

**Surviving an Alternative Reality:  
A Qualitative Analysis of Adolescents' Experiences of  
Psychiatric Hospitalisation**

Thesis submitted to

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Doctorate in Clinical Psychology

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## **DECLARATION**

This thesis is an original piece of work that has been submitted in partial fulfilment of the degree of Doctorate in Clinical Psychology. The literature review and research report contained within this thesis have not been submitted for any other degree, or to any other institution.

## **TARGET JOURNAL**

British Journal of Clinical Psychology

(For both the literature review and the research report).

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## WORD COUNT

	<b>Excluding references</b>	<b>Including References</b>
Part One: Literature Review	8083	10,511
Part Two: Research Report	12,292	14,459
Part Three: Critical Appraisal	3657	3967
<b>Total excluding Appendices</b>	<b>24,332</b>	<b>28,937</b>
Appendices		4,863
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## THESIS ABSTRACT

### **Title: A Qualitative Analysis of Adolescents' Experiences of Psychiatric Hospitalisation**

Catherine Painter, Trainee Clinical Psychologist

#### **Part One: Literature Review**

*Purpose:* To explore current knowledge about the psychological impact of psychiatric hospitalisation.

*Method:* A Computerised literature search was completed using six publication databases. Relevant papers were identified and reference list and prospective citation searches were conducted. Particular inclusion and exclusion criteria were employed.

*Results:* Very little literature has explicitly investigated the psychological impact of psychiatric hospitalisation. However, findings around psychological concepts such as identity, stigma, coercion and trauma have started to indicate the nature and extent of psychological responses. The majority of studies are atheoretical in nature and lack methodological rigour.

*Conclusions:* Further research is needed to incorporate psychological theory into an understanding of the experience of psychiatric inpatients. Future research should include rigorous empirical studies within acute adult populations and exploratory qualitative studies with other age/client groups.

#### **Part Two: Research Report**

*Objectives:* To explore adolescents' experiences of psychiatric hospitalisation, including the psychological impact of the experience and coping mechanisms.

*Method:* The data from semi-structured interviews with ten adolescents was analysed using the grounded theory method (Glaser & Strauss, 1967).

*Results:* A process model was developed around the core category 'Living in an Alternative Reality'. Contributory categories highlighted the possible impact of hospitalisation and outcome categories suggested the ways in which adolescents coped.

*Discussion/Conclusions:* The results suggest that the experiences of adolescent inpatients may be similar to adult experiences. The clinical implications of the findings, such as the need to maintain connections with family and friends and foster supportive relationships within the ward environment, highlight the need to prioritise the service-user perspective in clinical settings and future research.

#### **Part Three: Critical Appraisal**

A reflection on the overall research process is provided. Practical and theoretical issues of interest are discussed, including the influence of the self in qualitative research, the editing process, and power and control.

Word Count: 299.

**PART ONE:**  
**LITERATURE REVIEW**

**Exploring the Psychological Impact of Psychiatric Hospitalisation**

## **ABSTRACT**

*Purpose:* A literature review was carried out to explore current knowledge about the psychological impact of psychiatric hospitalisation.

*Method:* A computerised literature search was conducted using six major publication databases. Following the identification of relevant papers, reference list and prospective citation searches were also carried out. Particular inclusion and exclusion criteria were employed.

*Results:* Very little literature to date has explicitly investigated the psychological impact of psychiatric hospitalisation. However, findings around psychological concepts such as identity, stigma, coercion and trauma, have begun to indicate the nature and extent of psychological responses. The majority of studies are atheoretical in nature and lack methodological rigour. Overall, minimal empirical research has been conducted on this topic.

*Conclusions:* Further research is needed from a psychological perspective, in order to incorporate psychological theory into an understanding of the experience of psychiatric inpatients. Future research should include rigorous empirical studies within acute adult populations and exploratory qualitative studies with other age/client groups.

Word Count: 157.

‘In the mental hospital, the setting and house rules press home to the patient that he is, after all, a mental case who has suffered some kind of social collapse on the outside, having failed in some over-all way, and that here he is of little social weight, being hardly capable of acting like a full-fledged person at all.’

(Goffman,1961: p. 140-141)

# 1. INTRODUCTION

## 1.1 Historical Context

The lived experience of individuals who find themselves outwith society has historically been of interest within various fields of study. The sociologist Erving Goffman's seminal work 'Asylums' (Goffman, 1961), provided an example of an early attempt to interpret the experience of the psychiatric inpatient. Goffman was interested in the concept of the total institution, and how those within such institutions managed to form enclosed societies whilst maintaining a sense of the human self (Goffman, 1961). Whilst Goffman's methodologies and theoretical stance have been criticised in recent years (see Weinstein, 1994), his work undoubtedly set the tone for subsequent interest in this topic. Most early research investigated the sociological experience of psychiatric hospitalisation, often from an 'objective' viewpoint, with researchers using observational methods and even posing as patients (e.g. Deane, 1961; Goldman, Bohr & Steinberg, 1970; Moos & Houts, 1968; Rosenhan, 1973). Contemporary researchers have applauded the ethnographic approach of this work, which provided a rich and detailed picture of the institutions of the time (Quirk & Lelliott, 2001).

Whilst the seeking of service-user views was becoming commonplace in the United States (e.g. Allen & Barton, 1976; Colvin, 1978; Lee, 1979), the UK was slower to follow suit. Studies added to the knowledge base and the concept of the psychiatric patient as 'consumer', but were limited to the quantification of patient experience through surveys and structured interviews (e.g. Gordon, Alexander & Dietzan, 1979; McIntyre, Farrell & David, 1989, Raphael & Peers, 1972). In theoretical terms, the nature of patienthood and the uncertainty of patients' social roles, dominated discussion (see Erikson, 1957; Maxson, 1974; Osofsky & Fry, 1985; Pine & Levinson, 1960).

Debate also surrounded the Labelling Theory approach to mental illness, whereby proponents of the approach believed that the consequences of labelling someone as a ‘mental patient’ were inherently negative. Critics however, upheld that the patient role, epitomised by hospitalisation, was in the long run beneficial. In a review of relevant research, Weinstein (1983) concluded that Labelling Theory indeed underestimated the degree of positivity experienced by psychiatric inpatients, although patients were strongly opposed to generalised labels of mental illness. In general, theoretical ideas about the psychological impact<sup>1</sup> of psychiatric hospitalisation were slow to develop, particularly in the UK, where researchers were concentrating on the development of methods to source service user views.

## **1.2 Contemporary Context**

The ability to generalise research investigating the experience of psychiatric hospitalisation is affected by the ever changing nature of health care provision. The closure of large psychiatric hospitals and the move towards community based services (as seen to various degrees in the Western world), will have affected the experience of the psychiatric inpatient, and thus the results of associated research. In reviewing UK research, Quirk & Lelliott (2001) concluded that the drop in inpatient beds had resulted in only the most difficult and disturbed patients being admitted, leading to volatile ward environments. More specifically, national surveys have concluded that wards are non-therapeutic environments, which lack safety and individualisation of care (Ford, Durcan, Warner, Hardy & Muijen, 1998; Sainsbury Centre, 1998 & 2004). Such findings, along with a multitude of others decrying the state of contemporary inpatient psychiatric care (e.g. Muijen, 1999; Owen, Tarantello, Jones & Tennant, 1998; Walton, 2000; Warren &

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<sup>1</sup> The term ‘Psychological Impact’ is used throughout this review to reflect the author’s interest in the ways in which, and extent to which, psychiatric hospitalisation may affect the overall psychological functioning of an individual, in the broadest sense.

Beardsmore, 1997), lead us to wonder what today's psychiatric inpatient can expect from the experience of hospitalisation<sup>2</sup>.

In terms of contemporary relevance to the profession, as psychologists we are fascinated by the way in which individuals make sense of, and cope with, a variety of human experiences. As Clinical Psychologists we must also be concerned as to how those experiences affect our therapeutic relationship with clients. A considerable number of the clients who seek our help will have experienced psychiatric inpatient care at some time, or indeed may be facing an imminent admission. Thus the need for understanding the psychological impact of the inpatient experience will be pertinent with many clients. Whilst there is an ongoing debate around the utility of providing psychological input to current psychiatric inpatients (see Munro, Baker & Playle, 2005), it is clear that if and when this occurs, the ability to work with the experience and to understand its impact on overall mental health will be paramount. Further, as psychologists, our relationship with those in crisis is also likely to increase, as we become eligible for the role of Clinical Supervisor, which replaces the current role of Responsible Medical Officer in respect to the care of those individuals detained under the Mental Health Act. Psychologists taking on this role will be involved in ensuring that people comply with compulsory care plans, and as such this new facet of the profession will arguably place Clinical Psychologists in a more powerful position than ever before, making it timely to consider the psychological impact of one of the most important forms of care for vulnerable clients.

In consideration of the above, the present review presents and appraises literature pertaining to the experience of psychiatric hospitalisation and in particular seeks to answer the question: 'What

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<sup>2</sup> Various television documentaries and newspaper articles have also questioned the safety and efficacy of wards, contributing to wider 'cultural stories' of their inadequacy.

is the psychological impact of this experience?’ This is followed by discussion of implications for clinical practice and priorities for future research.

### **1.3 Search Strategy**

A three part search strategy was employed. Initially, six major publication databases were interrogated: PsychArticles, PsychInfo, MedLine, PubMed, Cinahl and SocialSciSearch. The following primary search terms were used: ‘Psychiatric Hospitalisation’, ‘Psychiatric Inpatient Care’; along with additional terms, ‘Service-User Experiences’, ‘Psychological Impact’ and ‘Psychological Effects’, to refine the search. A wide range of papers were identified, whereby the abstracts of those most relevant were reviewed before inclusion. Included articles were checked for reference to other papers containing any of the relevant search terms. Finally, pertinent articles were subjected to a prospective citation search to unearth subsequent research.

The current review aimed to include research published after 1990, in order that clinical implications remained as relevant to the present as possible, and that the context of the subsequent research study fitted closely with current service provision. International research was included, despite the fact that there may be slight differences in inpatient environments between countries. In order to gain a broader perspective of the literature, and as many papers used a qualitative approach, there were no exclusion criteria based on the quality of scientific design. However, dissertations, other unpublished works, and papers not published in the English language were not included. Due to the author’s interest in qualitative approaches and the consideration that such approaches would provide the most insight into psychiatric inpatients’ subjective experience, key qualitative studies were reviewed in some detail and placed in the context of wider bodies of research

## **1.4 Overview of the Current Literature**

Current research around the experience of psychiatric inpatient care proved problematic to review as it was not contained in one coherent body of literature. In addition, very little research to date has expressed an explicit interest in the psychological impact of psychiatric hospitalisation. Instead, the experience has been understood from a medicalised or sociological perspective, reflected by the inclusion of most papers in psychiatric or sociology journals. Nonetheless, the findings of a number of studies do provide insight into the possible psychological impact of hospitalisation, through discussion of psychological concepts such as stigma, identity and self-esteem. It is hoped that a review of such findings will raise psychological interest in the experience of psychiatric hospitalisation through the discussion of implications for clinical practice and priorities for future research.

## **2. SATISFACTION, SURVEY AND OUTCOME RESEARCH**

Service-user views have grown in importance in the assessment of health services over the last few decades. Consequently, patient satisfaction with services has become a frequently audited concept. The majority of studies report a moderate level of satisfaction with psychiatric inpatient care, whereby females, younger patients and those detained under the Mental Health Act are more likely to be dissatisfied overall (see Greenwood, Key, Burns, Bristow & Sedgewick, 1999; Lovell, 1995; Parkman, Davies & Leese, 1997; Perrault, Rogers & Leichner, 1996). Whilst satisfaction research is often reported as reflecting the overall positivity of the inpatient experience, there are questions around the validity of the concept of satisfaction and the methodologies used to measure it (Avis, Bond & Arthur, 1997; Williams & Wilkinson, 1995). Further, satisfaction research is often unable to provide insight into which aspects of inpatient

care cause dissatisfaction among particular patients. A number of UK studies have utilised a basic survey method to evaluate services in slightly more detail. These studies have painted a negative picture of inpatient care, with participants complaining about boredom, lack of privacy, coercion and punishment, and feeling unsafe (Barker, 2000; Leavey, King & Cole, 1997; Rogers & Pilgrim, 1994). Despite highlighting the specifics of dissatisfaction, survey-based research provides a limited insight into the world of the inpatient, especially as it is often small scale, limited in scope and lacking in rigour (Quirk & Lelliott, 2001).

The vast body of outcome research related to psychiatric inpatient care has attempted to provide answers to numerous questions, usually in relation to specific demographic or diagnostic groups. For example, research has addressed: the effectiveness of inpatient care for a specific purpose (i.e. Hattenschwiler, Reusch & Hell, 2000); the effectiveness of inpatient care as compared to other forms of care (i.e. Harrington, Peters, Green, Byford, Woods & McGowan, 2000); the effectiveness of various forms of treatment within the inpatient environment (i.e. Beutel, Hoflich, Kurth & Reimer, 2005); and the effectiveness of different types of inpatient care (i.e. Xenitidis, Gratsa & Bouras, 2004). Although these examples are somewhat idiosyncratic, they do highlight the disparity of the field and the fact that studies are usually concerned with measuring outcome in terms of effect on primary diagnosis, or a particular measure of behaviour.

Whilst outcome studies undoubtedly provide insight into the effect of inpatient care on very specific aspects of psychological functioning, they do not focus on the overall impact of the experience of hospitalisation, above and beyond issues of diagnosis and prognosis. In addition, outcomes have traditionally been summarised using clinician-led measures, meaning the views of clients are frequently overlooked.

### **3. THE PSYCHOLOGICAL IMPACT OF PSYCHIATRIC INPATIENT CARE**

Research exploring the experience of psychiatric hospitalisation has highlighted various themes of relevance to the current review and these findings are discussed below. The majority of authors did not explicitly discuss psychological theories in relation to their findings, and as such the current author has drawn upon relevant psychological theories where appropriate.

#### **3.1 Dignity, Identity and Self-Esteem**

The themes of dignity and identity are evident within the literature, whereby threats to these self-concepts appear to be associated with a loss of self-esteem in patients undergoing psychiatric admission. The exploratory nature of the literature means that clear theoretical and causal links cannot yet be made. However, as Goffman (1961) first suggested, psychiatric hospitalisation may be linked with an overall loss of personhood<sup>3</sup>. More recently (through his work with individuals with dementia in residential settings), Kitwood (1997) has developed a theory of personhood, which recognises the importance of upholding dignity and individual identity in maintaining the well-being of clients. This may provide a framework for understanding why psychiatric hospitalisation leads to lowered self-esteem in patients, especially as survey research has highlighted the current lack of individualisation of care (Sainsbury Centre, 1998). Low self-esteem has been associated with lowered mood, difficulties in personal relationships, and decreased motivation and participation (see Fennell, 1999). This may therefore affect an individual's capacity for therapeutic engagement and overall recovery. In addition, inpatients

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<sup>3</sup> For Goffman, this loss of personhood was often attributed to the individual accepting the hospital's definition of them as 'insane'.

who feel their identity and dignity have not been respected may become suspicious and distrustful of professionals, thus affecting their future involvement with services.

Very few quantitative studies have addressed the impact of psychiatric hospitalisation on self-esteem. Rooney, Murphy, Mulvaney, O'Callaghan & Larkin, (1996) found that 46% of involuntary clients and 23% of voluntary clients experienced reduced self-esteem following admission. However, the specific causes of this reduction were not explored, and generalization is limited by a small sample size and a low response rate. Qualitative studies have attempted to explore this phenomenon in more detail.

Roe and Ronen (2003) interviewed 43 individuals during hospitalisation and then bi-monthly for one year following discharge. Using a grounded theory analysis the authors concluded that the process of becoming a psychiatric inpatient made 'a powerful statement about one's limited competence and capacity for independence' (Roe & Ronen, 2003. p.332). Participants spoke of having to confront the objective and personal meaning of hospitalisation, which led to painful confrontation of unwanted aspects of the self. In addition, participants described the loss of aspects of former identity such as perceived ability to function in everyday life. Becoming hospitalised therefore threatened healthy self-concept by promoting negative appraisals of the self and this in turn contributed to most participants experiencing hospitalisation as a major blow to self-esteem. Negative self-appraisal is recognised as a central feature in the development and maintenance of clinical depression (Fennell, 2004); thus it is hypothesised that hospitalisation may cause or exacerbate lowered mood in patients, mediated by decreased self esteem. This hypothesis has not been empirically tested in the literature.

Roe and Ronen's longitudinal design also allowed for retrospective discussion of the inpatient experience. Where hospitalisation was associated with loss of identity, reconstruction of self-esteem was viewed as an important path to becoming well and for preventing relapse (Roe & Ronen, 2003). These findings have therapeutic implications, whereby the adjustment of identity to maintain self-esteem may be important with current inpatients, whilst former patients may require assistance in rebuilding self-esteem. Letendre (1997) reported similar findings, in that participants experienced a loss of dignity and associated self-esteem upon admission, which translated into a dispossession of self-hood throughout the restrictions of their stay and from their perceived infantilisation by staff. This study benefits from the employment of clear techniques for data collection and analysis; data collection ceased after 38 interviews due to the saturation of categories, which befitted the constant comparative methodology being used (see Stiles, 1999).

Other qualitative studies have reported strong affective responses to the experience of psychiatric hospitalisation, such as feelings of exclusion, alienation, abandonment and dehumanization (Cutting & Henderson, 2002; Pereira, Furegato & Pereira, 2005). These findings were presented in relation to overall destruction of self-esteem, associated with a theme of institutionalisation. This theme is perhaps unsurprising given the context of Pereira *et al.*'s research, which was conducted on long-stay wards in Brazil, making it difficult to generalise. Nonetheless, Cutting and Henderson also reported institutionalisation as a recurring theme, leading them to conclude that many of the problems portrayed in historical works such as Goffman's 'Asylums' are still relevant in the UK today (Cutting & Henderson, 2002).

The qualitative research outlined above suggests that the experience of psychiatric hospitalisation may have a deleterious effect on the self-esteem of inpatients, mediated in some cases by threats to self-concepts such as identity and dignity. However, these links have not been tested

empirically as yet and research is minimal at present. While self-esteem has been conceptualised as a stable trait (Fennell, 2004), some authors have argued that self-esteem can be constructed situationally, as a function of the meanings that people bring to situations and the features of that situation which make the meanings relevant (Crocker, 1999). Thus it is possible that psychiatric hospitalisation leads to a contextual decrease in self-esteem through individuals' interpretation of the negative meanings of hospitalisation, alongside the day to day aspects of the experience which may be perceived as threatening to their identity and dignity.

It should be noted that not all research has reported negative findings in relation to identity. In a qualitative study investigating the therapeutic milieu of inpatient facilities, the authors concluded that the identity of patients was 'affirmed amidst kindred souls', whereby socialisation and connection with other patients was a particularly important aspect of the inpatient experience (Thomas, Shatell & Martin, 2002. p.103). Furthermore, seeing similarities between themselves and other patients helped participants to positively adjust their identity, in terms of normalising thoughts, feelings and events, and lessening the severity of their own illness experience. Whilst this study appears to provide contradictory evidence in light of the more negative findings discussed above, it is suggested that the authors' focus on therapeutic aspects of the inpatient experience may have facilitated an initial exploration of how this negativity is counteracted by patients.

### **3.2 Stigma and Self-Esteem**

Mental illness has been described as a stigmatised attribute, as psychiatric patients are often negatively portrayed as incompetent, violent and fundamentally different (Corrigan, 1998). Individuals have reported being mistreated due to being labelled mentally ill (Lundin, 1998;

Wahl, 1999) and research has shown that they often expect to be devalued, disadvantaged or disempowered (Link, Struening, Rahav, Phelen & Nuttbrock, 1997; Markowitz, 1998; Murphy, 1998).

The exact nature and extent of stigma attached to the label of 'mental patient' is difficult to ascertain from the literature. Whilst most authors have concluded that stigma is widespread and pervasive (Link *et al.*, 1997; Markowitz, 1998; Murphy, 1998; Wahl, 1999), others have minimised its existence (Gove & Fain, 1973; Aubrey, Teft & Currie, 1995). Quantitative conclusions are hindered by the use of varying definitions of stigma and different techniques of measurement. In addition, of relevance to the current review, is the fact that research has typically investigated the experience of mental illness as a whole, rather than psychiatric hospitalisation *per se*. Findings from the qualitative literature have supported the notion that psychiatric inpatients frequently have to face and cope with stigma, whereby being confronted with others' responses to hospitalisation is a difficult and painful experience (Cutting & Henderson, 2002; Roe & Ronen, 2003).

Stigmatisation around mental illness has been associated with various negative social consequences, including unemployment, lowered income and decreased social supports (Link & Cullen, 1990). In addition, research has demonstrated strong and enduring effects of stigma on psychological well-being (Link *et al.*, 1997; Markowitz, 1998) and adverse effects of stigma on life satisfaction (Markowitz, 1998). Markowitz's study in particular benefited from rigorous statistical analysis and a large sample size (n=610). In terms of the psychological impact on inpatients, the effect of stigma on self-esteem has received the most interest in the literature. Again, the association between these two concepts is not straightforward; whilst some studies have demonstrated the existence of a definite and long-lasting relationship (Link, Struening,

Neese-Todd, Asmussen & Phelen, 2001; Wright, Gronfiem & Owens, 2000), other authors have concluded that any association is complex and far from inevitable (Camp, Finlay & Lyons, 2002).

