

**An exploration of the experiences of being involved with
psychiatric services and psychiatric admission for
individuals with psychosis: an interpretative
phenomenological analysis**

and

Clinical Research Portfolio

VOLUME I

(Volume II bound separately)

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Systematic Literature Review

The application of interpretative phenomenological analysis (IPA) with individuals with psychosis - A methodological critique

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Abstract

Background: Interpretative phenomenological analysis (IPA) aims to capture and explore the meanings that individuals' assign to their own experiences. The use of IPA can help develop a detailed understanding of experiences and allow an in-depth account that quantitative methods cannot readily access.

Aims: With the increased use of qualitative methods such as IPA, the assessment of qualitative methodology becomes increasingly important. The aim was to conduct a methodological critique of the use of IPA within the psychosis literature.

Method: The principles of IPA, alongside the recommendations to assess the methodological quality of IPA studies from Brocki and Wearden (2006), were developed into a tool to support qualitative evaluation of IPA studies by Veitch and Gumley (2007). This tool was used to aid this review.

Results: The studies varied in quality and the extent they followed the principles of IPA. They varied in all aspects including; data collection, sample size, presentation of themes, reflexivity and validation

Conclusions: IPA appears to have achieved a place within qualitative methodology and is being used increasingly within health and clinical psychology. As a similar review has not been carried out previously, it is hoped this review will contribute to the literature.

Declaration of interest: None

Introduction

Interpretative phenomenological analysis (IPA) is a relatively recent qualitative approach that is being widely used in health, clinical and social psychology. IPA aims to capture and explore the meanings that individuals' assign to their own experiences and it has been said that the perception of individuals as 'self interpreting beings' is at the heart of IPA (Taylor, 1985 as cited in Smith & Eatough, 2006). It also recognizes the role the researcher plays in accessing and understanding the individual's experience and acknowledges that access to the individual's experience may be affected by the researcher's own beliefs and thoughts. Therefore, Smith and Osborn (2003) have described it as '*the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world*' (p.51). This emphasis on sense making by both the participant and researcher suggests a theoretical alliance with the cognitive paradigm that is dominant in contemporary psychology. As IPA can be described as relying on cognition and attempting to unravel the relationship between what people think, say and do, as a central analytic concern (Smith, Jarman & Osborn, 1999). However, while mainstream psychology continues to remain committed to quantitative and experimental methodology, IPA moves away from this as it employs in depth qualitative analysis.

It has been suggested that IPA is suited to research of a complex and personal nature (Kay & Kingston, 2002). Therefore, it is appropriate for studies with individuals with psychosis as this can be a distressing and traumatic experience. Understanding this

experience can be a difficult and complex process and the meanings derived from the experience are likely to be highly salient. The use of IPA can help develop a much more detailed understanding of experiences and allow an in-depth account that quantitative methods cannot readily access. Thus, it is important to determine the usefulness of the findings of studies using IPA in terms of understanding the unique experience of individuals with psychosis and whether or not they have conformed to the stated principles of IPA. However, to date there has not been a systematic review examining the use of IPA within the psychosis literature and such a review will therefore contribute to the literature and guide future research in the field of psychosis.

With the increased use of qualitative methods such as IPA, the assessment of qualitative methodology becomes increasingly important. Dixon-Woods and colleagues have stated that there are now over 100 proposals regarding quality criteria in qualitative research. Such proposals may be useful in identifying the quality criteria that might be used, but, as yet there has been no consensus on a suitable method for assessing the quality of qualitative research (Dixon-Woods, Shaw, Agarwal & Smith, 2004). It would be inappropriate to apply the models developed for quantitative methodology because qualitative research is not a unified field and utilises many different theories, techniques and methods. Furthermore, not only is there uncertainty and disagreement about how to identify and assess the quality of qualitative research, but, more importantly, on whether criteria for qualitative research should exist at all. It may appear to be a contradiction in terms to have

quality criteria for qualitative research as it could be argued that the use of criteria and checklists suppress the creative and interpretative aspects that lie at the very heart of this approach. Yet, on the other hand, in order to have confidence in the quality of such invaluable research, some way of assessing the quality distinct from the criteria used to assess the quality of quantitative research is needed. Therefore, it could be proposed that the criteria should be used as a guide rather than a strict requirement.

