and think to myself you can get through this, you got through that (….) it was horrific, really…. ''* Valerie;17: 641-645 *''I suppose it did, the last admission did one thing for me I suppose, it keeps under recovery path, you know it was so horrendous that, if I let…. (…) so I work on my recovery every day and sometimes when I think oh why do I have to do this I just remember being back in there and I think I have to do this because otherwise I know when I'm heading so it's in some ways that horrendous experience is*

	keeping me well " Valerie; 5-6: 190-198 *"I now realise the only think I could recover from 2009 to spend these three years shut away…and in some, some degree you know it was…it cost me that (…) hmm but to some degree also I'm very grateful I had that time to repair…I needed that time ….."* 888;21:825-829 *"for me I think the end of suffering is forgiveness, the end of conflict is forgiveness….laughter is a really good healing bar, if you can really laugh at your pain - you have conquered it (laughs), it no longer owns you"* 888;28-29;1137-1141

APPENDIX 12: Counselling Psychology Review Submission Guidelines

- [redacted]

Source: The British Psychological Society

Website: http://www.bps.org.uk/publications/member-network-publications/member-publications/counselling-psychology-review

APPENDIX 13: Personal Reflexivity: The Poem

I have written the following poem around the time this research idea was born. It represents my attempt at capturing the essence of my difficulties that I encountered while working in a psychiatric ward through my interpretation of patients' experience. The poem denotes the intensity of the struggles I faced as it is rather a strong depiction:

~The place of shadows~

The rocky island, hidden in the ocean's eye
Deceiving incomers into the acceptable lie

The caring signs yet twisted greyish walls
The coldness of hearts and ignorance it calls

Appealing through strength, healing safety powers
Its taut reputation built on falsehood bowers

The forceful instruments, destroying armful hope
The powerful voices, pulling harmful dope

Inertia of lives and the vicious divide
Bringing the impact of poisonous preside

Caught in the battle that has uneven forces
Immersed in the path of dispirited sources

The place of shadows, with no easy escape
Haunting the future of the defeated shape

Un-helped and alone, overriding costs
Whatever the Views, they remaining Lost

Appendix 14 - A note on the terms used in the portfolio

The term 'distress' instead of 'mental illness' is mostly used throughout this portfolio. At times, when the context requires it, the psychiatric diagnostic labels and terms such as 'mental health field' are drawn on, other times such terms or related to them constructs may be placed in inverted commas or italics. This is due to the fact that the concept of 'mental illness' is associated with the medical model and therefore with matters related to *disease* and *sickness*. Hence the language used in this portfolio aims to represent a challenge to dominant assumptions that, as argued, tend to medicalise and pathologise common and/or every day stresses and difficulties. In addition, researcher strived for an epistemological consistency by placing emphasis on experience and phenomenology rather than 'disorder'. Furthermore, since diagnostic concepts presented in the DSM by American Psychiatric Association (now in its 5th edition, 2013), due to their categorical nature, are not infrequently argued to be disjunctive and lacking validity and reliability (Bentall, 2004; Boyle, 1999; Cromby et al. 2013; Read, 2004) this portfolio mainly refers to the term 'psychosis' (which has not escaped scrutiny either however has been deemed to constitute a compromise and a golden mean) instead of relying on more problematic psychiatric diagnostic labels such as 'schizophrenia' or 'bipolar disorder' – all of which may include psychotic experiences such as hallucinations or delusions.

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