In an early qualitative study (included despite its date of publication due to its direct focus on the experience of psychiatric hospitalisation), Townsend and Rakfeldt (1985) sought to explore how the stigma of hospitalisation interacted with patients' self-efficacy and self-concept. The study benefited from triangulation of methods and from contact with participants at different stages of their experience of hospitalisation. For 'first-contact' patients hospitalisation was viewed as an inherently stigmatising experience, in terms of both self-concept and self-efficacy. For example, participants felt that they were viewed negatively by peers and communities, and that their options (e.g. for work/relationships) had been reduced as a result of hospitalisation. As may be expected, this led to most participants feeling strongly opposed to their admission. In order to deal with this, patients appeared to form strong cognitive boundaries between the other patients (seen as 'mad') and themselves (seen as 'sane').

Interestingly, as participants gained more experience of hospitalisation (through repeated admissions) they began to view the process more positively. Townsend and Rakfeldt (1985) posited that this was due to the changing definitions employed by patients. For example, they appeared to broaden their overall definitions of mental illness and to normalise the experience of hospitalisation. Presumably this allowed for the protection of their own self-concept as they began to identify with those previously viewed as 'insane'. Despite this protective mechanism, Townsend and Rakfeldt (1985) highlighted that the reduced self-efficacy experienced by first-contact patients led to restricted social contact and involvement with life tasks, which in turn appeared to play a part in leading individuals to adopt a 'chronic patient role'. As such, the

maintenance of self-efficacy and positive self-concept in such individuals may be of paramount importance in keeping future admissions to a minimum.

From a theoretical perspective, Modified Labelling Theory (MLT) has been employed to explain the connection between stigma and self esteem (Camp *et al.*, 2002). MLT attempts to build upon original Labelling Theory and suggests that people are likely to have internalised negative representations of mental illness even before becoming labelled. Low self esteem thus arises as individuals apply unfavourable social conceptions of mental illness to themselves (Link & Cullen, 1990). In this way, stigma appears to be another mediating factor in the complex relationship between identity and self esteem explored above. Furthermore, MLT suggests that it is not only the label of mental patient which adversely affects individuals, but also the way in which this label is minimised or confirmed by experiences (Camp *et al.*, 2002). A qualitative study by Gilmartin (1997) addresses this issue: Gilmartin interviewed five former psychiatric patients to explore the way in which they had made sense of their experience and drawn meaning from it. Instead of using overt analysis Gilmartin chose to present large sections of narrative to preserve adequate depth for discussion. Narratives appeared to support MLT, in that the failure of hospital treatment to normalise and validate participants' experience of mental illness was seen as more detrimental than the stigmatising label of mental patient itself.

Aspects of social role theory (Sarbin & Scheibe, 1983, cited in Gilmartin, 1997) were also relevant, whereby participants experienced shame and stigma around the granted role of 'mental patient', which had gradually been replaced by a positive self-identity around attained roles (husband, graduate, activist) acquired after hospitalisation. Whilst Gilmartin's research has little scope in terms of sample size or strict methodology, the theoretical discussion highlights the complexity of the effects of psychiatric hospitalisation upon self-concept and understanding.

Formerly hospitalised individuals must redefine themselves within the context of family, work and society following this potentially stigmatising and non-normative event (Gilmartin, 1997). As such, understanding and facilitating maintenance of the 'stories' of former and current patients may help clinicians in working with these populations.

Interestingly, findings from research with younger inpatients may reflect age differences in perception and management of stigma. Pugh and colleagues' relatively large sample (N=358) was drawn from an urban area in the United States and comprised four adolescent groups: currently hospitalised; formally hospitalised; those with siblings who had been hospitalised; and those with no experience of hospitalisation (Pugh, Ackerman, McColgan, Mesquita, Worley & Goodman, 1994). Most types of stigma (i.e. from family/peers) were perceived by all groups to be a regular problem for hospitalised adolescents. However, the most prominent finding concerned the fact that the more direct and current the adolescent's experience of hospitalisation, the less stigmatising they believed it to be. Pugh *et al.* (1994) emphasised how context determines meaning, in that adolescents within the hospital environment may come to endorse the hospital reality in terms of accepting the experience as valuable. Once outside, other contexts influence the construction of meaning, explaining why the formerly hospitalised group were not so positive. Findings were also related to a self-serving attributional bias, whereby individuals may over-exaggerate the positivity of their current situation in order to maintain a sense of control (see Pugh *et al.*, 1994).

In another interesting study, Hepper, Weaver and Rose (2005) found that at admission children did expect extra distress in terms of losing control of their social identity and being gossiped about by peers. However, interviews just prior to discharge revealed that children had in fact been able to protect their social identities with a number of inventive strategies, such as reinventing the

psychiatric unit and treatment as ‘cool’. Children’s perspectives and prejudices may not be as entrenched as adults’, allowing young patients to utilize this type of strategy to cope with encountering stigma.

It is unclear how these findings should be interpreted in light of the overall negativity associated with stigma in the adult literature, although they may link to the idea of a protective mechanism discussed in relation to Townsend & Rakfeldt’s findings above<sup>4</sup>. In addition, the existence of a uniformly negative reaction to stigma has been questioned by certain authors, who have provided evidence for a variety of personal responses to stigma, including low self-esteem, diminished self-efficacy, righteous anger and even indifference (see Corrigan & Watson, 2002). In any case, further research is needed to explore the experiences of adolescent and child inpatients in more depth and to further explicate the mechanisms behind differing responses.

Whilst the responsibility for erasing public stigma around mental illness falls within wider society, it has been suggested that mental health professionals should concentrate on the minimisation of self-stigma, essentially the negative effect of stigma on self-esteem (Corrigan, Kerr & Knudsen., 2005). Cognitive therapy has been identified as one approach that may provide an effective strategy for tackling self-stigma around psychiatric hospitalisation, with research demonstrating its utility in helping clients to reframe stigma as a normal event (Kingdon & Turkington, 1991).

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<sup>4</sup> Thus, adolescents may attempt to normalise their experience and to broaden their definition of mental illness in order to protect their self-esteem. Their ability to do this more quickly than adults (i.e. on first admission), may be explained by the possibility that their negative concepts are less entrenched than those of adults.

### 3.3. Coercion and Disempowerment

The issue of coercion, in particular in relation to compulsory admission and treatment, has received considerable attention in the literature and will clearly affect the experience of those inpatients detained under the Mental Health Act. A comprehensive summary of this literature is beyond the scope of the current review. However, research has been included where findings have relevance to the psychological impact on clients.

Beveridge (1998) suggested that compulsory admission may give rise to various emotions including fear, anger, distrust, humiliation and depression. Studies seem to confirm that at least half of involuntary clients experience anger after admission (Luckstead & Coursey, 1995; Rooney *et al.*, 1996) and other emotions such as fear, panic and confusion have also been reported to varying degrees (Morrison, Bowe, Larkin & Nothard, 1999; Luckstead & Coursey, 1995; Joseph-Kinzelman, Taynor, Rubin, Ossa & Risner, 1994). Low response rates, small sample sizes and the retrospective description of admissions, urge caution when interpreting these results.

Studies have also explored coercive interventions used within the inpatient environment (e.g. restraint, seclusion, enforced medication) and have indicated that such interventions can have various negative psychological effects including fear, anger and paranoia (Greenwood *et al.*, 1999; Leavey *et al.*, 1997; McIntyre *et al.*, 1989). The satisfaction-survey nature of this research precludes detailed conclusions about the subjective experience of clients. It has been suggested that the effects of involuntary treatment will lead to difficulties in establishing therapeutic relationships, decreased treatment compliance and poorer overall outcomes for clients (Allen, 1999); however this suggestion has not been fully investigated in the literature.

Qualitative research has again attempted to describe the subjective experience of inpatients in more detail. In a well-designed and well-reported study, Miedema and Stoppard (1994) highlighted two themes of particular importance to their female participants; the need to seek asylum, and the feeling of being controlled. In the case of the former, involuntary hospitalisation provided a respite from the everyday responsibilities of family life. However, with this relinquishing of responsibility came feelings of restriction, coercion and powerlessness. This issue has particular relevance for psychologists, who work from a stance of collaboration and empowerment, as these feelings are likely to foster suspicion and mistrust in clients who have experienced the inpatient process. This polarity of outcome was also demonstrated by Johansson and Lundman (2002) who described the experience of involuntary patients as a balance between losses and opportunities. Participants reported being restricted in autonomy and violated in terms of their physical integrity and human value, which caused them to feel devalued and disempowered (Johansson & Lundman, 2002). However, participants also reported being respected as an individual in certain ways, and being protected and cared for (Johansson & Lundman, 2002). These observations may reflect findings from the quantitative literature, which have demonstrated that involuntary patients are often negative about the inpatient experience at the time of admission, but become more positive as they get better and begin to recognize the value of their involuntary commitment (see Luckstead & Coursey, 1995)<sup>5</sup>.

Research has also demonstrated overtly positive aspects to compulsory care. For example, participants in a qualitative study have described finding refuge in the environment of a locked ward, which freed them from the demands of everyday life (Thomas *et al.*, 2002). Similarly, in another study 36% of participants found the isolation and restriction of the hospital ward helpful

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<sup>5</sup> In a review of studies exploring the outcomes of coerced hospital treatment, Nicholson urges caution in accepting this view without question due to 'numerous methodological flaws in the literature' (Nicholson, 1999. p. 148).

(Vartiainen, Vuorio, Halonen & Hakola, 1995). Other reported positive aspects of admission include relief, security, companionship and protection (Farnham & James, 2000). The setting of these studies and the social background of participants must be taken into account however. Admission to a maximum security ward for example (as in Vartiainen *et al.*, 1995), will mean participants' attitudes and reactions are affected by differing factors to those admitted to a general psychiatric ward.

Whilst coercion and disempowerment often relate to involuntary admission and compulsory treatment, this is not always the case. Voluntary patients may also experience feelings of restriction and disempowerment during inpatient care (Eriksson & Westrin, 1995; Morrison *et al.*, 1999; Rooney *et al.*, 1996) and these feelings may be linked to relatively minor impositions and rules. For example, children have been shown to experience the inpatient environment as restricting privacy and autonomy, due to being unable to use their usual methods for managing distress, such as telephoning a friend or retreating to their room (Hepper, Weaver & Rose, 2005).

Whilst very few studies have placed findings in psychological context, self-determination theory may provide a framework for understanding (see Ryan & Deci, 2000). Self-determination theory argues that self-motivation and well-being within a given environment are dependent on opportunities for the satisfaction of basic human needs, including autonomy, competence and relatedness (Ryan & Deci, 2000). Contexts such as psychiatric inpatient environments, which thwart the satisfaction of these needs, can therefore undermine motivation, involvement, performance and wellness (Lynch, Ryan & Plant, 2005). Thus clients who perceive coercion and a loss of autonomy may experience lower motivation for participation in therapeutic activities and may view services more negatively overall, leading to decreased compliance and contact with services in future (Rogers, 1993).

The notion of 'learned helplessness' may also be relevant, whereby the continual loss of personal control experienced by some patients may lead to learned helplessness, the results of which include lowered motivation, decreased self-efficacy and depression (Seligman, 1975). For example, Roe and Ronen (2003) reported that passivity generated by the inactive patient role, and the sense that 'compliant' patients were 'good' patients, produced a sense of hopelessness and helplessness in participants. Further research is needed to incorporate these theories properly into the investigation of the psychological impact of inpatient care.

### **3.4 Fear and Vulnerability**

Quantitative research has demonstrated that psychiatric inpatients are frequently exposed to various types of risk on wards, including interpersonal violence and aggression (Davis, 1991; James, Fineberg & Shah, 1990; Mellesdal, 2003; MILMIS, 1995; Owen *et al.*, 1998; Sainsbury Centre, 1998; Walker & Seifert, 1994) and sexual harassment (Barker, 2000; Lelliott, Audini & Darroch, 1995; MILMIS, 1995). Nursing research in particular has highlighted the fact that this has compromised the therapeutic potential of wards (Hummelvoll & Severinson, 2001; Quirk & Lelliott, 2001), with the most pessimistic of commentators describing contemporary wards as a 'dumping ground' for service-users who cannot be managed in the community (Muijen, 1999).

Studies have shown that violence is typically perpetrated by a small number of patients (Owen *et al.*, 1998; Pearson, Wilmot & Padi, 1986; Tam, Engelsmann & Fugere, 1996), who are more likely to be young males with a history of violence, who have been involuntarily admitted to hospital (Davis, 1991; James *et al.*, 1990; Morrison, 1992). Staff members have also been implicated in violent incidents such as aggression and sexual harassment (Cusack, Frueh, Hiers, Suffoletta-Maierle & Bennett, 2003; Kumar, Guite & Thornicroft, 2001; Wood & Pistrang,

2004). Methodologically, it is hard to draw conclusions about the exact nature and amount of violence faced by inpatients, as studies use varying definitions of violence and alternate units of measurement. For example, some studies have made overall statements about level of violence (Sainsbury Centre, 1998), whilst others have measured incidents per month (Owen *et al.*, 1998) or per bed daily (Walker & Seifert, 1994). In addition, the research literature as a whole has focused on how to identify potentially violent service users and to manage associated risk, resulting in a paucity of research dedicated to service users' subjective experiences as witnesses and victims of violence on wards (Kumar *et al.*, 2001).

While user surveys have reported subjective feelings of being unsafe on the part of service-users (Barker, 2000; Mind, 2004; Sainsbury Centre, 1998), qualitative research has explored these feelings in more depth. In a recent interview study, Wood and Pistrang (2004) found that experiences such as verbal aggression, physical violence and sexual harassment, led to patients feeling frightened and vulnerable. Environmental factors such as shared bedrooms also increased subjective vulnerability. Further, staff members made the interesting observation that when new patients were around 'older patients' the new patients tended to feel more fearful about their future and their own prognosis.

Placing similar findings in a psychological context, Cusack *et al.* (2003) reported that participants experienced a number of 'harmful' events as inpatients, in that they were thought to be capable of producing or exacerbating psychological distress. Events included being subjected to aggression, being around other patients who were frightening or just very sick, and witnessing other patients being restrained. Participants consistently reported experiencing fear, horror and helplessness in response to such events. Further, Kumar *et al.* (2001) reported that focus group participants concentrated on the psychological rather than physical effects of violence on wards (such as

anxiety and tension), which led to these experiences dominating their memories of hospitalisation.

Female patients in particular appear to be susceptible to feelings of fear and vulnerability, whereby threats focusing on gender, such as personal boundary infringements by staff or other patients, can increase female patients' sense of vulnerability (Wood & Pistrang, 1994). Reports of high levels of male violence, fear of assault and an overall feeling of lack of safety, caused Cutting and Henderson (2002) to conclude that female inpatients were largely functioning as women in a man's world, which contributed to a sense of isolation and disempowerment. Whilst such findings may lead to calls for a return to single-sex wards this may not always be supported by service-users. For example, some female patients have indicated a preference for mixed sex wards despite experiencing occasional feelings of vulnerability, due to the fact that overall, the opportunity for interaction and social contact with both sexes was deemed important for recovery (Cleary & Warren, 1998). In the case of this particular study, the creation of separate areas on the ward for both male and female patients, whilst keeping some communal areas, was considered an adequate improvement to the ward environment.

It seems reasonable to suggest that continual existence within a potentially threatening environment will have some psychological impact on inpatients. Exposure to threatening situations whether real or imagined, along with associated feelings of fear and vulnerability, may lead to new or increased anxiety in inpatients. This in turn may exacerbate their existing difficulties, hinder therapeutic engagement and/or prolong the overall process of recovery. Further research is needed to investigate these hypotheses, as the effect of witnessing or experiencing violence and/or aggression has not yet been systematically evaluated in the service-user population.

While issues of safety on wards should be of primary concern politically, individual psychologists may attempt to monitor and manage fear and anxiety in current and former patients, not least through provision of a safe environment to discuss such concerns. Specific intervention programs have been shown to be effective for staff member victims of violence on wards (Flannery, Fisher, Walker, Littlewood & Spillane, 1991; cited in Kumar *et al.*, 2001). As such, there is a need for the development of comparable programs for service-users, considering the likelihood of similar psychological consequences (Kumar *et al.*, 2001). Further, whilst research has focused on staff and systemic strategies for managing risk in the inpatient environment, research has demonstrated that service-users also employ their own strategies, such as avoidance and seeking the protection of other service-users and staff (Quirk, Lelliott & Seale, 2004). This insight provides clues as to how the physical and social environment of wards may be altered to facilitate greater therapeutic potential for clients.

### **3.5 Trauma and Post-traumatic Stress**

With the above literature in mind, researchers have begun to investigate the possibility that psychiatric hospitalisation may be a sufficiently traumatic event to cause post-traumatic stress symptoms in inpatients. Thus, post-traumatic stress disorder (PTSD) may be a useful paradigm for understanding patients' psychological response (Shaw, McFarlane & Bookless, 1997).

Psychiatric admission could satisfy criteria in the ICD-10 operational definition of PTSD, in that it may be of an exceptionally catastrophic or threatening nature to cause distress in anyone (Morrison *et al.*, 1999). In addition, whilst a psychotic episode resulting in hospitalisation does not strictly qualify for the stressor criterion in DSM-IV, it has most of the characteristics of events that tend to trigger the disorder (Shaw *et al.*, 1997). Events which occur during

hospitalisation, such as violence and sexual assault, do classify as DSM-IV defined traumatic events and have been termed ‘Sanctuary Trauma’ (Cusack *et al.*, 2003). Witnessing or experiencing Sanctuary Trauma during hospitalisation produced higher subjective distress scores and a longer period of feeling upset following discharge, compared to those who had not experienced such events (Cusack *et al.*, 2003).

Studies investigating the incidence of PTSD post hospitalisation have reported percentages of participants meeting caseness for PTSD as ranging from 11% to 67% (Cusack *et al.*, 2003; Frame & Morrison, 2001; McGorry, Chanen, McCarthy, Van Riel, McKenzie & Singh, 1991; Meyer, Taiminen, Vuori, Aijala & Helenius, 1999; Morrison *et al.*, 1999; Priebe, Broker & Gunkel, 1998; Shaw *et al.*, 1997; Shaw, McFarlane, Bookless & Air, 2002). The mean percentage from these studies stands at 44%. Whilst these findings suggest that PTSD may be a useful framework for understanding the psychological response of a substantial proportion of inpatients, results must be interpreted with caution for a number of reasons. Sample sizes are relatively small for empirical research and consist of heterogeneous groups in terms of diagnosis, number of previous admissions and illness severity. Large proportions of participants had also experienced traumatic events prior to hospitalisation, which may have confounded results. In addition, participants were often asked to describe admissions retrospectively, meaning that trauma since hospitalisation may also have biased results (for further discussion see Morrison, Frame & Larkin, 2003).

All studies, with the exception of Morrison *et al.* (1999) and Priebe *et al.* (1998) investigated the incidence of a post-psychotic PTSD, where trauma was assessed in relation to both psychotic symptoms, and the experience of treatment and hospitalisation. Thus it is difficult to ascertain the exact experiences which generated post-traumatic phenomenology. However, McGorry *et al.* (1991) stated that PTSD symptoms appeared to be ‘linked especially to the experience of

hospitalisation' (McGorry *et al.*, 1991. p.255-256); whilst Shaw *et al.* (1997) concluded that aspects of treatment and hospitalisation caused considerable distress, which undoubtedly contributed to the individual's overall psychological response. Further, Meyer *et al.* (1999) found that hospitalisation accounted for 24% of reported traumatic symptoms.

The above findings do not allow for clear conclusions to be drawn around the possible relationship between psychiatric inpatient care and PTSD. However, they do provide some empirical support for the emotional impact of various aspects of hospitalisation, whereby the majority of participants in all studies reported strong emotional reactions and varied symptoms including intrusion and arousal, even when these did not constitute PTSD caseness. Aspects of hospitalisation which were distressing for participants included coercive treatment, such as seclusion or enforced medication (Morrison *et al.*, 1999) and less obviously traumatic experiences, such as: being away from family and friends, worrying about losing custody of children (Shaw *et al.*, 1997) and separation from usual daily activities (Shaw *et al.*, 2002). Cusack *et al.* (2003) suggested that the term 'Sanctuary Harm' be applied to such events which do not meet the DSM-IV criteria for trauma, but which are nonetheless distressing, frightening or humiliating for vulnerable clients. The wider implications of experiencing either Sanctuary Harm or Sanctuary Trauma may include new or exacerbated psychiatric and psychological symptoms and an increased mistrust of services in clients (Frueh, Dalton, Johnson, Hiers, Gold, Magruder *et al.*, 2000).

The body of literature concerning psychiatric hospitalisation and trauma suggests that it may be necessary to routinely assess patients' reactions to psychiatric admission in order to provide specific intervention to those suffering with high levels of distress or associated PTSD. This is particularly pertinent given that further impairments in social functioning and increased incidence

of depression, anxiety and suicide are commonly associated with untreated PTSD (Marmer, 1994, cited in Morrison *et al.*, 1999). In addition, further research is needed with more homogenous samples, larger sample sizes and carefully constructed designs. This would allow for the interpretation of the effect of hospitalisation (and treatment), above and beyond psychotic phenomena or any previous or post-discharge trauma.