Brocki and Wearden (2006) reviewed the use of IPA in health psychology. Their aim was to establish the extent to which the papers reviewed conformed to the principles of IPA. They reviewed the method of data collection, sample size, sampling strategy and data analysis. They also discussed the wider applicability of the research and adherence to the theoretical foundations and procedures of IPA. Therefore, the principles of IPA, alongside the recommendations to assess the methodological quality of IPA studies from Brocki and Wearden (2006) were developed into a tool to support qualitative evaluation of IPA studies by Veitch and Gumley (2007). This tool was used to aid this review of IPA studies. The aim was not to establish the efficacy of IPA as a qualitative method but instead to review the principles of IPA within these studies.

Review Question and Aims

Question

How are the principles of IPA reflected in studies investigating individuals' experiences of psychosis?

Aim

To undertake a methodological critique of studies conducted with individuals who have psychosis, which have used IPA

Methodology

Selection Criteria of studies

Published studies were included in the research if they met the following criteria. The study used interpretative phenomenological analysis to explore individuals' subjective experiences of psychosis. Participants included were adults diagnosed as having schizophrenia or adults who have experienced psychosis e.g. ICD-10 (World Health Organization, 1992) criteria for schizophrenia, schizotypal and delusional disorders (F20-29), a diagnosis of mania with psychotic symptoms (F30.2), bipolar affective disorder (F31.2, F31.5) or mood congruent delusions and hallucinations (F32.3, F33.3).

Studies were excluded if they did not use IPA, were not included in peer reviewed scientific journals, were not written in the English language, and were studies that did

not include interviews with the individual experiencing psychosis or with a member of their family or were conducted with individuals with a learning disability.

Search strategy

Several approaches were used to search for relevant studies:

Electronic Search

Five computerised databases were searched: MEDLINE (1950 to March 2008), EMBASE (1980 to March 2008), CINAHL (1982 to March 2008), Psychinfo (1967 to March 2008), British Nursing Index (1994 to March 2008).

Search terms included “schizophrenia” or “psychosis” or “delusional mood” or “delusions”. This was combined with the methodology type that included “interpretative phenomenological analysis” or “IPA” or “phenomenological analysis” or “qualitative research”. The final search strategy is presented in Table 1.

Insert Table 1 here

Hand searching

To further inform the sensitivity of the search strategy the *Journal of Mental Health and Qualitative Health Research* were hand searched and 5 further studies were found (Birch, Lavender, Cupitt, 2005; Knight & Moloney, 2005; Longo & Scior, 2004; Macdonald, Sauer, Howie & Albiston, 2005; Rhodes, Jakes & Robinson, 2005),

of which only 1 met criteria (Rhodes, Jakes & Robinson, 2005). The references of the included studies were also manually reviewed to further inform the sensitivity of the search strategy.

Therefore in total 10 studies were identified and reviewed they met the above stated inclusion criteria (Campbell & Morrison, 2007; Knight, Wykes & Hayward, 2003; Newton, Larkin, Melhuish & Wykes, 2007; Osborne & Coyle, 2002; O'Toole, Ohlsen, Talyor, Purvis, Walters, & Pilowsky, 2004; Perry, Taylor & Shaw, 2007; Pitt, Kilbride, Nothard, Welford & Morrison, 2007; Rhodes & Jakes, 2000; Rhodes & Jakes, 2004; Rhodes, Jakes & Robinson, 2005). These studies are summarised in Table 2.

Insert Table 2 here

No studies were excluded based on the quality of the studies. However, 4 studies were not included in the review as they did not meet the inclusion criteria. These studies are summarised in Table 3, clearly stating the reason for exclusion.

Insert table 3 here

Criteria specifically developed by Brocki and Wearden (2006) and adapted by Veitch and Gumley (2007) for studies using IPA were used to assess the quality of the literature (see Appendix 1.1).

Methodological Critique

The focus of the papers reviewed varied greatly. They included exploring the experiences of paranoia (Campbell & Morrison, 2007), stigma (Knight *et al.*, 2003) recovery (Pitt *et al.*, 2007), first episode service (O'Toole *et al.*, 2004), group CBT amongst young service users (Newton *et al.*, 2007) and delusional content (Rhodes & Jakes, 2005). The only commonality was that the individuals included had all experienced psychosis and IPA was the method used to explore their experiences. A summary of the studies reviewed and their findings are presented in Table 2.