## **4. DISCUSSION**

### **4.1 Current State of Research**

Little research to date has explicitly addressed the psychological impact of psychiatric inpatient care. Whilst psychological concepts have been highlighted by the findings of existing research, these have rarely been placed in the context of psychological theory. This may reflect the wider systemic picture, in that Clinical Psychologists have traditionally distanced themselves from direct work with psychiatric inpatients. However, psychiatric inpatient care clearly has some effect upon the psychological functioning of current and former patients. The current review has highlighted the complexity of the inpatient experience, whereby psychiatric patients may undergo challenges to their self-concept, self-esteem and self-efficacy, resulting in strong affective reactions. Research has also begun to investigate the incidence of post-traumatic symptomatology as a result of psychiatric inpatient care. Exact causal factors, types and frequency of psychological outcomes, have not been adequately established by the literature as yet.

Methodologically, a number of factors must be taken into account. Research around the experience of psychiatric inpatient care has overwhelmingly been conducted with adults of working age in acute settings. This is particularly true of UK research. This limits the

generalisability of findings to other age groups or inpatient settings. Legal status of psychiatric patients may have a considerable effect upon individual psychological outcomes (Allen, 1999). Consequently, the fact that many studies include both voluntary and involuntary patients may confound results in some way. In addition, research in some arenas, for example around stigma and PTSD, has looked at wider topics (mental illness/psychosis) rather than focussing on psychiatric hospitalisation as a discrete experience. Again this may bias findings, or at least limit their utility in terms of drawing conclusions in the context of this review. Sampling techniques were rarely mentioned by authors. Convenience samples from single institutions were often used, meaning that the generalisability of quantitative findings may be limited, especially considering the international origins of a substantial proportion of the research. In addition, use of exclusion criteria coupled with low response rates in some cases, may have introduced a selection bias, as excluded or non-responding clients may have different views about the inpatient experience.

The use of qualitative techniques in many cases was appropriate considering the exploratory nature of the research and the focus on the subjective experience of participants. Quantitative tools for measurement can be developed in the future as clearer ideas about the possible psychological impact of psychiatric inpatient care emerge. Most studies were published in peer reviewed journals, which was reflected by the careful adherence of many authors (i.e. Cutting & Henderson, 2002; Hepper *et al.*, 2005; Johansson & Lundman, 2002; Letendre, 1997; Wood & Pistrang, 2004) to qualitative research guidelines, in terms of ensuring transparency and reflexivity in the methods used (see Mays & Pope, 2000). Despite this, the overall picture tended towards a lack of transparency, with authors rarely stating their epistemological standpoints, and sometimes relying on vague or untested methods for data collection and analysis. The use of mental health professionals to conduct interviews in many cases may also have affected the findings of qualitative studies.

Overall, despite the wide variety of approaches used and the differing backgrounds of authors, research has begun to establish the possible psychological effects of psychiatric inpatient care. Research suggests that becoming a psychiatric inpatient may have negative consequences for one's self-esteem and psychological well-being, possibly resulting in new or exacerbated psychological or psychiatric symptoms. Causal or mediating factors appear to include: the compromising of identity and dignity upon admission; the stigma attached to inpatient psychiatric care; the real or perceived coercion of involuntary admission and some aspects of treatment; and the violence and aggression faced by patients on contemporary wards. Some positive effects, for example those around shared identity and the provision of sanctuary, have also been reported.

#### **4.2 Implications for Clinical Psychology**

Research findings have highlighted the problematic nature of psychiatric inpatient care, indicating that issues such as safety, coercion and dignity, need to be continually addressed by staff and policy makers. The current system of psychiatric inpatient care may be potentially damaging psychologically, especially for those clients admitted involuntarily who appear more likely to perceive coercion and thus suffer associated consequences. The new role of Clinical Supervisor will increase Clinical Psychologists' contact with individuals needing inpatient care and thus raises the pertinence of these issues for the profession.

On an individual basis, clients who have experienced psychiatric inpatient care may have been further damaged psychologically by their hospital experience. This may foster mistrust of those working in the health care professions, which may in turn compromise the therapeutic relationship. Existing research highlights the need for understanding of the inpatient experience, whereby psychologists may utilise that understanding in various ways: to help individuals facing

admission to prepare for the experience for example; to assist current inpatients in the successful adjustment of their identity or the normalisation of stigma; and to allow former inpatients to work through traumatic experiences to minimise resulting symptomatology. Overall, the most useful way to assist psychiatric inpatients psychologically is likely to become apparent on a case by case basis, through the process of individual assessment and formulation. Finally, psychologists may also be well placed to work systemically with staff and services, to facilitate understanding of the impact of inpatient care on the client and to assist in the development of more effective inpatient services.

#### **4.3 Future Research Priorities**

Research conducted from a psychological standpoint is needed, to understand more fully the psychological impact of psychiatric inpatient care. This is a complex area of research and findings tend to be contradictory and largely dependent on context. As such, exploratory research with populations other than adult inpatients is needed, to examine in detail specific contexts which have yet to be studied. The experiences of adolescents or older adults for example, are likely to differ from those of the adult population, due to the different developmental demands, life events and external pressures operating for these groups. Qualitative methodologies would be suited to this type of research owing to the need to collect rich and detailed data in order to begin to form theory. Any research utilising a qualitative approach should ensure the transparent reporting of research methodology and the rigorous employment of processes such as reflexivity, iteration and grounding, to ensure adequate validity and to allow theoretical conclusions to be constructed (Stiles, 1999).

The experience of psychiatric hospitalisation needs more rigorous investigation in terms of concepts such as stigma, coercion, violence and aggression. Concepts need better clarification in the literature, so that the exact nature and frequency of potentially damaging events faced by individuals can be better ascertained. In addition, greater transparency is needed in terms of tools used for measurement, in particular concerning their development and psychometric properties. Instead of convenience samples of diverse groups of inpatients, future research should attempt to obtain homogenous samples such that firmer conclusions can be drawn around causal factors of psychological distress.

Research including validated measures of emotional responses, self-esteem and theoretical constructs such as learned helplessness and self-determination, could help to clarify psychological responses. Whilst prospective randomised controlled trials would be problematic to conduct in terms of ethics and methodology, longitudinal research with baseline and follow-up measurements, would assist in the reduction of confounding variables such as pre-hospitalisation trauma. Finally, the impact of any negative psychological effects on therapeutic alliance and outcome must be investigated to allow the implications for Clinical Psychologists to be fully explored.

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**PART TWO:**  
**RESEARCH REPORT**

**Surviving an Alternative Reality:  
A Qualitative Analysis of Adolescents'  
Experiences of Psychiatric Hospitalisation**

## ABSTRACT

*Objectives:* Little research to date has investigated adolescent psychiatric inpatient care from a service-user perspective. Further, whilst research conducted with adult populations has started to highlight the possible impact of psychiatric hospitalisation, minimal research has been conducted from a psychological standpoint. The current study thus aimed to explore adolescents' experiences of psychiatric hospitalisation, with particular reference to the possible psychological impact of the experience and the ways in which hospitalised adolescents cope.

*Method:* Semi-structured interviews were conducted with ten adolescents with experience of psychiatric inpatient care. Data collection and analysis was guided by the grounded theory method (Glaser & Strauss, 1967) which led to the production of a process model grounded in the experiences of the current participants.

*Results:* The core category of the final model was termed 'Living in an Alternative Reality', which reflected the unusual nature of the overall hospitalisation experience from the adolescent perspective. Various factors contributed to the experience of living in an 'alternative reality', including unexpected and difficult to understand experiences, and the feelings of restriction and disconnection participants experienced during admission. Participants used various strategies to cope with the everyday experience of hospitalisation and to manage the effects of the experience on their developing identity.

*Discussion/Conclusions:* The study's results are discussed within the context of pre-existing literature and relevant psychological theories. The clinical implications of the findings, such as the need to maintain connections with family and friends and foster supportive relationships within the ward environment, highlight the need to prioritise the service-user perspective in clinical settings and future research.

Word Count: 254.

## **1. INTRODUCTION**

Very few research studies have explored adolescents' experiences of psychiatric hospitalisation, despite the current health service focus on seeking service-user views (Dept. of Health, 1998). Inpatient provision will always be necessary for some adolescents, particularly those with complex needs who may arguably remain in contact with services throughout adulthood (Fisher, 1994). As such, the ability to understand, improve and support young people through this experience is likely to be important for a wide variety of mental health professionals. Studies that pertain to adolescent psychiatric inpatient care (APIC) are reviewed, including those investigating adequacy of provision, efficacy and outcomes, and patient satisfaction. It is argued that the current research is needed to ground existing findings relating to service provision within an understanding of the entire experience from the service-user perspective.

### **1.1 Adolescent Inpatient Care in Context**

'Adolescence' as a distinct life-phase has been recognised by various societies for centuries (Parry-Jones, 1995). Despite this, widespread development of separate mental health services for adolescents was not seen until the 1960s (Parry-Jones, 1995). Since that time service development has largely continued on an ad hoc basis, due to a lack of central planning (Gowers & Cotgrove, 2003). However, in recent years the Quality Network for Inpatient Child and Adolescent Mental Health Services has aimed to 'demonstrate and improve the quality of child and adolescent inpatient care' by reviewing service standards on a regular basis (Shingleton-Smith, Thurley & Thompson, 2006. p.7). In addition, governmental standards such as those contained within the National Service Framework for Children and Young People (Dept. of Health, 2004), have contributed to the ongoing shaping of psychiatric inpatient services.

Discussion of the detail and nature of the many standards pertaining to APIC is beyond the scope of the current study. However, it is worth noting that it is often unclear how, or even if, adolescents themselves have been consulted during the service development process. For example, the National In-Patient Child and Adolescent Psychiatry Study (NICAPS) did not collect any data from young people. One national service development study conducted from a slightly different perspective was published by Young Minds in 2003, and aimed specifically to give a 'voice' to young service users, by gathering data from young people directly and by involving them in the design and dissemination phases. Whilst some recommendations (i.e. around staffing and bed provision) echoed those previously published by NICAPS, others (i.e. around the need for clearer information and more support post-discharge) gave more of a flavour of the actual experience of young inpatients (Street & Savenberg, 2003).

## **1.2 Nature and Adequacy of Provision**

Research over the last ten years has investigated the national and local picture with regard to the nature and adequacy of APIC. The number of beds available decreased during the 1990s, despite level of need remaining constant (Dimond & Goldberg, 1999). Adequacy of provision as detailed by NICAPS is not standard across the country (see O'Herlihy, Worrall, Lelliott, Jaffa, Hill & Banerjee, 2003) and has been reported as alarmingly low in some localities. For example, Gowers, Clarke, Alldis, Wormald & Wood, (2001) reported that only 0.3% of adolescents needing psychiatric admission during a one-year period in the North-West were admitted to an adolescent psychiatric unit, (others were treated as outpatients or admitted to adult wards). Studies focussing on the admission process have concluded that many factors including ethnicity and perception of urgency may influence who gets admitted (Dimond & Goldberg, 1999); but

there is an overall consensus that treatment on adult wards is not appropriate in most cases (Worrall & O’Herlihy, 2001).

Adolescent inpatient units generally accept young people with a wide range of psychiatric diagnoses, whereby indicators for admission include: a need for intensive assessment, a need to ensure safety, and/or the management of complex problems (Cotgrove & Gowers, 1999).

Research suggests that the majority of young inpatients will be admitted under a section of the Mental Health Act and are likely to have ‘adult-type’ diagnoses, i.e. schizophrenia, personality disorder (Mears, White, O’Herlihy, Worrall, Banerjee & Jaffa, 2003). Whilst most units operate under standard inpatient NHS services, a small number of units with an increased level of security do exist, for those young people who present a high level of risk or who have very complex presentations. However, very little research has been conducted on these units (see Wheatley, Waine, Spence & Hollin, 2004). Some units have a specialist focus such as eating disorders, but most do not (O’Herlihy *et al.*, 2003). In addition, findings from a national postal survey indicated that staffing levels were often inadequate, in terms of number of psychiatrists, number of qualified nursing staff and staff mix (Jaffa, Lelliott, O’Herlihy, Worrall, Hill & Banerjee, 2004). Thus the ability of units to provide adequate care may be hampered by the differing needs of individuals and the lack of a full multi-disciplinary team (Calton & Arcelus, 2003).

Most general adolescent units employ eclectic therapeutic principles and the amount of individual therapeutic work offered is usually the most variable factor (Cotgrove, 2001). Evidence-based practice has not typically been a priority for adolescent units, suggesting that individuals may not always receive the most useful therapeutic input (Cotgrove, 2001). Further, it has been suggested that the environment of the adolescent inpatient unit may be changing due to the specific

difficulties of the young people who are admitted (Gowers & Rowlands, 2005). Research in the UK has indicated growing levels of violence on wards (Calton & Arcelus, 2003), whilst research in New Zealand has highlighted an increasing trend of co-morbid substance abuse problems, which may well be echoed in the UK (see Swadi & Bobier, 2003).

### **1.3 Efficacy and Outcome Studies**

Compared to other areas of healthcare provision, relatively little research to date has investigated the efficacy of APIC (Gowers & Rowland, 2005). A number of authors have reviewed the existing literature pertaining to generic outcomes in APIC (i.e. Blanz & Schmidt, 2000; Curry, 1991; Gowers & Rowland, 2005; Pfeiffer & Strzelecki, 1990; Pottick, Hansell, Gaboda & Gutterman, 1993) and have concluded that APIC is generally beneficial in terms of both short and long-term outcomes. In terms of outcomes for specific psychiatric problems, variable findings have been reported in relation to eating disorders, depression, psychosis, conduct disorder, substance misuse and obsessive-compulsive disorder (see Green, 2002). Unfortunately, interpretation is further complicated by the fact that many studies were conducted outside the UK and may thus include a wide variety of treatment standards and goals<sup>6</sup>.

Overall, authors have highlighted significant methodological limitations in the body of research investigating the efficacy of APIC, including absence of control or comparison groups, limited provision of demographic and symptom information, lack of standardised outcome measures, and the fact that efficacy is frequently measured by the treating clinician only (see Blanz & Schmidt, 2000; Gowers & Rowland, 2005). Very few randomised controlled trials have been carried out

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<sup>6</sup> See Rothery, Wrate, McCabe, Aspin & Bryce, (1995), for an investigation of the treatment goals most commonly employed in the UK.

(Cotgrove, 2001) and those that have, have suggested that APIC outcomes may in fact be comparable to those achieved by alternative forms of care such as home-based or outpatient treatment (see Mattejat, Hirt, Wilken, Schmidt & Remschmidt, 2001). As such, more systematic research is required in this area, including studies examining adolescent-led ratings of outcomes, to assess whether these support outcomes reported by clinicians and referrers.

#### **1.4 Satisfaction with Services**

Service-user satisfaction has been measured in relation to different aspects of APIC (i.e. staff members, group therapy, education programs and medication), as well as in terms of overall satisfaction with the inpatient experience, whereby specific and overall satisfaction levels are generally reported as being 'high' (Gusella, Ward & Butler, 1998; Healthcare Commission, 2004; Kaplan, Busner, Chibnall & Kang, 2001; Piersma, 1986)<sup>7</sup>. Studies investigating referrers' and parents' satisfaction with adolescent psychiatric inpatient services have reported similarly encouraging results (Bradley & Clark, 1993; Gowers, 1991). Despite the apparent positivity of these findings, Stallard (1996) has highlighted a number of problems which preclude generalisation of satisfaction findings, including low response rates, lack of consideration of reliability and validity, and the fact that satisfaction surveys are usually one-off events. With particular reference to child and adolescent services, Young, Nicholson & Davis (1995) have identified further complications, including the need to assess both child/adolescent and parent satisfaction, and the possible cognitive immaturity of younger inpatients. The complexity of adolescent relationships with authority is also liable to complicate the interpretation of any

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<sup>7</sup> The findings of these studies may be somewhat confused by a) the inclusion of participants of varying ages, making it difficult to draw out the views of adolescents as separate to those of the younger children/adults also included, and b) the inclusion of both outpatient and inpatient services in measures of overall satisfaction.

satisfaction data and must be taken into account alongside attitudinal, demographic and clinical factors (see Gowers & Cushlik, 1992).

### **1.5 Experiential Studies**

Very few researchers to date have attempted to explore adolescents' perspectives of APIC beyond measuring their satisfaction with services. Survey data has been used to investigate adolescents' views on broad concepts such as the 'meaningfulness' of different elements of APIC (i.e. psychotherapy, nursing, daily conversation) or the 'importance' of different needs (i.e. privacy, visitation, education). These studies tell us slightly more about the psychiatric inpatient experience from an adolescent perspective. For example, 'just being with other adolescents' was rated as the most meaningful aspect of APIC by a group of 105 young inpatients (Grossoehme & Gerbetz, 2004). Advantages of APIC rated by another group (n=69) included getting healthy and meeting new people, whilst disadvantages included losing contact with friends and being away from home (Gusella *et al.*, 1998). Although these findings begin to provide clues about the experience of adolescent inpatients, the lack of detail within survey data makes it difficult to place such findings in any meaningful context.

One qualitative study conducted in the UK, which explored adolescents' experiences of inpatient treatment for anorexia, has provided some further insight into the inpatient experience. The interview accounts of the young participants were characterised by 'conflicts and dilemmas' (Colton & Pistrang, 2004, p.307). For example, participants spoke of the two-sided nature of their relationships with other inpatients, characterised by the idea of 'support vs distress'. Another oppositional theme was identified in relation to treatment: 'collaboration in treatment vs being treated', whereby the extent to which participants felt they played an active role in their treatment

varied throughout their admission. In particular, this theme related to the structure of the ward, which at times felt punitive and at other times felt helpful. The authors concluded that it was vital that the 'psychological needs' of hospitalised adolescents were adequately addressed, particularly in terms of maximising the supportive aspects of their relationships with other inpatients and staff in the context of the ward environment (Colton & Pistrang, 2004, p. 315). The lack of experiential research conducted with adolescent inpatients to date, highlights the need for further qualitative research conducted from the service-user perspective.

## **1.6 Summary**

In summary, research has found that APIC is a constantly developing area of health service provision, where resources appear to be stretched and variable across the UK. Those entering APIC are likely to have complex problems and may be confronted with a difficult ward environment and an ad hoc approach to therapeutic input. Nonetheless, research suggests that APIC is likely to be beneficial, particularly in the area of symptom reduction. The few studies that have explicitly explored adolescents' experiences of psychiatric inpatient care suggest that adolescent inpatients are confronted with various conflicts and dilemmas, and that non-specific aspects of inpatient care such as meeting and being around new people, may be just as important as the more formal side of care. Given the limited research in this area the current study was thus designed to add to the knowledge base about adolescents' experiences of psychiatric inpatient care, with particular reference to the possible psychological impact of this experience.

## **2. METHOD**

### **2.1 The Research Question**

The research questions explored in the current study were:

1. What are adolescents' experiences of psychiatric hospitalisation?
2. In what ways does the experience have a psychological impact on adolescents?
3. How do adolescents cope with the experience of psychiatric hospitalisation?

### **2.2 Research Design**

The collection of rich experiential data can provide a good starting point for investigating previously under-researched topics, particularly where complex thoughts, emotions and meanings are likely to be involved (Barker, Pistrang & Elliott, 2002). A qualitative research methodology utilising semi-structured interviews was thus deemed most appropriate in the current study. Qualitative enquiry has a long history within anthropology and sociology (see Ashworth, 2003; Woolgar, 1996) and there is increasing recognition of the utility of qualitative methods in exploratory health and clinical psychology research (Dingwall, Murphy, Watson, Greatbach & Parker, 1998; Turpin, Barley, Beail, Scaife, Slade, Smith *et al.*, 1997).

### **2.3 The Researcher's Own Position**

Qualitative methodologies are compatible with various epistemological frameworks on a realist/constructionist continuum (see Madill, Jordan & Shirley, 2000; Schwandt, 2003). In approaching the current study the researcher adopted a critical realist position, which is arguably

particularly useful within psychological research, as it demands openness and reflexivity on the part of the researcher, which increases the rigour of any study (Stevenson and Cooper, 1997). According to her position, the researcher accepted the existence of an external world independent of human representation, whilst also acknowledging the role of subjectivity and social context in the production of knowledge (see Madill *et al.*, 2000). As such, she expected that participants would have access to their experiences of psychiatric hospitalisation and would be able to represent these during interviews. Nonetheless, she recognised that participants would be free to present this knowledge in different ways, according to their own views, feelings and opinions, and that data would be to some extent co-constructed within interviews. The researcher also acknowledged that her own experiences, which included 18 months working as a researcher on adult psychiatric wards and eight months working as a Trainee Clinical Psychologist with adolescents in an outpatient setting, would influence her interpretation of the research findings. The researcher's thoughts on these issues were continuously reflected upon throughout the research process, as detailed in section 2.8 below.

## **2.4 The Grounded Theory Method**

The grounded theory method (Glaser & Strauss, 1967) was chosen to guide the current study. Grounded theory (GT) endeavours to discover the meanings people attribute to their experiences through the systematic interpretation of rich data, whereby the overall goal of the analysis is to develop substantive theory which is 'grounded' in the data (Glaser & Strauss, 1967). This interplay between discovery and interpretation is commensurate with a critical realist stance, as it contains elements of both positivism and constructionism (Madill *et al.* 2000). GT was chosen above other qualitative methods (such as IPA, discourse analysis) as the researcher felt it was

most likely to assist her in her aim of developing a theory-driven account of participants' experiences. Due to word constraints, further notes on GT are included in Appendix A.