All findings were limited to the information contained within the published studies. The criteria will be summarized below, however, a detailed comment on all criteria for each paper was not possible and therefore only the pertinent findings are presented. Also, the length of the articles varied and thus some of the methodological detail may have been excluded in the shorter papers due to word limit constraints.

A subsample of the papers (n=3) were reviewed by the first author of the IPA guide and the findings reported regarding strengths and weaknesses were in concordance with the author's perspective.

Sampling

Smith and Eatough (2006) state that published IPA studies have included, '*sample sizes of 1, 4, 9, 15 and more.*' However, they also state that sample size depends on a number of factors including; '*the richness of the individual cases*' and '*the pragmatic restrictions one is working under*' and there is no '*right*' sample size (p.328). However, there is an emerging consensus on the use of small sample sizes in IPA. Smith and Osborn (2003) suggest '*five or six as a reasonable sample size for a student project using IPA.*' (p.54) Furthermore, Smith and Eatough (2006) have recently been arguing the case for a sample size of one, as this would allow a thorough understanding of that individual's experience and also allow the researcher to focus on relationships between aspects of this individual's account. This may be helpful because of the difficulty large sample sizes can cause the researcher in exploring in detail and gaining an in-depth understanding of participants' experiences which could result in a '*superficial qualitative analysis*' (Smith & Eatough, 2006; p327). However, the single case would have to be chosen carefully if it was to be focussed on exclusively.

The emphasis within IPA studies is for researchers to aim for a purposive homogenous sample as opposed to random or representative sampling. This is done in order that the research question is relevant and has significance for the sample group. The papers included in this review did not explicitly state that they were purposively sampling their group. However, the research questions were pertinent to

the participants sampled, for example in the Newton et al. (2007) paper there were cultural, ethnic and geographical differences amongst the group but all the participants were experiencing distressing auditory hallucinations and had taken part in group therapy.

In the studies reviewed, participant numbers varied from four (Osborne & Coyle, 2002) to twenty five (Rhodes & Jakes, 2005). It was easier to engross oneself within the participants' experiences in the studies that used smaller sample sizes as they were more descriptive and coherent. For example, Perry et al. (2007) explored 5 service users experiences following a first episode of psychosis and one of the three super ordinate themes to emerge was the importance of '*belonging versus alone*' and, within this, the importance of employment emerged. Through reading the following excerpt taken from the paper it was clear that the authors understood the individual's experiences and, more importantly, they were able to convey this to the reader in order for the reader to also appreciate the individual's experiences.

I felt really hopeless when I finally quit my job. I didn't know what to do. I just thought well that's it, I thought my condition's just going to get worse. And I'll end up going to hospital and then I'm never going to be able to get a job again. (Participant 3, Pg 3, Ln 6).

(Perry et al., 2007; p.788)

In contrast, Rhodes and Jakes used larger sample sizes in all three of their papers and this made it difficult for the reader to obtain a full understanding of the participants' experiences (Rhodes & Jakes, 2000; Rhodes & Jakes, 2004; Rhodes, Jakes & Robinson, 2005). In 2005 they explored delusional content in 25 participants,

however they reported that of this sample, seven were interviewed and a further fifteen examples of delusions were examined using medical file notes. It is unclear how many transcripts were subject to IPA but their analysis suggested '*six major groups or conceptual domains*' (p.388) of which one was '*Negative interaction domain*' and the individual's feelings of being controlled or dominated. The following quote was taken to illustrate this:

'I was hypnotized to forget.....you can be programmed to do something'.

(Rhodes & Jakes, 2005; p.390)

It may be that the larger sample size did not allow for an in depth analysis but rather a '*superficial*' one, as was suggested may happen when using larger sample sizes by Smith and Eatough (2006). The reader is therefore left with more of a descriptive illustration of delusional content than an interpretative one.

Furthermore, these studies did not exclusively use IPA but instead also incorporated the use of other qualitative methodologies within their analysis. In their 2000 paper, Rhodes and Jakes used two different types of analysis. Analysis for their first phase was carried out with 14 participants and included IPA with features of '*grounded analysis*'. The second phase of the study followed Miles and Huberman (1994) ideas concerning within-case analysis. When interviewing participants about highly emotive experiences such as psychosis, researchers should try and do justice to their experiences when reporting them, in order that the reader can appreciate what the individuals have experienced and IPA, when done well, allows you to do this.

However, the use of mixed methodology in these papers made the findings difficult to follow and meant it was difficult to obtain an understanding of individual experiences.