## **2.5 Procedure**

### **2.5.1 Ethical Approval**

Ethical approval for the current study was sought from the Local Research Ethics Committee (Leicestershire, Northamptonshire & Rutland 1) and was granted in April 2007. Additional ethical approval was also granted by the University of Leicester Psychology Research Ethics Committee, as required for all postgraduate research<sup>8</sup>.

### **2.5.2 Sampling and Recruitment**

Purposive sampling was employed in the initial stages of recruitment. This type of sampling allows for the generation of 'a rich set of materials' from which to begin the analysis (Pidgeon & Henwood, 1996. p.89). Potential participants were identified by the researchers' field supervisors<sup>9</sup> and six participants were recruited in this initial phase. Theoretical sampling was used in the later stages of participant recruitment and consisted of sampling four further participants to expand the developing theory. For example, earlier interviews had indicated that there may be a chronological element to some of the developing categories and that the properties of the categories may differ at various points of admission. In order to explore this further the researcher sampled two participants who were nearing discharge after long admissions, to gain a

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<sup>8</sup> See Appendices B and C for copies of ethical approval.

<sup>9</sup> Participants were recruited from two adolescent units: An NHS adolescent inpatient unit, and an adolescent unit at an independent hospital catering for NHS clients.

retrospective perspective. The process of simultaneous data collection and analysis was continued, until the researcher felt that a suitable level of conceptual density had been reached.

The same recruitment procedure was followed in the case of every participant according to the research ethical approval. For example, permission was sought from the Responsible Medical Officer co-ordinating the young person's care prior to contacting them. Potential participants were given a detailed information sheet<sup>10</sup> and those who were interested in participating were asked to bring an adult to a preliminary meeting, to answer any further questions or concerns the young person (or their parents/guardians) might have, prior to setting an interview date.

### **2.5.3 Interview Procedure**

Interviews took place at participants' homes or in a quiet room on one of the adolescent units. Informed consent was sought and recorded just prior to the interview taking place<sup>11</sup>. Participants were informed of the steps they could take if they were to become distressed following the interview and in the case of current inpatients an informal 'contingency plan' was recorded. Interviews lasted between 20 and 100 minutes and were recorded on a digital voice recorder, which allowed the researcher to concentrate on the interview rather than needing to make detailed notes (Barker *et al.*, 2002; Smith, 1995). The interviews were conducted along ethnographic lines (see Burman, 1994) and the researcher set aside some time after each interview to record any initial impressions or reflections in a reflexive journal, as advised by Charmaz (2003a; 2006).

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<sup>10</sup> See Appendix D.

<sup>11</sup> In the case of participants under the age of 16, informed consent was also sought from at least one parent/guardian. See Appendix E for a copy of the consent form.

#### **2.5.4 Interview Guide**

An interview guide was developed and used flexibly, in that the researcher both asked questions from the guide and was directed by the particular participant and the issues which seemed most relevant to them at the time. Within a grounded theory study the interview guide may also be developed between interviews, according to the principles of theoretical sampling (see Charmaz, 2006). In the current study, the interview guide was refined throughout the data collection period to facilitate the testing out of initial theoretical constructions and categories<sup>12</sup>.

#### **2.5.5 Transcribing**

Charmaz (2003a; 2006) has proposed that researchers should always complete their own transcribing in order to begin the process of becoming immersed in their data. In line with this suggestion the researcher transcribed each of the interviews in the current study, within two weeks of the interview taking place. Pseudonyms were used for all participants and all other individuals mentioned during interviews. In addition, any potentially identifying information (such as place names) was removed or altered. The completed transcripts are included as an addendum to this thesis with a guide to the transcript conventions listed on page 3.

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<sup>12</sup> Copies of the initial and final interview guides can be found in Appendix F.

## 2.6 Participants

The inclusion criteria for the current study stated that participants should: be aged 13-19, have been resident at a psychiatric inpatient unit for at least two weeks in the last 18 months, and be deemed well enough to participate (by the Responsible Medical Officer involved in their care). Conversely, the exclusion criteria stated that participants should not have significant learning or developmental difficulties. An anonymised list of the participants and their demographic information is presented in Table 2.

**Table 1: Demographic Information About The Research Participants**

<b>Participant</b>	<b>Gender</b>	<b>Ethnicity</b>	<b>Age</b>	<b>Current Inps?</b>	<b>Length of Adm.</b>	<b>No. of Previous Adms/ Route to Current Adm.</b>
P1- Britney	Female	White British	13	No	6 Wks	1 <sup>st</sup> Admission GP- Outpatient Psychiatry
P2- Holly	Female	White British	17	No	4 Wks	1 <sup>st</sup> Admission GP- Outpatient Psychiatry
P3- Mike	Male	White British	16	Yes	3 Ms	1 <sup>st</sup> Admission Not Disclosed
P4- Cameron	Male	White British	16	Yes	5 Ms	1 <sup>st</sup> Admission Adm. from Residential Care
P5- Chris	Male	White British	18	Yes	18 Ms	1 <sup>st</sup> Admission Adm. from Prison
P6- Mags	Male	White British	15	Yes	36 Ms	1 <sup>st</sup> Admission Adm. from Secure Unit
P7- Phoenix	Female	White British	19	Yes	36 Ms	1 <sup>st</sup> Admission to APIC Adm. from Adult Psychiatric Ward
P8- Yasmin	Female	White British	19	Yes	14 Ms	1 <sup>st</sup> Admission Adm. from Prison
P9- Natalia	Female	White British	17	Yes	11 Ms	1 <sup>st</sup> Admission Adm. from Eating Disorders Unit at same hospital (previously prison)
P10- Keira	Female	White British	17	Yes	2 Ms	1 <sup>st</sup> Admission Adm. from A&E

## **2.7 Data Analysis**

A variety of texts on grounded theory were used to inform the current analysis, in particular the procedure proposed by Charmaz (2006). The researcher supported the philosophy and procedure outlined by Charmaz (in particular her ideas around the co-existence of rigour and creativity) and considered that this approach could be usefully employed from a critical realist perspective.

### **2.7.1 Line By Line Coding**

The first stage of the analysis involved ‘naming each line of...written data’ in order to become aware of categories and processes (Charmaz, 2006. p. 50). The researcher attempted to use active codes in order to gain a sense of action and sequence, and ‘in vivo’ codes which served to ensure a close fit to the data (see Charmaz, 2006). Initial codes were written directly onto the transcripts, whereby an example of line by line coding can be found in Appendix G.

### **2.7.2 Focussed Coding**

As the initial direction of the data became more apparent, focussed coding was more readily employed. This stage of the analysis involved using the most significant and/or frequent initial codes to begin to explain larger segments of data (see Charmaz, 2006). In particular, the researcher generated focussed codes which made the most ‘analytic sense’, in terms of being able to comprehensively describe the data (Charmaz, 2006. p. 58). An example of focussed coding in the current study can be found in Appendix G.

### **2.7.3 Raising Focussed Codes to Theoretical Categories**

In the final stage of analysis the relationships between focussed codes were more fully explained. Theoretical categories were thus developed to conceptualise the relationships between earlier codes and to advance the direction of the emerging theory (Charmaz, 2006). A core category, which accounted for all of the data, was decided upon and expanded (see Dey, 2004). In the current study a diagram was developed to represent the links between higher order categories, in which the core category represented the central phenomenon of the study (see page 67).

### **2.7.4 Memo-Writing**

Memos were used as a key tool for the development of codes at every stage of the current analysis. Memos may include: explanations of or modifications to codes/categories, general theoretical reflections, ideas for theoretical sampling, or links to the literature (Pidgeon & Henwood, 1996). The researcher found that writing memos helped her to engage with the data, whilst also allowing for wider reflection on the emerging themes and related theoretical ideas. An example of a memo can be found in Appendix G.

## 2.8 Enhancing Quality

Stiles (1993) has suggested ‘trustworthiness’ as an overarching criteria for the evaluation of qualitative research, where standards of good practice include: openness about researcher’s orientation and preconceptions, repeated cycling between data and interpretation, close engagement with data, and the grounding of interpretations with examples (Stiles, 1993)<sup>13</sup>.

In relation to data collection, digitally-recording interviews and transcribing the data have been repeatedly advocated as useful ways for the researcher to enhance the ‘reliability’ of findings (Charmaz, 2006). Including subtle nuances of interview data in transcripts (such as pauses and emphases) and placing quotations in context (by including preceding questions) are also important (Silverman, 2006).

In terms of analysis the researcher considered that employment of key aspects of the GT methodology would help to ensure the production of a good quality piece of research<sup>14</sup>. For example, the constant comparative method is particularly useful in ensuring that the researcher remains closely aligned to the data (Corbin & Strauss, 1990) and also helps move the analysis to a higher level of abstraction, which is necessary if the findings are to be seen as theoretically useful (Suddaby, 2006). In addition, the use of processes such as deviant case analysis and comprehensive data treatment should help the researcher to generate valid and verifiable results (see Silverman, 2006).

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<sup>13</sup> These general standards have been supported by subsequent authors (see Elliott *et al.*, 1999; Henwood & Pidgeon, 1992; Yardley, 2000) and appear to map closely onto the aims of grounded theory (Dingwall *et al.* 1994). As such, the frameworks provided by Stiles (1993) and Elliott *et al.* (1999) were used as general quality control guidelines in the current study.

<sup>14</sup> Various authors have published quality guidelines specifically relating to grounded theory research, whereby those presented by Corbin & Strauss (1990) and Suddaby (2006) informed the current study.

Checking the credibility of the analysis is another important facet of ensuring quality and this can be achieved in a number of ways, for example through triangulation of data, use of respondent validation, or repeated analysis of a data set (Elliott, Fischer & Rennie, 1999; Silverman 2006). Unfortunately the scope of the present study precluded the use of additional data collection methods to triangulate results. Further, whilst respondent validation was considered, it was decided that respondents may not recognise their original accounts as the analysis became increasingly conceptual (see Morse, Barrett, Mayan, Olson & Spiers, 2002). In the current study, line by line coding of a section of interview data was carried out by the researcher's field supervisor and by the members of the researcher's qualitative research group<sup>15</sup>. The considerable similarities with the researcher's own coding suggested that the developing analysis was grounded in the data and was thus adequately credible.

Finally, reflexivity or 'owning one's own perspective' has been advocated as a fundamental concept in ensuring the quality of qualitative research (Elliott *et al.*, 1999; Henwood & Pidgeon, 1992). Keeping a diary or log encourages this type of critical self-awareness (Silverman, 2006). As such, the researcher kept a reflexive journal throughout the course of the current study which helped to highlight how her own perspectives may have been affecting the analysis (Charmaz, 2006). For an example extract from the reflexive journal, see Appendix G.

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<sup>15</sup> The researcher attended a regular qualitative research group, with two other researchers conducting doctoral research and a facilitator who had experience of using the grounded theory method. The main aim of the group was to share experiences and provide support throughout the research process.

### 3. Results

The following section presents an account of the current grounded theory analysis. The resulting process model, consisting of one core category and five main categories, is depicted in Figure 1, page 67. An overall description of the process model and core category is presented, followed by more detailed exploration of each of the main categories and sub-categories. Brief supporting quotes are provided within each sub-section and additional quotes can be found in Appendix H<sup>16</sup>. In every case quotes are referenced using the participant's pseudonym and the line number of the corresponding transcript (e.g. Chris/117).

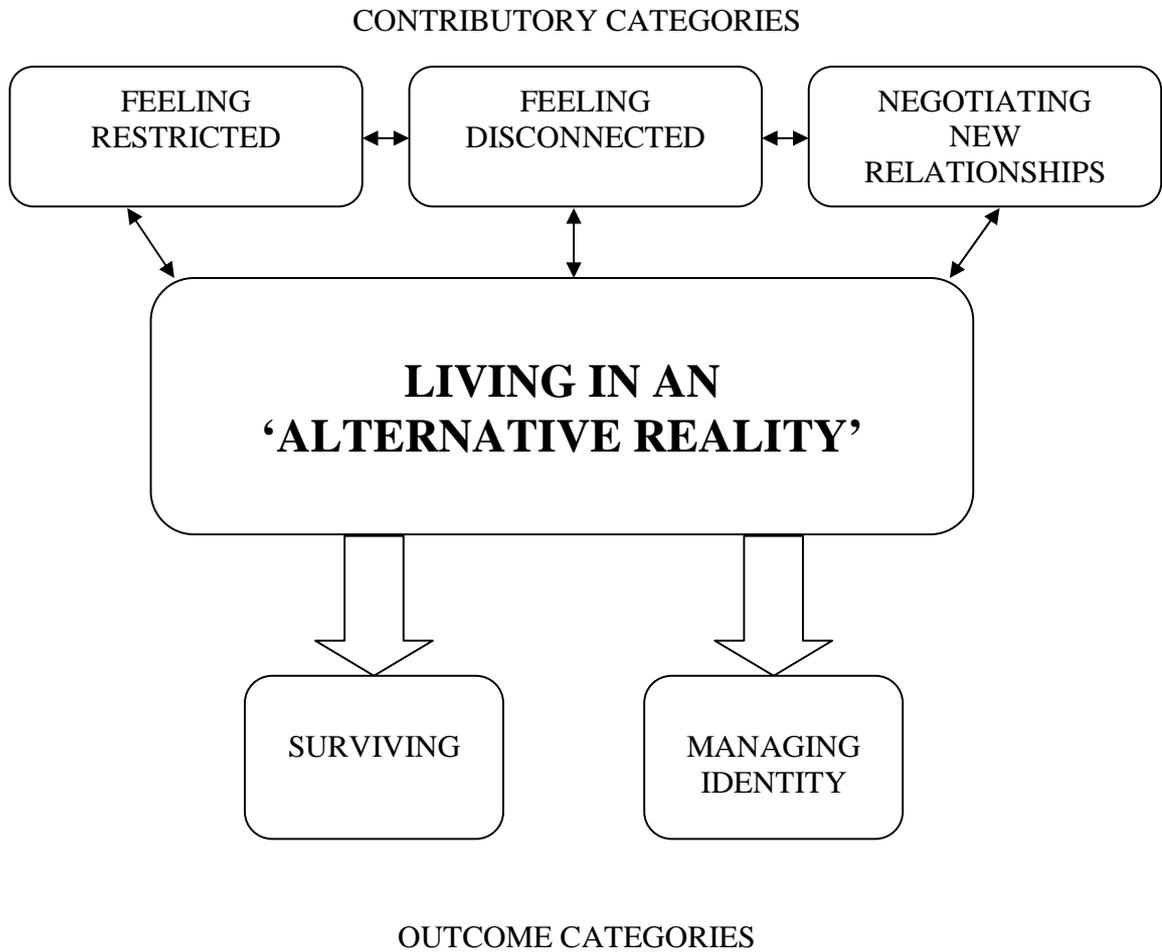
#### 3.1 Overview of the Model and Core Category

Charmaz (2006) describes the core category in a grounded theory analysis as the key factor which conceptualises the 'story' of each transcript. Main categories thus represent the primary aspects of the story whilst sub-categories further explicate the narrative details. The core category generated from the current analysis was termed 'Living in an Alternative Reality' to reflect the way in which participants experienced hospitalisation as outside of their normal sphere of reference. Five main categories were identified: Feeling Restricted, Feeling Disconnected, Negotiating New Relationships, Surviving and Managing Identity. Each of these related to the core category and were comprised of further sub-categories as explored in the relevant sections below.

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<sup>16</sup> A numbered asterix within the text (e.g. \*1) directs the interested reader to further supporting quotes contained within Appendix H.

**FIGURE 1: THE PROCESS MODEL**



### 3.1.1 The Process Model

The five main categories were grouped under two organisational headings within the process model: contributory categories and outcome categories. These boundaries were somewhat artificial, as participants did not always neatly group their experiences in this way. Nonetheless, for the purposes of the model the researcher found it useful to do so, particularly as it helped her understanding of the core category. The main categories of 'Feeling Restricted', 'Feeling Disconnected' and 'Negotiating New Relationships' all contributed to participants' sense of living in an alternative reality during admission (e.g. living with unusual rules and routines, feeling disconnected from normal everyday life, managing community living with unfamiliar people), whilst the main categories of 'Surviving' and 'Managing Identity' were viewed as outcome categories, as they dealt with the ways in which participants responded to, and managed the experience of living in an alternative reality.

It should be noted that contributory categories were seen as component parts of the core category rather than casual factors per se. This is reflected in the cyclical nature of the model (indicated by double-headed arrows) whereby feelings of restriction (for example) may contribute to participants' overall sense of living in an alternative reality, whilst at the same time, feelings of living in an alternative reality may exacerbate participants' feelings of restriction. There were also relationships between some of the main categories. For example, many of the rules and routines which contributed to participants feeling restricted, also exacerbated their feeling of disconnection from the outside world (e.g. not being allowed phone contact with friends). Both these categories in turn affected the way in which participants were able to negotiate new relationships on the ward, and all three contributory categories influenced the emotional reactions described by participants and the coping strategies they chose to employ in response.

### 3.1.2 The Core Category: Living in an Alternative Reality

The sense of living in an alternative reality permeated all participants' accounts of their experience of hospitalisation. The overall feeling was one of difference; that this was an experience both unknown and unusual, which differed from participants' everyday lives in countless ways and was consequently difficult for those on the 'outside' to understand (\*1).

*“It was just like completely different to anything else I’ve ever experienced, it’s like I don’t know, I just can’t put it into words, how different it was.” (Holly/199)*

*“I don’t think you can understand unless you’ve been here yourself”*

*(Natalia/372)*

The feeling of living in an alternative reality had implications for participants' reactions to, and ways of coping with, the experience. Participants had to deal with the unexpected and out of the ordinary on a daily basis, which evoked a range of emotions such as fear, disgust and confusion. This appeared particularly hard at the start of an admission when participants knew least about what to expect (\*2):

*“I remember just going into the office and it was (.) really weird because I was talking to someone about self-harming and stuff like that, and we had to go through all the paperwork and then I had to go and have some sort of medical stuff done (.) and it was kind of scary ‘cause I was new in that situation and I didn’t know what to expect. It was horrible.” (Keira/98)*

These unexpected or difficult to understand experiences were not confined to the start of admission however, with participants witnessing violence, aggression and self-harm frequently throughout admission (\*3). In particular, seeing other young people in distress was very hard for participants and appeared to be a key contributor to their sense of things being different or strange (\*4).

*“I: So how did you feel when you saw that, when you saw someone that was obviously quite poorly?”*

*P: I don't, I don't know...it was just something like this alternative reality thing and it was just like, like there was nothing I could do about it and stuff and (.) like, like I didn't know what was going on so I didn't, I just didn't know what to think”*

*(Holly/433)*

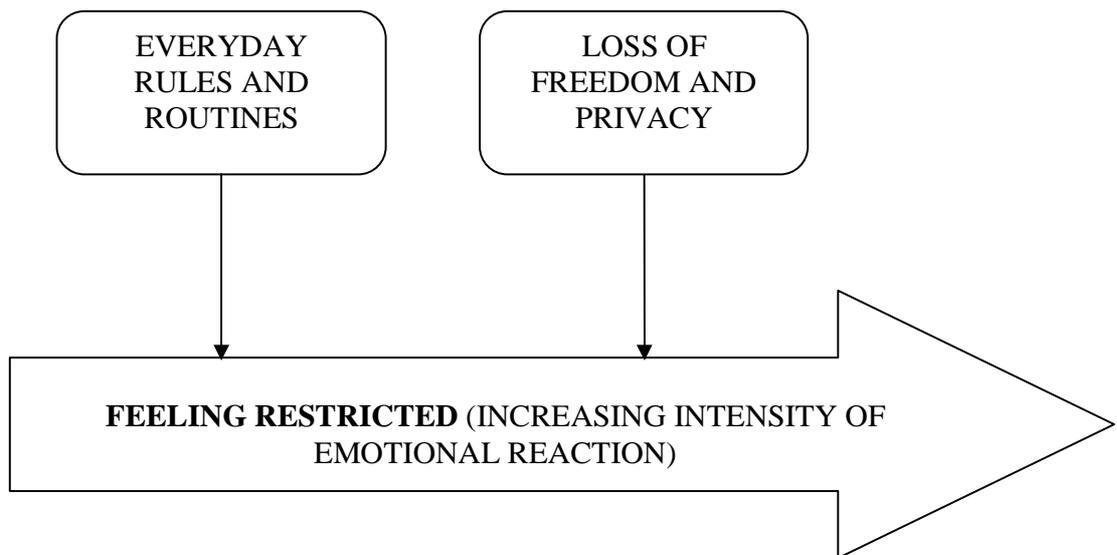
In addition, the more mundane aspects of hospitalisation (such as being away from home, in a new and unfamiliar environment, governed by unusual rules and routines) were also unnerving for young people and led to them feeling restricted and disconnected, which in turn exacerbated their sense of living in an alternative reality during admission (as explored below). Overall then, various factors contributed to the feeling of living in an alternative reality and moving forwards seemed in many ways to involve reconnecting to the 'real world'. For example Phoenix, a young woman nearing discharge, described the importance of re-learning “*life skills*” such as going shopping and using public transport, in the process of recovery. The following sections explore all aspects of this process in more detail.