Data Collection

The use of semi-structured interviews has been described as the exemplary method of data collection for IPA (Smith & Osborn, 2003). This form of data collection allows both the researcher and participant to engage in a dialogue and questions can be adapted in the light of participants' responses. The interviewer is able to probe interesting, important or even unexpected issues that may arise and follow on from the participants' own interests or concerns, which is one of the basic concerns of IPA. It attempts to gain access to the experiential world of the participant and attempts to understand it from the perspective of that person, thus, semi-structured interviews facilitate this as they are flexible and facilitate rapport. The researcher is not dictated by the interview schedule but rather guided by it. In doing this, the participant is perceived as the experiential expert on the subject and the researcher is guided by the participant in his/her experiences and will be able to gain a thorough understanding of their experiences. However, it is also important to note that such rich verbal accounts can also be collected through other means, including participants writing autobiographical or personal accounts, taking part in online interviews, diaries or email interviews.

All studies with the exception of one used semi-structured interviews as their method of data collection; O'Toole et al. (2004) used focus groups. Campbell and Morrison (2007) stated '*... in line with recommendations for IPA (Smith et al., 1999) questions were open ended and neutral*' (p.66). Newton et al. (2007) reported that '*...questions were open, and were generally constructed in order to prompt narration, reflection and evaluation rather than rationalization*' (p.131). Knight et al. (2003) also stated that the use of semi structured interviews '*...enabled the interviewee to discuss issues of prime concern or interest to themselves, and as such, the interview is neither rigid in sequence nor in usage of all questions stated. Questions were kept deliberately open, providing cues for participants to talk with a minimum amount of interruption or constraint by the interviewer.*' (p.213). The authors also reported that they prepared a greater number of questions than are commonly used in IPA studies because of the potential difficulties that may arise in interviews with participants with psychosis. Newton et al. (2007) also found that the participants sometimes needed further prompting and the questions needed to be asked more than once or in different ways. The paper by Newton et al. (2007) was the only paper, following Knight et al.'s (2003) paper, to acknowledge this explicitly and to attempt to address it, with a greater number of questions. Rhodes & Jakes (2004) used detailed case notes and also interviewed 9 of their 23 participants in order to triangulate their data.

Brocki and Wearden (2006) suggested the importance of conveying an understanding of how the interview was constructed, or including a copy of the interview so that the reader may judge the quality of the interview and the impact this may have had on the

data obtained. However, they note that in their review, papers' rarely detailed this information. Similarly, it was found that only one paper in this review provided a copy of their interview (Campbell & Morrison, 2007), while others gave information about what topics the questions focussed on (Knight *et al.*, 2003; Pitt *et al.*, 2007) and gave example questions (Newton *et al.*, 2007; Rhodes & Jakes., 2000; Rhodes, Jakes & Robinson, 2005). Perry *et al.* (2007) stated the broad areas the discussions focussed on, which gave the reader a better understanding of the types of questions posed, but they added, '*Although these questions were used to guide the discussion, the order of the questions was flexible and a non-directive approach was adopted to encourage participants to develop and elaborate their own narratives about their experiences.*' (p.784).

In IPA research '*there is no attempt to test a predetermined hypothesis of the researcher; rather the aim is to explore, flexibly and in detail, an area of concern*' (Smith & Osborn, 2003; p.53) but as Brocki and Wearden (2006) have suggested, without providing a copy of the interview but stating the topic areas covered, the researchers are, in effect, structuring the analysis before the data collection begins, especially if the themes obtained are similar to the topic areas. Furthermore, the papers included in this review gave very little information on how interviews were constructed. Newton *et al.* (2007) stated that the '*development of the schedule was informed by established conventions for semi structured interviews (Mishler, 1986 and Smith, 1995)*' (p.131) and Osborne and Coyle (2002) stated their interview was '*.....informed by existing models of grief.*' (p.309). O'Toole *et al.* (2004) explored

service users' experiences of first episode intervention using focus groups. They stated that a '*topic guide*' was used in their focus groups, but gave no information on the types of questions included or what they focussed on. Newton et al. (2007) state, '*Focus groups have a tendency to produce consensus and to marginalize dissenting voices.*' (p.145) and it has also been suggested that data elicited from focus groups may be different from interview data, but this may depend on the issues being discussed. For example, participants may not feel comfortable discussing more personal matters within a group setting.

Generalisability

IPA is not opposed to making general claims in relation to larger populations, but is committed to the analysis of small numbers of cases which may subsequently lead onto generalisations. Brocki and Wearden (2006) found that some authors did argue for the generalisability of their results and state that whilst an IPA analysis may not strive for generalisability, neither should it merely retell the respondents' accounts. '*The aim is not to create a representative study, but to understand the manner in which stigmatisation impacts on the lives of certain individuals.*' (Knight et al., 2003; p211).

The authors included in this review tended to discuss the issue of generalisability in the discussion and limitations section of their papers and made the point that obtaining representative results is not the aim of qualitative research. O'Toole et al. (2004) mention that their small sample size may significantly limit the

generalisability of their results but they do say that the views expressed '*will only reflect the views of those who attended the group...*' (p325) and they also acknowledge that this is a standard approach in qualitative research. Pitt et al. (2007) also explicitly state that generalisable results are not the purpose of qualitative research. However, some of the papers reviewed did not mention this (Campbell & Morrison, 2007; Rhodes & Jakes, 2004; Rhodes, Jakes & Robinson, 2005).

Analysis

Smith and Eatough (2006) have said that IPA is not a prescriptive approach but '*provides a set of flexible guidelines which can be adapted by individual researchers*' (p.133) and that this is especially true when it comes to the analysis.

All papers reviewed here explicitly state that they are using IPA but, as Brocki & Wearden (2006) also found, the extent to which the authors describe the analysis process varies from paper to paper, with most referencing Smith et al.'s (1999) detailed account of the analytic process. However, Newton et al. (2007) referred to Reid, Flowers and Larkin (2005). Rhodes et al. (2005) describe their method of analysis as a '*thematic approach drawing principally on methods illustrated by Smith*' (p386). However, they also used an additional type of analysis which involved the use of matrices as described by Miles and Huberman (1994). Furthermore, O'Toole et al. (2004) also refer to Miles and Huberman (1994) and Millward (2000), despite explicitly stating that they are using IPA. Campbell and Morrison (2007),

Knight et al. (2003), Newton et al. (2007) and Osborne and Coyle (2002) all describe the analysis process in detail. Knight et al. (2003) also compared IPA to other methods in order to justify their choice of IPA, which helped the reader appreciate the usefulness of this method with this particular population.

‘However, these approaches contain inherent difficulties for the present investigation, which aims to examine the association of verbal report, behaviour and cognition, without discounting potentially key themes due to their frequency within the text.’

(Knight et al., 2003; p.211)

Evaluating the analysis

It is important that the connection between participants’ own words and the researchers’ interpretations is not lost. Smith and Eatough (2006) stated that if the researcher has been successful *‘it should be possible for someone else to track the analytic journey from the raw data through to the end table’* (p338). The aim is to provide an account which moves between the descriptive to the different levels of interpretation, but at all times clearly differentiating the participants’ words from the researchers’ analysis. They also state that sufficient data should be presented for the reader to be able to assess the usefulness of the interpretations.

The use of excerpts from transcripts is emphasised in order to provide a grounding of the themes in the person’s own words, which is central to IPA. Perry et al. (2007) managed to do this beautifully through using the individuals own words to illustrate and label the themes, *‘Labels were chosen because they were felt to represent the*

essence of the theme. Where possible, participants' words were used to label themes in order to stay close to the original transcripts.' (p784). The themes were labelled; *'What's it all about?'*, *'Banged up'*, and *'Belonging versus alone'*. This was the only paper to do this for all emergent themes.

O'Toole et al. (2004) attempted to bring the themes from the three focus groups together and displayed these using a data display procedure adopted from Miles & Huberman (1994). This was the only paper to have done this and while it was clear what themes emerged, it was felt the authors were simply describing what was said and illustrating with quotes. The outcome of experiences was one of the themes that emerged and this was shown through the following quotes; *'I'm a lot more confident being on my own'*, *'I feel a lot more independent'*, and *'I used to hear voices very loud, loud has gone down'* (p.323) and while they described the outcome of the experience, a level of interpretation has been lost.