### 3.2 Contributory Categories

#### 3.2.1 Feeling Restricted

'Feeling Restricted' was a contributory category in that participants' experience of feeling restricted during admission contributed to their overall sense of living in an alternative reality. In particular, the existence of unusual rules and routines made daily living very different from life outside hospital. As shown in Figure 2, two closely linked sub-categories added to participants' feelings of restriction, whereby participants felt increasingly restricted with each of these aspects of ward life.

**Figure 2: Main Category- Feeling Restricted**



##### 3.2.1.1 Everyday Rules and Routines

The rigid routine of ward life made a substantial contribution to participants' feelings of restriction and was frequently associated with minor negative emotions such as boredom and annoyance (\*5). General rules associated with community living also affected participants as illustrated in the quote below:

*“What I found stressful was the fact of (.) when I first moved into the hospital I loved watching films. Now I used to watch 18s all the time and I came here and I was told I’m not even allowed to watch 15s because there was two lads on the unit that was 14”*

*(Chris/304)*

Interestingly, some participants used analogies to convey how they had experienced daily life in hospital. These analogies suggested that: a) the ward environment was indeed very different from the usual everyday environments young people might expect to find themselves in and b) that they were nevertheless able to make sense of the ward environment in terms of other more ritualised environments they may have encountered (\*6):

*“It reminds me so much of an old people’s home...all the nurses walking around...and the fact that you wasn’t really allowed out, and you had your set times for stuff and it was just how I expected an old people’s home to be”*

*(Holly/242)*

### 3.2.1.2 Loss of Freedom and Privacy

The loss of freedom and privacy associated with hospitalisation engendered strong emotional reactions from participants and was frequently described as the ‘worst’ aspect to being admitted (\*7). In particular, the process of observation caused participants to feel scrutinised and infantilised, which in turn led to them feeling increasingly restricted (\*8). Control and responsibility played a key role here, in that participants felt that others had taken control over them (\*9). Phoenix’s words below illustrate how difficult it was to manage this feeling and how it affected her relationships with staff at the start of her admission:

*“I got very angry with a lot of people I shouldn’t have got angry at. I got quite violent, um towards the staff because I saw them as keeping me prisoner, keeping me prisoner inside this place...I just felt really hostile towards the staff for keeping me here, for locking me in.”*

*(Phoenix/105)*

However over time, as the young person made progress, they appeared more able to reflect on the amount of containment they may have needed at the start of admission and were thus able to view the actions of staff in a different light (\*10).

Participants were also more able to understand the need for certain rules or losses of freedom/privacy at any point during their admission, if they were able to see the relevance to their or others’ well-being. Thus in these cases rules and routines appeared to take on a more protective/individualised quality in participants’ minds (\*11).

*“like some of the people weren’t allowed to have baths with the door locked for obvious reasons and stuff, and it’s like you could just see why they had that rule”*(Holly/365)

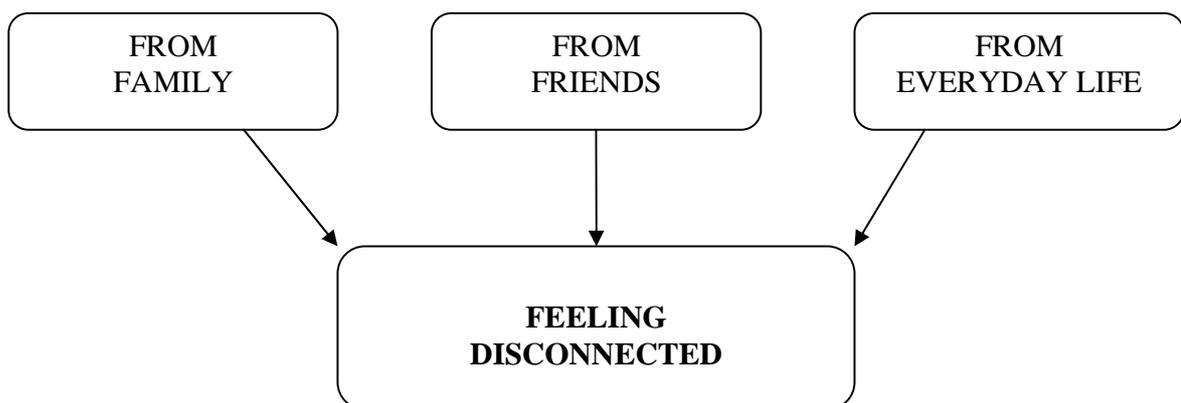
Overall, regaining freedom and autonomy was an important part of the road to recovery and appeared to be associated with positive outcomes such as increased self-esteem (\*12).

Participants’ responses to and ways of coping with the overall experience of feeling restricted are explored in more detail in section 3.3.1 below.

### 3.2.2 Feeling Disconnected

'Feeling Disconnected' was also understood as a contributory category, in that participants' sense of feeling disconnected from their normal reality appeared to exacerbate their overall feeling of existing within an alternative reality during hospitalisation. As shown in Figure 3, participants identified three types of disconnection; 'From Family', 'From Friends' and 'From Everyday Life'. Mike represented a deviant case in this category, in that he did not speak explicitly about feeling disconnected from his life outside of hospital. However, Mike did report that he had not had any contact with any family, carers or friends since his arrival at hospital. In the context of the category of feeling disconnected it therefore appeared that Mike may have experienced the most extreme level of disconnection of all participants, and that this may have been difficult for him to discuss.

**Figure 3: Main Category- Feeling Disconnected**



### 3.2.2.1 From Family

All participants (except Mike) described feeling disconnected from their family during their admission. For many participants this was the most difficult aspect to being in hospital and was associated with feeling isolated and alone (\*13). The amount of contact, either by phone or face to face, which participants were able to have with their family during admission, impacted on their feelings of disconnection and was thus important for their well-being (\*14). As such, participants struggled when they felt that family had forgotten them (\*15) or when their family relationships were strained, as illustrated by the series of short quotes taken from Cameron's transcript below:

*“I used to see them every two weeks but I've since fallen out with them so I've not seen them for a few weeks...They probably want me here...they probably don't miss me...I don't have a good relationship with any of my family. I've got no-one to talk to if I have a problem”* (Cameron/295...)

Further, not being around to help out with family difficulties, to witness family events, or just to see younger siblings grow up, was difficult for those participants on longer admissions (\*16) and was associated in some cases with a feeling of helplessness due to loss of role within the family:

*“Since the accident I mean every single day my sister's asking for me to come and see her, but she just doesn't realise no I'm not coming, I can't come see her... I was the man of the family, the very time the family needed me I was locked up”* (Chris/639)

### 3.2.2.2 From Friends

Participants also experienced disconnection from friends and found it difficult to maintain existing friendships within the ward environment, due to ward rules or the conflicting priorities of their hospital and home lives (\*17). Unlike family relationships, which on the whole appeared to remain intact despite hospitalisation, friendships were more likely to change or deteriorate during the time of admission. For some participants these changes were manageable, as it was clear their friends still considered their friendship important, due to the fact they still initiated contact of some sort (\*18). However for others, hospitalisation, marked by a lack of contact, resulted in a long-term breakdown of friendships, which caused them to feel hurt and saddened (\*19). Being admitted to a mental health unit in particular appeared to contribute to the deterioration of friendships, with participants experiencing misunderstanding, stigma and prejudice from peers<sup>17</sup> (\*20):

*“I don’t think many people are quite open-minded about people going to a Psychiatric hospital. I think they probably thought I was going crazy or something...I think maybe they just wanted to distance themselves from me because of it” (Holly/672)*

The disconnection process was further complicated by the fact that some participants took an active role in disconnecting from friends as part of their recovery. Thus, the feeling of being disconnected from friends on being admitted to hospital was reflected upon positively later in admission by some participants, due to the perceived role those friends held in causing and maintaining their individual difficulties prior to admission (\*21):

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<sup>17</sup> Participants did not generally experience stigma from family members, although one participant, Natalia, explained that her parents had decided to keep her admission a secret from extended family, as they had felt “embarrassed”, which had caused Natalia herself to feel “upset”.

*“I was involved with a group that basically they were going down and they were trying to drag me down with them, a lot of drugs and alcohol and stuff, so I just come down here, and I’ve just cut off all contact with them, I didn’t want that for myself” (Phoenix/490)*

### 3.2.2.3 From Everyday Life

Alongside feeling disconnected from significant relationships, participants also experienced a feeling of disconnection from their everyday lives, as illustrated by the words of Cameron:

*“I mean not that long ago I went out into the community for the first time, and I was surprised all the stuff I’d forgotten, people doing their daily stuff...just seeing people gardening, walking the dog, waiting for the bus, driving about” (Cameron/305)*

Perhaps even more powerful, are the words of Chris and Yasmin who felt they were missing out on “*being eighteen*” and “*life*” respectively. Hospitalisation was therefore experienced as an interruption to daily life, which caused participants to miss out on particular events or valued aspects of their lives (\*22). Hospitalisation was also seen as affecting participants’ achievements and long-term goals, primarily due to the negative effect it had on their education (\*23). Peer comparisons played an important role here, in that participants were liable to compare their own achievements to those of their peers, as illustrated by the quote below (\*24):

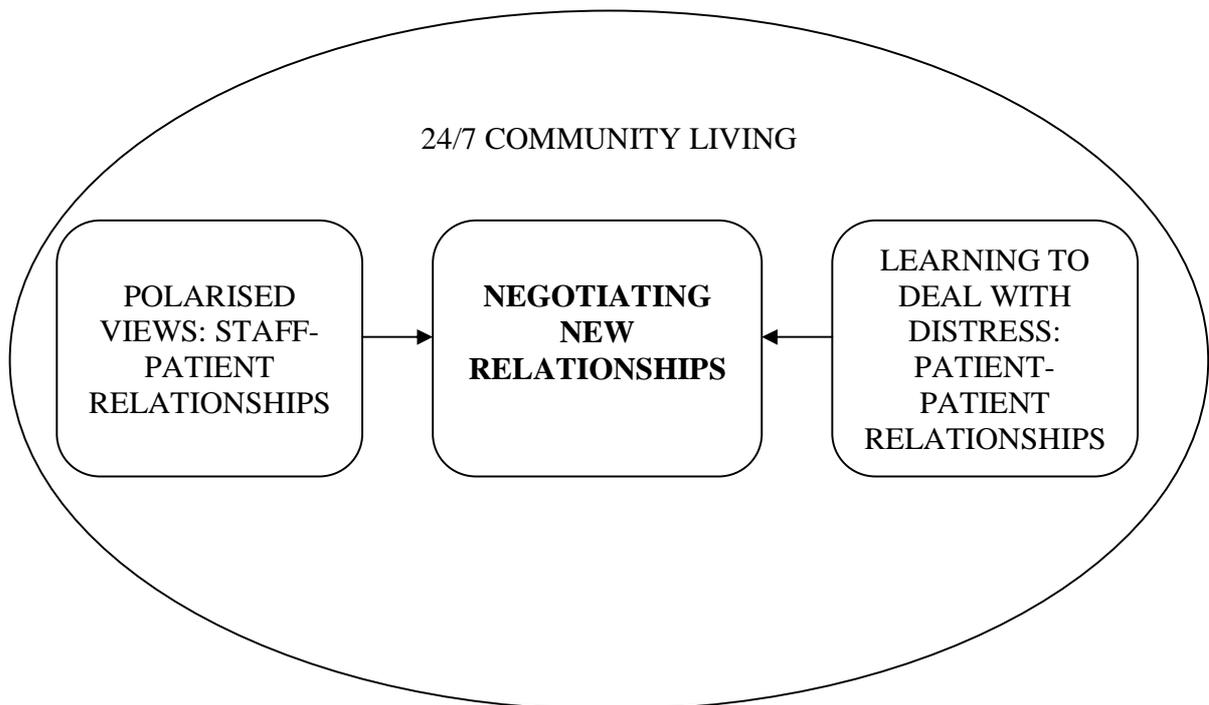
*“Well I look at other people my own age. See one of the staff down at reception, she’s the same age as me, and she’s got a job, and she’s you know been to college or whatever, and I’ve missed out on that. I should’ve been to college and I should be doing all these things that other people my age are doing, and I feel a bit trapped in here in that” (Phoenix/311)*

Once again, participants' responses to and ways of coping with the overall experience of feeling disconnected are explored in more detail in section 3.3.1 below.

### 3.2.3 Negotiating New Relationships

The final contributory category in the current model was termed 'Negotiating New Relationships' to reflect the active way in which participants were expected to navigate new and often complex relationships with staff and peers, within the unfamiliar '24/7' context of the ward environment, as illustrated in Figure 4.

**Figure 4: Main Category- Negotiating New Relationships**



### 3.2.3.1 Polarised Views: Staff-Patient Relationships

Participants' relationships with staff tended to be polarised, in that they would react positively to some staff and negatively to others (\*25). Whilst this was sometimes acknowledged as reflecting their personality, it was more frequently attributed to the actions of staff, with 'good' staff described as genuine and caring and 'bad' staff as manipulative and authoritarian:

*“Some staff are really, really good, they put up with a lot, and you can talk to them about anything, but others, you feel like they’re on a power trip and they set out to piss you off”*

*(Natalia/237)*

Participants also experienced polarised reactions to different aspects of the nursing role, whereby they valued the support offered by staff but disliked the risk-management aspect of the relationship (\*26). As such, staff finding time to talk to patients was seen as extremely important and appeared to damage relationships when it was not readily available (\*27). Indeed, Phoenix's words below suggest that talking with staff was important as it provided some 'normality' within the context of the 'alternative reality':

*“P: They’ll come and they’ll eat with you, we’ll have lunch together and tea together and we’ll sit together and chat and talk, just about normal everyday things.*

*I: Does that feel helpful do you think?*

*P: Yeah, because it really makes you realise that you’re being nursed by people as well, not just machines really.”*

*(Phoenix/152)*

Overall, participants appeared to take a reasonably passive stance in relation to managing their polarised reactions to staff. There was a sense that young people had little power in the ward environment and thus were required to ‘get on with it’ in terms of coping with those members with whom they had poorer relationships. For example, Cameron explained that he just tried to “ignore” staff members who tried to wind him up, whilst Phoenix relied on the fact that the most manipulative staff members “*tended not to last very long*” on the ward.

### 3.2.3.2 Learning to Deal with Distress: Relationships with Other Young Inpatients

Participants’ relationships with other inpatients were characterised by an ongoing process of learning to deal with others’ distress. Thus, in the early stages of admission participants were considerably affected by the obvious distress surrounding them in the ward environment (\*28). In particular, participants lacked knowledge and understanding about the specific difficulties faced by other patients, which caused confusion over how to act around other patients and feelings of helplessness and guilt due to not knowing how to respond (\*29):

*“Kirsty and Hannah they wouldn’t eat, and they would just sit there picking at their food, they wouldn’t eat. Don’t know what was the matter with them, think they had some sort of eating problem, and so here I was eating, and then one time, I felt really awful, there I am eating and those two are sitting there just picking at their food, while I was sitting there eating my chips and everything”*

*(Britney/481)*

As time went on however, participants became more able to tolerate seeing others in distress and were thus able to form closer relationships with some other inpatients. Learning about other young people's difficulties was an important part of this process, as it helped participants to feel safer and more equipped to respond to their peers' problems (\*30). In fact, proximity to other young people with 'problems' came to be a valued part of the hospitalisation experience, as it helped participants to feel less alone, to feel understood and to put their own problems into perspective (\*31).

Mike represented a negative case in this respect, as he drew a very clear dividing line between himself and all other patients, which he was not keen to cross. The researcher hypothesised that this may have been due to his relatively 'new' status on a long-stay unit. Thus he may not have moved past the initial stage of finding it hard to tolerate others' distress:

*"I don't mix with them... 'cause they're mentally ill...they're just mentally ill and I've got my own problems. I just don't wanna get involved in their mental illness"*

*(Mike/64)*

### 3.2.3.3 '24/7' Community Living

Participants frequently placed their relationships with staff and other patients in context, by explaining how all of these relationships had to be negotiated on a '24/7' basis (\*32). Thus participants had to manage community living, often for the first time, which again added to the unusual nature of the overall hospitalisation experience from their perspective.

*“I mean I’ve been frustrated before you know, I’ve been around somebody so long that they’ve got right on my nerves, and I’ve ended up flipping. You know, you’re with the same people 24/7...I mean you eat with them, you practically sleep with them, you do everything around them”* (Chris/284)

Community living was frequently associated with negative emotions such as frustration and anger towards other patients, incidents of aggression, and occasionally more far-reaching consequences, as described by Mags below:

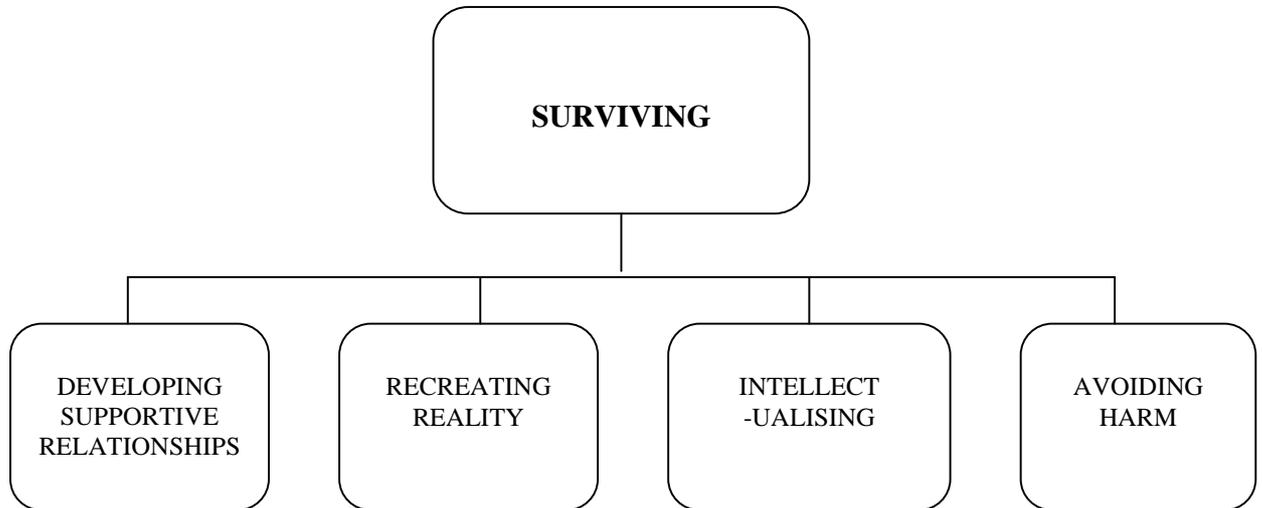
*“How can you get better when there’s another like million patients in the same hospital trying to get better? And if they make a mistake, you make a mistake. Just how the hell can you get better like I mean living with people? Do you know like me and another patient had a fight and how can we like behave and settle down and that while we’re in the same room and the same unit as that patient”* (Mags/166)

### **3.3 Outcome Categories**

#### **3.3.1 Surviving**

‘Surviving’ was understood as an outcome category as it encompassed the active strategies participants used to make sense of, and cope with, the experience of ‘Living in an Alternative Reality’ during hospitalisation. These processes appeared to help participants to manage the wide variety of emotions they experienced as a result of ‘Feeling Restricted’, ‘Feeling Disconnected’ and ‘Negotiating New Relationships’. As shown in Figure 5, four main sub-categories were identified:

**Figure 5: Main Category- Surviving**



### 3.3.1.1 Developing Supportive Relationships

Participants described developing supportive (i.e. reciprocal and non-judgmental) relationships with some of the other young inpatients (\*33), which appeared to help them cope with the negative emotions associated with hospitalisation, often through the simple process of listening and talking (\*34). Support could also take a more active form however. For example, Britney described how a group of residents helped one individual with the experience of feeling disconnected:

*“On her birthday as well nobody phoned her...none of her family sent her cards or anything and she got so upset, that like you know, all day she just kept hugging me and everything...we threw a little party, and like we joined, all us girls went into Kirsty’s dorm ‘cause it was the biggest, then we pushed the beds against the wall and put some music on and had a good time”*

*(Britney/1133)*

Supportive relationships were also important in helping participants to manage anger and aggression on the ward, whereby young people frequently talked each other out of difficult situations (\*35):

*“If they’re wanting to kick off then I’ll sit there and talk to them, make them change their mind. If they want to self-harm I’ll sit there and talk to them, stop them from doing it”*

*(Yasmin/230)*

Finally, participants appeared to feel safer the closer they were to other residents (\*36), indicating another important function of this coping strategy.

### 3.3.1.2 Recreating Reality

Participants spoke about the importance of taking part in ‘normal’ everyday activities on the ward (\*37), which was understood as them attempting to recreate a more familiar reality within the unfamiliar context of the ward environment. Actively recreating reality thus appeared to help participants cope with many of the unusual aspects of the hospitalisation experience, by alleviating boredom (\*38), minimising disconnections (\*39) and helping them to manage the restrictions of the ward environment:

*“We’ve got a church on site...going there gives me a bit of freedom out of this place. It gives me a chance to get out of here”*

*(Mike/164)*

Participants also used internal strategies to recreate a more familiar reality. For example, it was common for participants to view the other inpatients as family members (\*40), which appeared to help them to find a familiar role within the ward environment:

*“If I was at home I would be the man of the family so I would be looked at in protecting my family, and I look at the lads on the unit as my family, so you know, when one of them was getting attacked it was basically as if you’re saying you know, my mother or my brother was getting attacked. So I’d just forget you know, that they were patients, and split ‘em up”* (Chris/551)

### 3.3.1.3 Intellectualising

Participants employed a number of different intellectual strategies to survive their time in hospital, including normalising (\*41), rationalising, looking forward and thinking positively. These strategies were often used to help participants make sense of the overall experience of being in hospital and any associated outcomes, and appeared to defend against negative emotions such as shame and sadness. For example, Holly used rationalisation to understand why some of her friendships had broken down since she had been in hospital, whilst Chris used normalisation to cope with experiencing stigma (\*42):

*“I just think well, you know, that was then, and if you know they were like that, then they couldn’t have been real friends”* (Holly/689)

Further, looking forward and thinking positively appeared to be particularly useful in helping participants to think about the future and to minimise the overall impact of hospitalisation:

*“I: How have you kind of managed those feelings about having missed out on college and things?”*

*P: I just reassure myself I can always do it another time. Try and think positive and look forward”* *(Natalia/223)*

#### 3.3.1.4 Avoiding Harm

For some participants avoidance was an important coping strategy, particularly in terms of coping with the violence and self-harm they witnessed as an inpatient. This could take the form of active avoidance, for example walking away from arguments (\*43), or intellectual avoidance (\*44), as described by Phoenix:

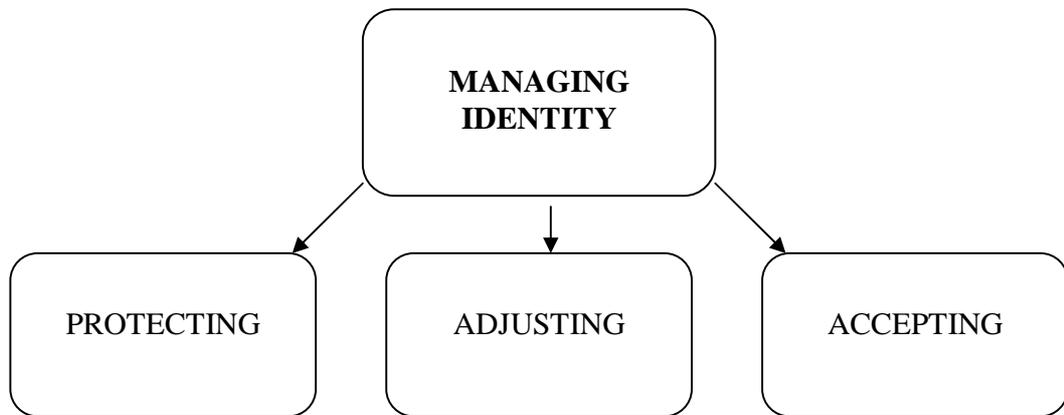
*“It’s hard when you’re living with all that violence. I would just try and shut off. I’d disappear into my own little world, my own bubble and just exist in that bubble.”*

*(Phoenix/466)*

#### 3.3.2 Managing Identity

Participants also used particular strategies to manage the impact of hospitalisation on their developing identity and sense of self. As shown in Figure 6, three distinct strategies were identified which, whilst distinct in the sense of being different from one another, were often used in conjunction by participants at different times or for different purposes, as explored below.

**Figure 6: Main Category- Managing Identity**



### 3.3.2.1 Protecting

It was sometimes important for participants to protect their identity from the full impact of hospitalisation and/or their diagnosis and they did this in a number of ways. For example, some participants viewed other patients as ‘mentally ill’ but did not include themselves in this category (\*45), which appeared to protect against the negative connotations of this particular label:

*“I don’t think I’m mentally ill, I’ve just got behaviour problems” (Mags/500)*

Further, some participants used more sophisticated methods to protect their identity, such as giving caveats to their diagnosis or externalising their psychiatric symptoms:

*“I have borderline personality, but I don’t have what most people have with it, I just have the attention part” (Chris/172)*

*“The panic attacks like aren’t who I am, they’re just like a part of me. Like um, there was a girl in there I was talking to, and she was saying that she really hates in when people say that she’s anorexic, ‘cause she’s not anorexic, just anorexia is a big part of her”*

*(Holly/743)*

### 3.3.2.2. Adjusting

Adjusting was also an important tool in terms of managing identity, whereby it seemed useful for some participants to adjust aspects of their identity, in order to counteract the negativity associated with a psychiatric admission. The active role some participants took in disconnecting from their previous friendship groups was a good example of this. Hence, having the ‘wrong friends’ came to be associated with the problems leading to hospital admission, meaning that participants needed to adjust their view of the type of friends they wanted and thus the type of person they had previously been. Being able to adjust goals or aspects of identity, although difficult, was therefore considered useful in relation to thinking about the future (\*46).

*“I used to hang around with people that was older than me and you know I’d drink with them, smoke weed, just do things like that...I’m gonna make new friends at home (.) good friends. And if they have contact with crime then fuck that I ain’t getting back in that...all I used to think about is drugs and sex, but I’ve changed now ‘cause all I think about now is just getting out of here, and meeting the girl that I wanna meet, have kids.”*

*(Mags/337)*

### 3.3.2.3 Accepting

Finally, the strategy of ‘accepting’ appeared to play a key role in managing identity in some cases. Accepting the existence of problems or accepting a diagnosis appeared to be synonymous with self-acceptance for some individuals, which was an important part of their starting and continuing to make progress on the ward (\*47). In particular, accepting their ‘illness status’ or their diagnosis appeared to help some individuals to feel less negatively about themselves and to feel more understood by others (\*48):

*“At first I thought I was kind of just attention-seeking and I was doing things just for no reason, but being here has made me think that I actually am ill. So I know it’s not an excuse or anything but it’s made me not feel as bad”* (Keira/394)

Cameron represented a negative case in this sub-category in that he felt very negative about himself and his future, despite being very ‘accepting’ of his personal difficulties and numerous diagnoses. Interestingly, Cameron appeared to have been given his diagnoses at quite a young age before coming to hospital, which may have affected how he felt about his overall prognosis. Further, Cameron’s experience suggests that acceptance in the context of the ward environment may be more helpful than acceptance *per se*, presumably because the attributions of what is being accepted are of particular importance (i.e. seeing yourself as ‘ill’ in the context of being admitted to hospital may be more useful than seeing yourself as ‘ill’ in wider society).

## **4. Discussion**

### **4.1 Interpretation of results**

The following section aims to interpret the results of the current research in the context of the research questions, pre-existing literature, and relevant psychological theory. Whilst psychiatric hospitalisation has been acknowledged as stressful for adolescents (Puotiniemi & Kyngas, 2004) very little research has explored the experience from a service-user perspective. The current model thus provides an initial understanding of psychiatric hospitalisation from the adolescent perspective, with particular reference to the possible psychological impact of the experience and to the ways in which hospitalised adolescents cope.

#### **4.1.1 Core Category and the Process Model**

'Living in an Alternative Reality' was chosen as the core category in the current model as it reflected the unusual nature of the overall hospitalisation experience from the adolescents' perspective. Further, the phrase 'alternative reality' was used by one of the participants, thus strengthening the face validity of the category name. The sense of living in a different world during hospitalisation has been reported by other groups of psychiatric patients and has been associated with the dehumanising and institutional nature of inpatient care and an overall feeling of being cut off from 'normality' (Cutting & Henderson, 2002; Letendre, 1997); seemingly reflected in the current categories of 'Feeling Restricted' and 'Feeling Disconnected'. In terms of the possible psychological impact of this experience, Lynam (2007) has discussed how research participants from similarly 'marginalised' groups have experienced diminished occupational

potential, decreased opportunities for new relationships and difficulty acquiring new competencies, due to others' assumptions about their decreased abilities.

The occurrence of unexpected or difficult to understand experiences on the ward was a key contributor to the feeling of living in an alternative reality. The fact that participants reported frequent incidences of violence, aggression and self-harm is concurrent with previous research findings which suggest that inpatient wards are unsettled and volatile places (Calton & Arcelus, 2003; Davis, 1991; James, Fineberg & Shah, 1990; Mellesdal, 2003; Owen, Tarantello, Jones & Tennant, 1998; Walker & Seifert, 1994). Research conducted with adult psychiatric inpatients has begun to explore the psychological impact of such experiences and has highlighted the likelihood of strong affective reactions such as fear and horror (Cusack, Frueh, Hiers, Suffoletta-Maierle & Bennett, 2003). In the current study participants appeared to experience similar emotional reactions particularly at the start of admission.

As Geoff Brennan an experienced psychiatric nurse describes; 'In-patient wards can be frightening for everyone. They are strange places, full of strange people and strange rules' (Brennan, 2007. p.163). In the current model, the main categories of 'Feeling Restricted' and 'Negotiating New Relationships' reflected the way in which environmental and relational aspects of hospitalisation contributed to participants' sense of living within an alternative reality during admission. The experience of 'Feeling Disconnected' also added to the core category, in that participants' sense of living in an alternative reality during admission was exacerbated by their sense of disconnection from their family, friends and usual routine. Again, this compounds the sense of the psychiatric hospital as some 'other-world' which inpatients must first come to terms with, then learn to live with, and finally begin to extricate themselves from.

#### **4.1.2 Contributory Categories**

The experience of 'Feeling Restricted' during admission has been well documented by research with adult psychiatric inpatients and has been linked with strong affective reactions such as anger, fear and humiliation (Beveridge, 1998; Luckstead & Coursey, 1995; Rooney, Murphy, Mulvanney, O'Callaghan & Larkin, 1996). The current participants felt scrutinised and infantilised as a result of being observed on the ward and were particularly angry and upset at the start of admission. In relation to this, findings from qualitative research have suggested that the loss of dignity, identity and social roles associated with a psychiatric admission promote negative appraisals of the self, which may in turn lead to heightened negative emotions (Letendre, 1997; Roe & Ronen, 2003). Letendre (1997) terms this the 'domination process' to reflect the way in which inpatients feel they have been completely dominated by staff. This process may be even more applicable to adolescent inpatients, who may not have chosen to come to hospital and who may have even less power due to their age and social status. Interestingly, participants tended to view their initial containment more positively as they moved through their admission, a finding which has also been reported by other researchers (Luckstead & Coursey, 1995).

The current research identified 'Feeling Disconnected' as another key aspect of the hospitalisation experience. Disconnection from family was most upsetting for participants and highlighted the need for adequate contact during admission. In addition, research has demonstrated the importance of engaging families in inpatient care in terms of ensuring a good treatment outcome (Brinkmeyer, Eyberg, Nguyen & Adams, 2004). Attachment theory (Bowlby, 1969) may be a useful theoretical framework for understanding this particular category. Thus, children and young people with psychiatric difficulties may be more likely to have an insecure attachment to their primary care-givers, making it harder for them to successfully manage a

prolonged period of separation (Heard, 1981). Further, whilst adolescence undoubtedly involves achieving autonomy and individuation from parents, this is usually most successful when it is completed gradually and with close parental support (Hill, 1993). This suggests that staff working with hospitalised adolescents may need to be mindful of the possibility of becoming ‘interim’ attachment figures, who would presumably need to provide a secure base for the adolescent within the ward, from which they could begin to reconnect with the outside world.

Interestingly, the process of disconnection from friends was particularly complicated and appeared to be mediated by various factors. The fact that some participants experienced stigma was unsurprising considering the wealth of evidence supporting the existence of stigma for this group (e.g. Link, Struening, Rahav, Phelen & Nuttbrock, 1997; Markowitz, 1998; Murphy, 1998; Wahl, 1999). However, as suggested by previous literature, participants did not demonstrate completely uniform reactions to stigma (see Corrigan & Watson, 2002). For example, whilst Holly demonstrated a negative emotional reaction, Chris appeared to be ‘righteously angry’ and Britney’s reaction could be described as ‘indifferent’. In terms of perceived value of existing friendships, it was notable that a number of participants chose to actively disconnect from their previous friendship group. Considering the loss of personal control associated with feeling restricted, it is hypothesised that this was one area in which adolescents felt more able to take some control back, which may have been important in re-instating self-efficacy and self-esteem.

The disconnection from everyday life experienced by participants suggests how hospitalisation may have more far-reaching effects upon overall achievement and life events. Research conducted with adult participants has started to explore the effects of hospitalisation on employment and family relationships, both directly and as mediated by decreased self-efficacy and self-esteem (see Townsend & Rakfeldt, 1985). Participants in the current study were

certainly concerned about their future prospects and were particularly prone to comparing themselves to their peers who did not have psychiatric difficulties or had not experienced hospitalisation. According to social comparison theory (Festinger, 1954) this may be expected, as social comparison tends to increase at times of individual stress and anxiety. Consequently, participants' close relationships with other inpatients may have been of particular importance in terms of protecting them against these negative peer comparisons.

'Negotiating New Relationships' represented the final contributory category in the current model. Participants experienced polarised relationships with staff, which could be interpreted using the psychodynamic concept of splitting. This suggests that individuals in psychiatric distress may view the world in black and white terms in order to gain relief from internal distress (Halton, 1994). In institutional environments, this may cause some staff to be viewed as all 'good' and some as all 'bad' (Menzies, 1979). Participants also described 'split' reactions to individual staff members according to which aspect of the nursing role they were adopting at the time. This tension between different aspects of the nursing role has been similarly highlighted from the perspective of staff members, who have identified how difficult it is to balance therapeutic interventions with the level of crisis and risk management demanded on contemporary inpatient wards (Fourie, McDonald, Connor & Bartlett, 2005).

Actual difficulty in accessing consistent support from nursing staff may also partly explain why the current participants placed such a high value on the development of supportive relationships with other young inpatients. Participants' relationships with other inpatients generally developed over time and involved participants moving from a position of fear and uncertainty towards understanding and mutual support. This finding builds upon previous research which has highlighted a polarity in participants' relationships with other inpatients (Colton & Pistrang,

2004) and introduces a chronological element to relationship change. Further, whilst the importance of peer relationships has been identified by previous research (i.e. Grossoehme & Gerbetz, 2004; Thomas, Shatell & Martin, 2002), Mike's reaction to other inpatients in the current study and the negative aspects to peer relationships described in '24/7 community living', highlight that close peer relationships will not be appropriate or necessarily helpful for every young person at every point during admission.

#### **4.1.3 Outcome Categories**

The variety of coping strategies described within the main category 'Surviving' suggested that participants were constantly reacting to, and dealing with, their experience of hospitalisation in an active and responsive way. Some coping strategies employed by participants related directly to the ward environment and involved replacing or substituting important relationships or roles. For example, the need to develop supportive relationships with other young inpatients may have been in response to a perceived lack of emotional support from staff (as discussed above), whilst reinstating reality appeared to relate to participants' need to rebuild a familiar environment and carve out known roles for themselves within the ward setting. The latter of these strategies in particular may have protected against decreased self-esteem, as this has been linked with loss of role in psychiatric inpatients (Roe & Ronen, 2003). Avoiding harm represented another way in which participants protected themselves in the ward environment and supports previous research which has demonstrated that service-users often take an active role in keeping themselves safe on wards (Quirk & Lelliott, 2004). Finally, the intellectual strategies utilised by participants can be understood within a psychodynamic framework, which would suggest that strategies such as normalisation and rationalisation constitute defence mechanisms, employed to protect the individual from harmful or unbearable inner feelings (Lemma, 2003).

Developing individual identity is generally accepted as one of the key tasks of adolescence (Hill, 1993). As such, it is perhaps unsurprising that the process of 'Managing Identity' emerged as a distinct category in the current model. Previous research conducted with adult psychiatric inpatients may be of assistance in understanding the strategies employed by adolescents: For example, 'first-contact' patients have been shown to draw strong cognitive boundaries between themselves (seen as sane) and other patients (seen as mad) as in the current category of 'Protecting'. These boundaries are seen as protecting the individual from the most negative attributions associated with psychiatric admission; particularly those related to self-concept and self-efficacy (see Townsend & Rakfeldt, 1985). Interestingly, 'Adjusting' tended to be most frequently employed by those young people whose difficulties had a strong behavioural component or were strongly influenced by environmental factors. This suggests that employing an 'active' coping strategy was appropriate, as the young person may have perceived these problems as controllable on some level. Conversely, the strategy of 'Accepting' was perhaps more appropriately employed by those individuals who perceived less control over their difficulties (i.e. those with a stronger 'mental-health' component).

The three strategies were not necessarily used in opposition. Instead they appeared to represent intertwined processes. For example, it is hypothesised that accepting the existence of problems on some level may be important for beginning to move forward, whilst protecting may be necessary to minimise the overall negativity of that which is being accepted. The importance of acceptance, in relation firstly to self-acceptance and secondly to recovery from mental health problems, has been recognised by other researchers and is gradually being formalised within psychological theory and practice. For example, Acceptance and Commitment Therapy has been shown to reduce symptomatology and rate of rehospitalisation in individuals with psychosis (Bach & Hays, 2002). Further research is needed to explore the roles of Protecting, Adjusting and Accepting in

this context in more detail, and to investigate the complex relationships between the three strategies.

#### **4.1.4 Summary**

In summary, the current research has provided an initial insight into the experience of psychiatric hospitalisation from the adolescent perspective. Results support ideas from pre-existing literature which suggest that the hospitalisation experience invokes an affective response and impacts upon psychological constructs such as self-esteem and identity. Finally, adolescents appear to employ a variety of coping strategies and particular identity-management techniques to ‘survive’ the unusual experience.

#### **4.2 Clinical Implications of results**

A number of key themes have emerged from the current research, which emphasize the importance of particular clinical implications from the adolescent perspective. These can be represented as suggestions for those working in APIC, which if employed, may help to minimise the overall psychological impact of the hospitalisation experience and increase young inpatients’ ability to cope:

- **Information:** Provision of comprehensive and accurate information to adolescents themselves, according to how much they ‘want’ to know (i.e. about wards/units, reasons for rules and restrictions, and what they may expect from other inpatients).
- **Facilitating Supportive Relationships:** Provision of adequate levels of informal ‘emotional support’ from nursing staff, alongside access to formal individual/group therapy. Regular community meetings to minimise difficulties associated with ‘24/7’ community living.

- **Maintaining Connections:** Ensuring adequate contact with family and friends (as desired by the individual). Incorporation of 'everyday' activities into the ward timetable.
- **Acknowledging the Alternative Reality:** Explicit recognition of feelings of disconnection and restriction associated with admission (where these exist); chance to share and explore these feelings with other patients. Assigning ward roles to individual patients to protect against decreased self-esteem. Follow-up after discharge to process hospitalisation experience.
- **Enhancement of individual coping strategies:** Both in terms of coping with everyday ward life and minimising overall psychological impact of hospitalisation.
- **Staff Education:** Around possible impact of hospitalisation process on young person, using ideas from current model and relevant psychological theory (e.g. attachment theory).
- **Service Planning:** To consider issues raised by the current research in service planning and commissioning (i.e. how can inpatients' experience of the 'alternative reality' be minimised?)

### **4.3 Methodological Critique**

Whilst the current study had an adequate sample size for qualitative research it may have been useful to continue with theoretical sampling to include alternative perspectives. For example, the researcher would have liked to have interviewed more discharged patients to fully explore the retrospective perspective on the experience of hospitalisation. However, ethical and logistical concerns made this difficult within the confines of the current study. The fact that the current sample were 'self-selected', may also represent a limitation to the study, as participants may not have been representative of all young inpatients (see Parker, 1994). In relation to this, it is hoped that the exploration of both positive and negative experiences and the use of theoretical sampling, will have encouraged a more comprehensive picture of hospitalisation to emerge.

The researcher was satisfied that those categories included in the current model were adequately saturated, in that they were repeatedly presented within the data. Those sub-categories which were less well-supported were omitted from the final model, in the hope that the finished model would provide a rich but general conceptualisation of psychiatric hospitalisation from the adolescent perspective. The inclusion and discussion of negative cases helped to further explicate the model. The credibility of the current findings are supported by the use of grounded theory techniques, such as the constant comparative method, and by the coding checks carried out by the researcher's peers. In addition, the use of a reflexive journal throughout the research process helped the researcher to reflect upon the influence of her own views and attitudes on the emergent analysis (see Critical Appraisal).

Finally, whilst the current model is well grounded in the experiences of the current participants, it may not be representative of the experiences of all hospitalised adolescents. However, the fact that the sample was drawn from two separate (and in some ways quite different) adolescent units, should increase the transferability of the current findings. In addition, the fact that the research findings appear to support and build upon previous research findings with other hospitalised groups, suggest that they may be expected to explain the experiences of other adolescents in psychiatric inpatient care, to a reasonable extent.

#### **4.4 Future Research**

The exploratory nature of the current study means that it provides a starting point for a wide range of future research. For example, it would be interesting to conduct similar exploratory studies with other participant groups (i.e. older adults) or in different settings (i.e. general hospitals) to see if similar issues emerge. In terms of quantitative research, the experience of

stigma within this group warrants further investigation (i.e. prevalence, types of stigma encountered, long-term effects of stigma, differential reactions to stigma), as does adolescents' use of different coping strategies and identity-management techniques. Longitudinal research is needed to more fully explicate the long-term effects of psychiatric hospitalisation upon educational and occupational achievement, and could also help to explore outcomes of inpatient care from an adolescent perspective. Finally, whilst the current model has started to explore the possible psychological impact of psychiatric hospitalisation, further research is needed to fully investigate the affective responses of young inpatients and the effects of hospitalisation upon psychological constructs such as self-esteem and self-efficacy.

#### **4.5 Conclusions**

Very little research to date has explored psychiatric hospitalisation from an adolescent perspective. The current research aimed to fill this gap in knowledge, with particular reference to the possible psychological impact of the experience. The resulting process model centred around the idea of 'living in an alternative reality', whereby participants described having to cope with a new and unfamiliar environment, which was cut off and different from their normal adolescent 'reality' in a variety of ways. Findings hinted at the psychological impact of this experience, including affective reactions and effects upon self-esteem and identity, and the ways in which adolescents coped. It is hoped that the emergent findings will encourage further consideration of the adolescent perspective in both clinical work and future research.

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**PART THREE:**  
**CRITICAL APPRAISAL**

**Reflecting on the Research Journey**

## **CRITICAL APPRAISAL**

### **1. Overview**

The following chapter provides a reflection on the research process as a whole and is based upon the researcher's reflexive journal. Instead of presenting a chronological account of the research journey, I have chosen to discuss particular issues which gave me 'pause for thought' as I conducted the research, in the hope that this will be more interesting for the reader.

### **2. Influence of the Self**

The need to recognise and explore the effect of the 'self' on the research process is widely acknowledged by contemporary qualitative researchers (see King, 1996). In the current project aspects of my 'self' and my own attributes and preferences were apparent at every stage of the research process. For example, my existing interest in psychiatric inpatient care (which developed as a result of conducting research on adult psychiatric wards prior to clinical training), coupled with my preference for qualitative research methods (born of an interest in language and meanings, rather than numbers and statistics), undoubtedly influenced my decision to explore the current research topic.

During the interview and analysis phase of the project I was also aware of the influence of my own ideas on the emerging model. I had been through a reasonably long admission to a general hospital during my undergraduate degree and could clearly recall the bizarre feeling of detachment from my usual life I had experienced during this time. How did this knowledge influence my construction of the main category 'Feeling Disconnected'? I was especially careful

to ensure that my understanding of this category was grounded in participants' accounts, by using the constant comparison method and through cycling between data collection and analysis.

Nonetheless, I recognise that this category held personal significance and was thus particularly interesting for me to explore.

In terms of my epistemological stance as a critical realist, it feels important to acknowledge how recently I have adopted this standpoint. Ideas around epistemology were not something I had considered in any detail prior to clinical training and I found it challenging to question and explore my own notions of what constitutes knowledge and its construction. Critical realism felt like a useful framework for conducting interviews and analysis, as it allowed me to recognise the influence of social context, whilst also maintaining a sense of being able to represent 'reality' on some level. In relation to the current model, ideas of reality held particular importance, as the core category by its very nature spoke of an altered 'reality'. My understanding of this in epistemological terms was that participants had access to their own 'realities' (that is, their own internal worlds of meaning and understanding that they could identify and describe), both prior to, and during admission, and that the core category thus represented the shift between these realities that participants experienced as a result of hospitalisation.

### **3. Using Two Locations**

The decision to use two locations to conduct my research was not only a theoretical consideration but also a practical one, as I had been advised of the struggles of previous trainees in accessing participants from one location. In retrospect however, the use of two different research locations (one NHS inpatient unit and one unit at an independent hospital) had considerable implications at various stages of the research process. The majority of my final participants were sampled from

the independent hospital and on reflection there appeared to be a number of obstacles affecting access to participants at the NHS unit, both practical (smaller numbers of current inpatients, difficulty liaising with Responsible Medical Officers) and attitudinal (Responsible Medical Officers less likely to agree to their client being approached, less overall enthusiasm or acceptance of research taking place). This was despite the fact that both sets of inpatients were ultimately under NHS care. Further, sampling discharged clients was particularly difficult from both locations, ensuring that the final model was mainly representative of the views of adolescents who were currently experiencing hospitalisation.

There were apparent differences between the two sampling locations. For example, the independent hospital appeared more likely to admit young people from a wider range of 'unstable' backgrounds (such as prison, or the care system), under the Mental Health Act, for much longer admissions. These differences became even more noticeable when I began conducting interviews. For example, the sense of conducting an interview with a young person who had experienced a month-long admission as a result of suffering frequent panic attacks, felt quite different to conducting an interview with a young person who had been admitted to hospital five months ago, straight from prison, as a result of a serious eating disorder and heroin addiction. Whilst hospitalisation felt like a brief interlude in the life of the first individual, (compounded by the fact they were no longer in hospital), it felt more like the 'end of the road' for some participants, and certainly more 'all-encompassing' in terms of their current existence. Thus I felt more hope and positivity in some interviews than others, which in retrospect was probably related as much to the participant's overall 'story', as to their specific experience of hospitalisation.

I was initially worried about how I would develop a model that adequately encompassed the experiences of these very different individuals. Nonetheless, as analysis continued it became

apparent that commonalities ran through each of the transcripts and I began to think of the differences I encountered as points on a continuum, rather than indicators of an entirely separate experience. Thus the experience of feeling disconnected was relevant for all participants, but became more pronounced and had greater implications for those on longer admissions. In essence then, using two locations provided me with participants who had had different experiences who were initially viewed as negative cases, but were gradually incorporated into the theoretical account through further analysis. In terms of the trustworthiness and transferability of the current findings (see Stiles, 1993) I therefore believe that the use of two locations will have strengthened the current research, and will allow for greater confidence in applying the findings to other contexts and to the experiences of hospitalised adolescents in general.

#### **4. Selection of Participants**

In relation to the above, I have also reflected on the different sampling methods used in the current project and how they may have affected the developing model. The first six participants were purposively sampled, which essentially meant that all those who responded favourably to my initial contact were invited to participate. In the case of the NHS unit this stage involved sending letters to all individuals who had been resident at the unit in the last 18 months. This resulted in two eventual participants. In the case of the independent hospital information sheets were handed out to all current inpatients, which resulted in four more participants. Analysis was conducted continually as these interviews were completed.

Fortunately I had enough time remaining following this stage to move beyond purposive sampling to begin theoretical sampling. During this stage, I considered my developing analysis and asked questions about who I could sample to begin to fill in gaps and further conceptualise

my categories. In particular, it seemed important to explore the chronological elements to categories such as feeling restricted and feeling disconnected, which led to my sampling two participants who were nearing the end of long admissions. In addition, I was aware that both of the participants I had purposively sampled from the NHS location were no longer inpatients. As such I was keen to interview a young person who was currently resident at that location, to explore whether they would represent a negative case in my developing analysis (which was largely based on the accounts of young people currently resident at the independent hospital).

During theoretical sampling I was necessarily more targeted in giving out information to specific young people and my field supervisors were particularly helpful in this regard. Whilst I was initially uneasy about the amount of direction I was bringing to the analysis in this stage, I gradually began to see the usefulness of theoretical sampling and to acknowledge its importance in developing the current interpretation of the hospitalisation experience to a high level of conceptualisation. In retrospect I am aware that there were many other ‘types’ of participants I would have liked to speak to (given the time); a young person with repeat experience of admission to the same unit for example, to explore how this may exacerbate or minimise feelings of restriction/disconnection, or a young person who felt more positively about the rules and routines of ward life. I would also have valued the chance to explore negative cases from the current analysis in more detail, perhaps by returning to the young people to gain their perspective on my interpretation of their experiences within the context of the developing model.

## **5. The Use of Interviews**

I chose to use interviews to collect the current data as this seemed the most appropriate and straightforward method considering the aims and time constraints of the current research.

Initially, I felt reasonably confident about my skills in using this method (due to previous experience as a research interviewer), but on reading some of my initial transcripts I was more critical of my ability to conduct a 'good' interview. I was concerned about the 'back and forth' nature of some of my interviews; particularly considering the maxim that the interviewee should always be talking more than the interviewer (see Smith, 1995). However, when I reflected on some of the reasons behind this, I could see that factors such as some of the adolescents' reluctance to engage with the interview process, particularly around sensitive and sometimes abstract topics, were influencing the interview process. As such, I attempted to develop my interviewing style (e.g. by asking participants to provide concrete examples) according to these factors.

My skills in clinical interviewing had developed considerably during clinical training and consequently I was used to employing techniques such as summarising and interpretation within the context of interviews. Returning to research interviewing was thus difficult on some levels, as it appeared to require a more formal and structured approach with less room for therapeutic interventions. Despite these difficulties, I supported the view of some authors that the two types of interview need not be that different, and that research interviews may well engender the development of insight, or result in an increase in empowerment, on behalf of the participant (see King, 1996). This seemed particularly important given the lack of previous research in this area. I was acutely aware of giving participants a voice to share their experiences and as such allowed myself some space within interviews to validate the experiences of participants through empathy and reflection.

The use of theoretical sampling in relation to the interview guide also felt problematic at times, as it required a particularly directive approach. Thus I initially felt uncomfortable about adding

specific questions to the interview guide, which necessarily pushed the interview in a certain direction. As I began to develop the process model however, the importance of focussing in on certain topics became apparent, as it helped me to add important details (such as chronological elements) to my emergent categories.

Interestingly, the use of interviews as a method of data collection has been scrutinised in recent years, with researchers arguing over whether interviews can truly be seen as a 'resource', that is a way of accessing the real experience of participants, or whether they are just a 'topic', that is a subject of interest in themselves, which can never really represent any real experience in any knowable way (Potter & Hepburn, 2005). Many of my internal struggles with the interviewing process appear to be related to this debate, as on one hand I was aiming to conduct the best interview possible (presumably to get the best 'real' data), whilst on the other hand I was concerned with the extent to which I was bringing my own agenda to interviews and questionable of my ability to remain neutral. Madill (2007) has proposed a middle ground, whereby researchers may see interviews as accessing something of participants' real experience, whilst also acknowledging that what is said will be a co-constructed, developed version of the 'truth'. This made sense for me, particularly as it seemed to fit with a critical realist position.

On reflection, I am aware that I could also have considered using alternative methods of data collection (such as focus groups) or collecting different types of data altogether (i.e. by asking participants to keep a written or photographic diary during their admission), which may have allowed me to explore different perspectives on the inpatient experience whilst also creating some distance from the debate around the usefulness of interview data.

## **6. Developing an Understanding of Grounded Theory**

I had been interested in qualitative research methods for some time and had gained experience of utilising qualitative methods in a variety of settings, prior to conducting the current research.

Despite this previous experience, I have been particularly aware of the way in which my practical understanding of qualitative research, and specifically Grounded Theory, has advanced during the research process. As discussed above, the consideration of epistemological issues was reasonably new to me and facilitated a deeper understanding of the foundations of qualitative research and its theoretical basis. Reading a variety of methodological papers (Corbin & Strauss, 1990; Rennie, 1998; Suddaby, 2006; Walker & Myrick, 2006) was particularly important, in terms of enhancing both my understanding of the process of grounded theory and my skills in carrying out data collection and analysis. Further, discussing my emerging categories and process model with a number of different people (research supervisor, field supervisors, members of my qualitative research group) proved invaluable, in terms of making sense of my findings and organising my model for writing up.

I have been able to ‘measure’ my advancing knowledge and skills to some extent, by comparing the process to that of completing my Masters Degree dissertation; also a ‘Grounded Theory’ project, investigating the experiences of survivors of domestic abuse as they navigated the family court system. On reflection, my use of grounded theory techniques (e.g. cycling between data collection and analysis, writing memos, theoretical sampling, constant comparison) in the first study was practically non-existent. Instead, I fell into the trap of conducting a sort of ‘thematic content analysis’, which is a criticism of many supposed grounded theory studies (see Suddaby, 2006). In the current study, the struggle to move beyond ‘topics’ to start exploring ‘processes’ was key in my developing understanding and allowed me to start to form a working theoretical

model, which went far beyond the basic descriptive write-up of the previous study. Hence, although I am unsure as to whether the current model represents formal theory as such, I at least feel it provides a rich conceptual account, which is well grounded in participants' experiences.

As well as advancing my understanding of grounded theory process and procedure, conducting the current research has consolidated my interest in, and enthusiasm for, qualitative research. Whilst I have been reminded of some of the less positive aspects of completing a qualitative project (the time consuming nature of transcription springs to mind), I have also rediscovered the creative and interpretative side of the process. I value the fact that qualitative research allows for polarity of outcomes, and embraces contradiction, variety and nuance, and wonder whether I would have been able to maintain a similar level of interest in a quantitative project.

## **7. Editing the Analysis**

Despite my enthusiasm for qualitative research, I particularly struggled with the issue of how to present a qualitative project within the confines of the doctoral thesis. I found the word count extremely restrictive, particularly in the method and results sections of the research report, where I was keen to present adequate detail about how I conducted the research and the resulting findings. Use of the appendices to present additional notes on grounded theory and supporting quotations was helpful in this respect. In terms of the development of the core category and the process model, a number of changes occurred throughout the period of data collection and analysis. For example, ideas around 'control' and 'emotional experiences' appeared central in the early stages of data analysis, but were gradually subsumed within higher-order categories, which were more adequately held together by the category of 'Living in an Alternative Reality'.

The initial process model contained eight main categories under three organisational headings; 'Prior to Admission', 'During Admission', and 'Coping and Moving Forwards'. This comprehensive model allowed for some description of participants' experiences before they arrived at hospital (for example their sense of feeling out of control), as well as an understanding of the outcomes of hospitalisation (such as regaining control and increasing understanding) from the participants' perspective. Unfortunately, it became impossible to present the full model within the research report due to the 12,000 word limit, and I was required to make decisions about which categories to include and omit.

As with the analysis phase of a grounded theory project, the writing up phase can also involve interplay between the technical and creative, whereby the researcher is required to pull the pieces of their research together to construct a coherent theoretical framework (see Charmaz, 2006). Bearing the current research questions in mind, I therefore decided to present the categories which most closely related to the impact of psychiatric hospitalisation and the way in which adolescents coped with this experience. These categories were understood within a new organisational framework ('Contributory' and 'Outcome' categories), which represented the relationships of the main categories to the core category. Whilst I was disappointed at being unable to present the full contextual model that I had initially developed to the reader, I was thus satisfied that the final process model was closely linked to the original aims for the current research.

## **8. Saturation**

Data collection in a grounded theory study traditionally ceases at a point of 'saturation', that is when further data no longer provides new information for the existing categories (Charmaz,

2006). The notion of saturation has caused controversy amongst researchers, both theoretically (that is can saturation ever be truly achieved) and practically, with researchers being criticised for proclaiming saturation without proving that they have achieved it (see Morse, 1995). In relation to this, Dey (1999; cited in Charmaz, 2006) has contended that categories in a grounded theory study are in fact suggested by data, rather than saturated by data, and that ‘theoretical sufficiency’ is thus a more appropriate term to describe the point at which data is no longer needed.

I certainly questioned the idea of saturation in relation to the current research, particularly considering the sample size and the ongoing presence of negative cases throughout the data collection process, which suggested that continued sampling may have generated additional detail for existing categories, or even completely new categories. Despite this, I felt that my account did move towards saturation during analysis, as constant comparison was used to continually add new properties to each of my categories, and an appropriate level of conceptual density was finally reached (see Glaser, 2001).

## **9. Power and Control**

As mentioned above, the issue of control was an underlying theme in the current research, which was often referred to in memos contextualising higher-order categories (e.g. a perceived lack of control was an important part of feeling restricted). Changes in control were also important as adolescents moved through the stages of hospitalisation. Thus participants described feeling ‘Out of Control’ prior to admission (one of the omitted categories) and as though others had taken control over them during the early stages of admission. Further, regaining personal control was an important aspect of recovery. In theoretical terms the idea of ‘locus of control’ may therefore be relevant, in that moving towards an internal locus of control has been shown to be a

particularly important part of the recovery process in the mental health literature (see Marsh, 2000).

Considering the importance of issues of control to adolescents' experiences of hospitalisation, it also seems pertinent to consider issues of power and control in relation to the research process. I attempted to reduce the power differential between myself and the participants as far as possible, both prior to interviews (e.g. by allowing them to actively decide to participate, by informing them that they could withdraw from the research at any point) and during interviews (e.g. by making it clear that they could choose not to answer questions, by normalising their experiences where appropriate). However it is clear that a power imbalance still existed.

As Tindall (1994) has highlighted, it is often impossible to achieve complete equality and mutuality in the research arena and so it remains important to acknowledge the existence of power dynamics. I was an adult professional, whilst the participants were young service-users, who appeared to have relatively little power in the context of the ward environment.

Unfortunately, risk issues meant I had to interview most participants on their ward, which may have increased the power differential. Conversely, I hoped that the fact I assured adolescents I was unrelated to either of the units in clinical terms, may have encouraged them to speak more freely. In summary, I accept that whilst I may have given adolescents the chance to speak out about their experiences of psychiatric hospitalisation, I have retained much of the power through my design of the interview guide, my interpretation of their responses and my conceptualisation of the final model.

## **10. Concluding Thoughts**

I am pleased that I have had the chance to begin to explore adolescents' experiences of hospitalisation and I have enjoyed the research journey and all of its high and low points. Given more time and resources I would be particularly interested in attempting to quantify the effects of hospitalisation on adolescents' self-esteem, and in exploring adolescents' use of identity-management techniques in more detail. Finally, I am hopeful that the resulting analysis and model will add to the existing literature and encourage greater recognition and exploration of adolescents' experiences in both the clinical and research arenas in the future.

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**APPENDIX A**  
**Additional Notes on Grounded Theory**

## ADDITIONAL NOTES ON GROUNDED THEORY

### History and Utility of the Grounded Theory Method

Grounded theory was first defined as a discrete methodology by sociologists Barney Glaser and Anselm Strauss in their 1967 book, *The Discovery of Grounded Theory*. At the time, sociological research primarily involved using quantitative methods to test propositions derived from ‘grand’ theories; the aim of which was to discover pre-existing and universal explanations of behaviour (Pidgeon, 1996). Glaser and Strauss argued that this over-reliance on the positivist paradigm was leading to impoverished theory development, as there were no ‘universal truths’ to be discovered (Charmaz, 2006). Instead, they proposed that theory should be ‘grounded’ in an iterative cycle of data collection and analysis, with the aim of discovering the subjective meanings placed on events and situations by individuals and groups (Glaser & Strauss, 1967). Glaser & Strauss’s proposal was unique in linking epistemological critique with practical techniques for systematic qualitative analysis (Charmaz, 2006). Thus grounded theory in its original form, can be said to contain both positivist elements (i.e. systematic techniques) and interpretative elements (i.e. focus on meaning), highlighting its usefulness from a critical realist perspective (Madill, Jordan & Shirley, 2000).

Since the initial appearance of grounded theory the methodology has been subject to various developments, too complex to be detailed here<sup>18</sup>. Whilst Glaser has consistently adhered to the initial description of the method (i.e. Glaser, 1978, 1992); Strauss, (alongside new co- author Corbin), has favoured the development of new technical procedures, including more detailed and

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<sup>18</sup> For detailed discussion of the development of grounded theory and differences between individual approaches, see Charmaz, 2003b; Corbin, 1998; Pidgeon, 1996; Rennie, 1998; Walker & Myrick. 2006.

proscriptive methods of coding (i.e. Strauss & Corbin, 1998)<sup>19</sup>. Recent developments to the approach have included constructivist revisions (see Charmaz, 2003a, 2003b, 2006; Pidgeon, 1996; Pidgeon & Henwood, 1996). The constructivist position argues that Glaser and Strauss's notion of 'discovering' theory from data relies too heavily on a positivist epistemology, as it implies that a set of social or psychological relationships exist objectively in the world, and are there to be discovered by neutral qualitative researchers (Pidgeon, 1996; Pidgeon & Henwood, 1996). Instead, the notion of theory 'generation' is proposed, whereby grounded theory methodology should be used flexibly, with increased recognition of the interpretative role of the researcher and the way in which theory is developed in the context of social and power relations (Charmaz, 2003a, 2003b, 2006).

Due to its focus on meanings and interactions within a local social context the grounded theory method may be considered particularly useful for Psychologists, and has been used in a wide range of psychological research (see Pidgeon, 1996). Writing in 1988, Rennie, Phillips & Quartaro, advocated the utility of the approach in bridging the gap between traditional deductive methodologies and 'new' phenomenological approaches to psychological research. More recently, Henwood and Pidgeon (1995) have highlighted the value of constructivist revisions in their ability to guide researchers along the 'analytic path' whilst also encouraging them to be open about their pre-existing ideas, concepts and perceptions (p.117). In health services research in particular, grounded theory studies may be useful in contributing to the development of the efficiency and effectiveness of services, whilst retaining a human perspective (Dingwall, Murphy, Watson, Greatbach & Parker, 1998).

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<sup>19</sup> Pidgeon (1996), has suggested that Glaser's approach can be described as more 'artistic/creative', whilst Strauss & Corbin's approach is more 'scientific'.

## Key Characteristics of the Grounded Theory Method

The central emphasis of the grounded theory approach is on the inductive development of theory from data (Glaser & Strauss, 1967). This is in contrast with a traditional approach to social sciences research, where data is used to verify pre-existing theory (Rennie *et al.*, 1988).

Grounded theory contains a number of characteristics that facilitate this theory development, the most important of which is the constant comparative method (Glaser & Strauss, 1967). Charmaz (2006) has defined this method as the continual sifting and comparison of data points, in order to explore similarities and differences. In the case of interview data this may involve comparing interview statements within the same interview, and then in different interviews, with the aim of developing theoretical codes or categories (Charmaz, 2006).

The generation of codes from the data is in itself, a key feature of most types of qualitative analysis (see Smith, 1995). In the case of grounded theory the researcher must work systematically through the data, generating labels for all data points (Glaser & Strauss, 1967). Pidgeon & Henwood (1996) have described this as a 'creative' process, where the researcher must balance their interpretation of data with the requirement that the codes 'fit' the data well. In this way, each concept earns its way into the theory by being repeatedly present in the data, which guards against researcher bias (Glaser, 1978). Various levels of coding may be employed dependant on which version of grounded theory is being used<sup>20</sup>. Regardless of version, the overall aim of the coding process is to develop the emerging theory through increasing levels of abstraction, in order to arrive at a core category, which accounts for all of the data (Dey, 2004). It

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<sup>20</sup> See Glaser & Strauss (1967) for details of substantive and theoretical coding; Strauss & Corbin, (1998) for details of open, axial and selective coding; and Charmaz (2006) for details of line by line and focussed coding.

is therefore expected that a 'saturation point' will be reached, insofar as new data no longer appear to add any new meaning to the proposed theory (Rennie, 1998).

Simultaneous involvement in data collection and analysis is another key feature of grounded theory research, whereby early theory development can help to shape subsequent data collection (Glaser & Strauss, 1967). There is an expectation that analysis will begin as soon as the first piece of data is collected; in this way, emerging themes and gaps in theory can be further investigated in later interviews/observations through the process of theoretical sampling (Charmaz, 2003a; 2006). Theoretical sampling involves the targeted sampling of events, people, or documents, to refine ideas as the research progresses (Glaser & Strauss, 1967). In practice, this may lead to a researcher seeking out a particular type of person to interview, or adding specific questions to their interview guide, in order to elaborate upon their emerging theory (Charmaz, 2003a; 2006). This process is in contrast to the type of sampling employed in traditional positivist research, where samples are generally sought in order to increase population representativeness or sample size (Dey, 2004).

Two final features of grounded theory explored in the literature are theoretical sensitivity and memo-writing. Theoretical sensitivity has been described in detail by Glaser (1978), and Strauss and Corbin (1998), and expresses the researcher's ability to respond to 'the subtle nuances of...meanings in the data' (Strauss & Corbin, 1998, p. 35). Theoretical sensitivity is expected to develop as the researcher moves through their analysis, and is facilitated by continually making comparisons, following leads, and establishing connections (see Charmaz, 2006). It is seen as an important feature of grounded theory, although there is disagreement in the literature over the

specific methods through which it should be achieved<sup>21</sup>. Memo-writing is less controversial and is espoused by most authors as an essential tool for expediting the research process. Memos are generated in parallel to the coding process, serve to assist the researcher in category development, and ultimately provide a secure base for reporting on the research (Corbin & Strauss, 1990).

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<sup>21</sup> According to Glaser, theoretical sensitivity can be achieved through immersion in the data; line by line, comparison by comparison. Strauss and Corbin however, have advocated the use of specific analytical tools to achieve theoretical sensitivity, which Glaser argues are too rigid and 'force' the data (see Glaser, 1992).

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**APPENDIX B**  
**Ethics approval letter**

**APPENDIX C**  
**University Ethical Approval**

**APPENDIX D**  
**Participant Information Sheet**

**APPENDIX E**  
**Consent Form**

**APPENDIX F**  
**Interview Topic Guide**

## **Adolescents' Experiences of Psychiatric Hospitalisation:**

### **Interview Schedule**

**(Initial script normal text. Additions to script underlined.)**

#### **Background Questions**

- How long since they were discharged (if applicable)?
- Length of current/most recent inpatient stay?
- Is/was this their first stay at an inpatient unit? Have they stayed at any similar units, or on adult psychiatric wards? Previous contact with services?
- Section/diagnosis...only if this comes up??
- Family situation...who do you live with, how far from the unit etc?

#### **Questions around Experience of Hospitalisation**

- Can you start off by telling me a little bit about what led up to this/most recent time in hospital?
- Did you have any expectations about what hospital might be like before you got here? (Hopes/Fears)
- Did you feel like you were involved in the decisions which led to you coming to hospital?
- Can you describe how you felt when you knew you would be coming here?
- How did you cope with your expectations/initial feelings on arrival at hospital?
- How does the experience differ from your experience of previous places you've stayed (i.e. residential homes, secure unit, prison)?
- How would you describe what being in hospital was like, to another young person?
- What has your experience of being in hospital been like- day to day?
- Lots of the young people I've spoken to have talked about the rules and routines which affect everyday life in hospital: Have you found it easier to accept/understand some kinds of rules? Which? What makes the difference?
- What has been the best thing about being in hospital?
- What have you missed most whilst you've been in hospital?
- Do you've feel you've missed out on anything whilst you've been in hospital?

- What have you found most difficult about being in hospital? How did this make you feel?/How did you cope with this?
- Other young people I've spoken to have described staying in hospital as an emotional experience: Can you tell me any more about this? (Types/intensity of emotion, different emotions at different times, what helps/makes it worse, how do you cope?)
- Can you tell me about your relationship with staff? (Positive/Negative)
- What about with the other young people? (Positive/Negative)
- How have your family reacted to/cope with you being in hospital? (Level of contact/support etc)
- What about your friends outside hospital?
- Have your relationships (with staff/other residents/family/friends) changed over the time that you've been in hospital? If so how?
- Overall do you think adults (staff/parents) understand what it is like for a young person in hospital?
- How has being in hospital affected your hopes for/feelings about the future?
- If nearing end of stay: What do you think has been the most helpful thing in terms of getting you ready to leave hospital? What have you had to work hardest on?
- Is there anything else important about being in hospital which we've not covered?

### **Debriefing**

- Thank them for taking part and say how much their views are appreciated.
- Do you have any questions you would like to ask about the interview?
- When the research is finished would you like to see a summary of the results?
- What would you like your name to be changed to when I type the recording?

**APPENDIX G**  
**Examples From Analysis**

## EXAMPLES FROM ANALYSIS

### Example of Line by Line and Focused Coding

Focussed Codes	Interview Extract	Line by Line Codes
<p style="text-align: center;"><b>FEELING DISCONNECTED FROM EVERYDAY LIFE  (PEER COMPARISON)</b></p> <p style="text-align: center;"><b>LINKS TO FEELING RESTRICTED?</b></p> <p style="text-align: center;"><b>COPING STRATEGIES- INTELLECTUALISING</b></p>	<p>“P: Well I look at other people my own age. See one of the staff at reception she’s my age and she’s got a job and she’s you know been to college or whatever, and I’ve missed out on that. I should’ve been to college and I should be doing all these things that other people my age are doing and I feel a bit trapped in here in that.</p> <p>I: Yes and how do you manage those feelings?</p> <p>P: I just concentrate and try and focus that I’m gonna be out of here in not to long”</p> <p><b>‘Phoenix’ (Lines 312-320).</b></p>	<p>-Comparing self to peer group</p> <p>-Missing out on education</p> <p>-Feeling disconnected</p> <p>-Missing out on age appropriate activities</p> <p>-Feeling trapped</p> <p>-Focussing on getting out</p> <p>-Looking forward</p> <p>-Thinking positively</p>

### Example Memo

**10/01/08 Feeling Restricted:**

Different types of rules and routines on the ward seem to contribute to participants’ overall sense of feeling restricted. However, some rules are seen as more protective (i.e. being observed to prevent self-harm/P2- line 365) and are viewed quite positively, whilst others are just seen as being ridiculous or annoying (i.e. having to go to bed at a certain time/P1- line 633). Rules which restrict freedom and privacy provoke the strongest reaction from all participants. Link to literature looking at effects of enforced admission/treatment in adult populations?

**Relates to codes:** ‘Feeling Disconnected’ and ‘Negotiating Relationships’ (e.g. certain rules hinder participants’ efforts to maintain and manage existing and new relationships).

### **Example Extracts From Reflexive Journal**

9/10/07: Having started to write the methodology section I'm finding it quite difficult to impose a coherent structure. Seems like this might be due to the cyclical nature of the GT analysis- thus hard to write it up in a linear fashion?!

13/12/07: Just completed my fourth interview and still struck by this sense of disconnection participants talk about. I can remember having that feeling really clearly after staying in hospital myself- does that mean I've been particularly sensitive to this idea? Need to be careful during coding process to really investigate this concept, and how often it arises- seems valid though as has come up in every interview so far.

**APPENDIX H**  
**Additional Quotations**

## ADDITIONAL QUOTATIONS

### LIVING IN AN ALTERNATIVE REALITY

(\*1):

*“I don’t think my parents know what it’s like ‘cause they don’t really understand. They think that (.) it’s like (.) like school but just in a different place. But it’s not, ‘cause you have to see Doctors and you have to talk to nurses and it’s hard”* (Keira/385)

(\*2):

*“I: What about when you first got onto the unit, what was that like?”*

*P: I hated it. I absolutely hated it...It was loud and people screaming and people you know, smearing shit all over the walls and I didn’t know what that meant”* (Natalia/101)

(\*3):

*“The alarms go off, sometimes numerous times a day, people attacking people, or self-harming, or just prating about sometimes as well”* (Phoenix/562)

(\*4):

*“Like Will he just stares at me, always comes and touches me when I’m eating, he snots all over the place, it’s proper weird”* (Mags/191)

### FEELING RESTRICTED

#### Everyday Rules and Routines

(\*5):

*“At night time we had set bed times, unless it was half term or anything...and that, it got really annoying, ‘cause every night I would be in bed for half past eight”* (Britney/625)

*“I: So what is it like being here day to day on the ward?”*

*P: Er it’s too boring sometimes ‘cause like you don’t have sessions or you do have sessions and when you haven’t got sessions you’re either asleep or you go out”* (Yasmin/78)

(\*6):

*“I’d describe it as Butlin’s with locked doors...you’ve just gotta get to your level four, which takes two months at the longest and then you can start having home visits, keep that and you’ll end up, you know in the end you’ll have unescorted home time”* (Chris150)

### **Loss of Freedom and Privacy**

(\*7):

*“I: So what’s actually the worst thing then?”*

*P: Being locked up with no freedom and just shit like that.*

*I: How does that make you feel?*

*P: Erm (2) like I wanna try and escape and run off”* (Mike/139)

(\*8):

*“‘Cause like every time I was straightening someone’s hair or I was straightening my own, the nurses were like watching me constantly...it just felt you know, really annoying ‘cause I felt like saying ‘ooh no I’m not two years old, I’m actually thirteen, I’m actually quite capable of using hair straighteners”* (Britney/604)

(\*9):

*“I: So what do you think you’ve found most difficult about being here?”*

*P: The locks, the doors, the keys. It’s quite daunting when you first come. You do get used to it to some degree over time, but still knowing that you can’t just go out, without someone letting you out, it’s a bit...it just makes you feel out of control”* (Phoenix/356)

(\*10):

*“At first it was very difficult to accept I was in a locked ward, I was locked up with lots of other people. That I couldn’t go to the toilet when I wanted to go to the toilet, I had to ask staff to unlock a door. If I needed supervising they’d supervise me through, they’ve got spy-holes in the doors...I was angry, very angry. But that shifted over time when I realised why they were doing it and that it wasn’t their fault I was in here at the end of the day...it seems more understandable”* (Phoenix/242)

(\*11):

*"I'm not allowed to use the toilet for 45 minutes after a meal which I understand"*

*(Natalia/173)*

*Nb- Natalia had been admitted with an eating disorder.*

(\*12):

*"I: Does that give you an incentive, what difference does having the levels<sup>22</sup> make?"*

*P: Yeah, 'cause you can get more freedom, I get to go into the community on my own...I feel great, confident as well, 'cause like they've got confidence in me, they trust in me"*

*(Natalia/259)*

## **FEELING DISCONNECTED**

### **From Family**

(\*13):

*"I: What would you say is the worst thing about being in hospital?"*

*P: Being away from my family. They're the only ones I can talk to" (Mags/211)*

(\*14):

*"I: So did your family come in and see you?"*

*P: Yeah, yeah my mum did. My mum came every day, and she brought like my stepdad and my brother on alternate days, and um yeah I would get like letters and stuff, and phone calls and*

*I: So it sounds like you had quite a lot of contact, was that helpful?"*

*P: Yeah definitely." (Holly/629)*

(\*15):

*"I just felt really horrible 'cause like my mum didn't come nothing, nor my brother or step-dad or anybody...I just felt really upset 'cause I was like you know, other people's parents come and make the effort" (Britney/1144)*

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<sup>22</sup> Some inpatient units employ a 'levels' system, where young people are placed on a particular level according to their current functioning and risk status. The level a young person is on thus determines how much freedom and autonomy they have in the context of the ward/hospital environment.

**(\*16):**

*"I: Do you feel you've missed out on anything?"*

*P: My sisters growing up and my dog got took away as well, my dog got taken innit, he got put down"* (Mags/308)

### **From Friends**

**(\*17):**

*"I missed school a little bit 'cause like I weren't seeing my friends...they were allowed to come and see me, but my mum had to bring them, and it was just like bringing them at a time that parents were comfortable with... and then Chloe phoned me at one time saying 'ooh you're trying to avoid me Britney', and I said 'well no, its just that I have things here, and like they are trying to do things here with me, and they don't want me trying to, you know, go out to too many places, 'cause then it undoes the things that they tried to teach me'"* (Britney/693)

**(\*18):**

*"I've been away from them for so long now I don't speak to them really, but they write to me and they phone me up and it's nice to know they still care"* (Natalia/355)

**(\*19):**

*"I had this group of friends, about seven or something and we was like really close and stuff, but the more time I had off, the further apart we grew...I said 'right you all have to write to me 'cause I'm gonna have a month (in hospital) like bored out of my mind, you've all got to write to me' and then none of them wrote to me, and I was just like 'oh ok great' ...I felt really quite betrayed and stuff"* (Holly/646)

**(\*20):**

*"they were like 'ooh that's a mental health institute' and...she said 'you've not got a problem inside your brain have you Britney?'" and then when I went to (inpatient unit) she wouldn't speak to me, wouldn't say anything to me, and she wouldn't even, at lunchtime, like I tried to sit next to her, and Jessica wouldn't sit next to me, and she'd like put her bag on the seat, so then I can't sit down"* (Britney/1252)

*“They’ve tried to be supportive, but they don’t really understand, and it’s making it hard because they think I’m just attention-seeking”* (Keira/347)

(\*21):

*“I’m not in contact with my friends, we were constantly getting in trouble together...it’s been difficult ‘cause they were a major part of my life, but I’ve gotta move on and make new friends otherwise I’ll constantly be getting into trouble”* (Chris/581)

### **From Everyday Life**

(\*22):

*“I mean I missed my eighteenth party because I was stuck in hospital and that really got on my nerves”* (Chris/385)

*“I used to go birdwatching, that’s something I miss...I miss just being out and about...Fresh air, I miss holidays”* (Cameron/327)

(\*23):

*“I: Is there anything else you’ve missed, or feel like you’ve missed out on while you’ve been here?”*

*P: A chance to get my education”* (Natalia/212)

*“P: I’ve missed exams (.) so I’ve fallen behind on school.*

*I: Is that worrying you or?”*

*P: Yeah ‘cause I’m gonna have to re-sit the whole year”* (Keira/224)

(\*24):

*“I: Do you feel there’s anything else you’ve missed out on from being here?”*

*P: A life.*

*I: What do you mean by that?”*

*P: Going college, doing what any other teenager would be doing. It feels a bit weird really being stuck in here”* (Yasmin/167)

## **NEGOTIATING RELATIONSHIPS**

### **Polarised Views: Staff-Patient Relationships**

(\*25):

*“Some of the staff I get on with but there are a few that wind me up...they do purposefully wind up the patients”* (Cameron/365)

*“Some of the staff are alright, but most of the staff are just pricks”* (Mags/45)

(\*26):

*“Overall the nurses were really nice, but they were just too protective over me”* (Britney/1407)

(\*27):

*“P: When you’re struggling you don’t normally get the support you need...you have to go to them and like plead them for support or you have to do something to get the support.*

*I: What do you do?*

*P: Kick off.*

*I: And what sort of support do you feel you need from staff at that time?*

*P: Someone to talk to”* (Yasmin/97)

### **Learning to Deal with Distress: Developing Relationships with Other Young Inpatients**

(\*28):

*“It was just really scary, to see someone act like and just be completely like zoned out kind of thing...like when she wasn’t pacing up and down she just used to sit in the chair and just rock backwards and forwards and her eyes would just like glaze over and stuff, and she used to look at you and you’d be like ‘oh my god’ ‘cause it just kind of brought it all back home where you were”* (Holly/452)

(\*29):

*“You’ll see people crying, and it makes you feel so bad, I just wanna help them or something but I know I can’t and it’s not very nice to hear it.”*

(Keira/195)

**(\*30):**

*“On the first few days I didn’t know what was wrong with them...and then, when I, like after we bonded then we started telling each other what was wrong, and then I knew they wasn’t going to do anything to me or around me because we were so close, so I never really, I was never really scared of them”*  
(Holly/399)

*“We all have an understanding of each other because we’ve stayed with each other, pretty much for, well since the time I’ve been here...So I know a lot of their problems and how to help and how to deal with them”*  
(Phoenix/348)

**(\*31):**

*“It’s nice (.) well not nice, but it’s more comforting to know that there’s other people in the same position as you. Though you wouldn’t wish it on anyone sometimes knowing that someone else is going through similar struggles to you can be quite helpful”*  
(Pheonix/304)

*“It makes you feel like, well there’s a lot of people worse off than me, ‘cause I spent six months wallowing in self-pity, and you just think [putting on wailing voice] ‘oh no-one’s ever been through this before, no-one can understand’ and then it’s like you go somewhere like that and there’s people that you could never even imagine having their problems”* (Holly/332)

### **24/7 Community Living:**

**(\*32):**

*“It’s quite difficult to get on with staff sometimes ‘cause you have to be around each other 24/7, and you have to get on with them really”*  
(Natalia/143)

*“It was a bit scary at first, because I’m not very good at making friends with people (.) and when you’re in a place with people for like all day, with them 24 hours a day, you’ve got to get on with them”*  
(Keira/121)

## **SURVIVING**

### **Developing Supportive Relationships**

(\*33):

*“We got on really well, looked after each other, we didn’t like take the mick out of each other”*  
(Britney/562)

(\*34):

*“If someone’s been to see like a Doctor or something and they’re looking quite upset, then everyone’ll ask how that person is. And if they’re not happy then they’ll just speak to the people, try and cheer them up”*  
(Keira/281)

(\*35):

*“I’ve lived with him for about two years, and moved from ward to ward with him and we’re just good mates...like when I used to get into a fight, he’d say ‘oh mate, keep your levels, watch out’ and that”*  
(Mags/259)

(\*36):

*“I: What helps you to feel safe do you think?  
P: Um, you got lots of friends and you can talk to them.”*  
(Yasmin/73)

### **Recreating Reality**

(\*37):

*“We have a take away night every Saturday...highlight of the week. That’s the only thing I actually look forward to”*  
(Cameron/250)

*“We had beauty days where we did each others nails and hair and that”* (Britney/566)

(\*38):

*“I: How do, what can you do to cope with it being boring?  
P: Um, I just read, or I just hang out with, hang out with some of the other people here. I’ve made a good friend and we just sit and talk for ages, and do craft activities and paint and draw and stuff like that to pass the time”*  
(Keira/142)

(\*39):

*"I phone my mum every few nights and speak to my family"* (Phoenix/336)

(\*40):

*"We was all like sisters really"* (Britney/562)

### **Intellectualising**

(\*41):

*"We kind of all had our problems and stuff, they wasn't like um (4) like we kind of just never noticed it, so it was just kind of normal and stuff"* (Holly/458)

(\*42):

*"I am not crazy, I just suffer from an illness you could suffer from, and any one of those kids could suffer from the same one...I don't care you know I'm (.) if they'd lived half of what I've had to live through they'd end up in hospital."* (Chris/871)

### **Avoiding Harm**

(\*43):

*"I: What do you do on the ward if that sort of thing (aggression) happens?"*

*P: I just take myself away"* (Yasmin/155)

(\*44):

*"We just kind of, like we never spoke about it, we just kind of pushed it to the back of our minds kind of thing"* (Holly/533)

## **MANAGING IDENTITY**

### **Protecting**

(\*45):

*"I: So would you say you've made friends here or?"*

*P: No they're all mental. They're all mentally ill people"* (Mike/178)

### Adjusting

(\*46):

*“I’m not in contact with my friends, we were constantly getting into trouble together...it’s been difficult ‘cause they were a major part of my life. But I’ve gotta move on and make new friends otherwise I’ll constantly be getting into trouble...so I just look at it as, you know, either say goodbye to them and lead a noble life, or stay with ‘em and be in and out of prison for the rest of your life. If I was to stay in contact with them I wouldn’t be able to go back to college and do more experience and get a proper job, and stuff like that”* (Chris/581)

### Accepting

(\*47):

*“I suppose in a way of saying, getting arrested and going to the secure unit, then prison, then hospital, has actually done me good, ‘cause I’ve had to face up to the life I’ve been living. I’ve been living a lie all my life (2) trying to hide everything from everybody, trying to make out you know, I’m not this troubled (.) youngster that everybody thinks I am, you know, I’ve got no problems at all, I’m perfect, when actually it’s vice versa, if you could think of a problem, you could guess that at some point I would feel it”* (Chris/832)

(\*48):

*“That’s when the Aspergers came out as well...I think it’s a good thing now ‘cause then I’m gonna get help and then wherever I go now, if I start kicking off or anything, they’re not gonna, well they’ll tell me off if I’ve been naughty, but they won’t yell at me and everything”* (Britney/118)