Newton et al. (2007) explored the experiences of group-CBT amongst a group of young people experiencing auditory hallucinations. They found that two main themes emerged and while the first theme was closely grounded in the data, the second is more interpretative and *'to some extent, more speculative'* (p.133). They state that within the second theme they *'offer an interpretative account of what it means for the participants to have such concerns, in the particular contexts in which they are attempting to make sense of their experiences.'* these are complimentary aspects of IPA (Newton *et al.*, 2007; p137). Knight et al. (2003) highlighted that the themes

were not chosen purely for their prevalence, stating: '*connections were made from the dialogue, rather than from a pre-existing theoretical position.*' (Knight *et al.*, 2003; p213) and '*Other factors, including the richness of the particular passages which highlight the themes, and how the theme helps illuminate other aspects of the account are also taken into account*' (Smith *et al.*, 1999, p. 226).

Rhodes and Jakes (2000) presented very short quotes from the transcripts within a table and there was no discussion of how themes were selected. They did not use excerpts from transcripts in their 2005 paper. In addition, in their 2004 paper, their use of categories rather than themes is confusing, as is the matrix presented on p214, but they did use excerpts from transcripts. Furthermore, Rhodes and Jakes description of themes resembled the overarching themes that were prevalent at that time and it became difficult as a reader to develop a full understanding of whether the themes presented in the results actually reflected the participants' experiences. In their 2005 paper it was difficult to follow what the participants said in interviews and how the authors interpreted those quotes and presented them. Furthermore the themes presented reflected the predominant theoretical thinking of the time, for example, there are similarities with Garety, Everitt & Hemsley's (1988) research into the characteristics of delusions and their emergent themes.

Campbell & Morrison (2007) presented very detailed evidence of their themes within the transcripts and also stated '*Some themes helped to explain others and these were identified as super ordinate concepts which held other themes together*' and the

'emerging themes were then cross-checked with the text to ensure that the analysis was firmly grounded in the accounts.' (Campbell & Morrison, 2007; p.66)

In order to gain a fuller understanding, it was helpful having the description of the themes strongly embedded and illustrated with quotations, as in the following example from Perry et al. (2007; p 786)

When I first got there I didn't like it cos I was locked in a room. There was just like a bed you know. And people used to walk past all the time and lift up like a little wooden panel and look through a glass window at me.

This evokes a sense of emotion in the reader and illustrates perfectly the subordinate theme that emerged of *'I just felt like an animal, being locked up all the time.'*

Reflexivity

In IPA research the analysis is the result of the interactions between the participants and the researcher. It is considered to be phenomenological (participants' account) and interpretative (researchers' interpretations of the participants' account). In order for the researcher to be able to unravel the meaning of the participants' experiences they need to interpret meaningfully how the participant makes sense of the world. These interpretations are based on the researcher's own understanding, beliefs, expectations and experiences (Smith *et al.*, 1999). Therefore, personal reflexivity

involves reflecting upon the ways in which our own beliefs, values and experiences will have shaped the research. IPA requires reflexivity from the researcher, who is expected to explicitly present his or her own perspectives (Willig, 2001).

Brocki and Wearden (2006) argued that this process should be acknowledged by the authors prior to and during the analysis stage, including their research interests, theoretical grounding and why they chose this area of research. They believe that this would assist in the interpretative facet of IPA. Perry et al. (2007) stated '*....it is acknowledged that the researcher was white and female and had pre-existing ideas about the importance of hope in recovery from psychosis.*' (p.791). However, in this review, while all the papers acknowledged the importance of acknowledging their own perspectives only three papers explicitly stated their own and factors that they believed may have shaped their interpretative frameworks (Newton *et al.*, 2007; Osborne & Coyle, 2002; Perry *et al.*, 2007). A particular strength of the Pitt et al. (2007) paper was that the researchers themselves were service users with personal experience of recovery from psychosis.

O'Toole et al. (2004) stated that it is important that the person conducting IPA is '*independent*' and thus their analysis was done by an independent researcher trained and practised in IPA. However, it is impossible for the person carrying out the analysis to be free from preconceptions and, although the independent researcher may not have had a vested interest in this research, his/her preconceptions should still have been acknowledged.

The paper by Campbell and Morrison (2007) discussed the role of the researcher from the outset in their recognition that IPA “*research is a dynamic process in which the researcher also has a role to play*” (p65). They also stated ‘*The emergent themes are grounded in participant’s narratives but it is inevitable that the researcher’s own conceptions are inherent in the findings. This is a necessary aspect of IPA but attempts were made to validate the final analysis by carrying out respondent validation.*’ (p.66).

Validation

IPA and qualitative research generally has raised questions of reliability and validity but it must be noted that IPA is subjective and researchers are unlikely to come up with the same analysis as one another. Yardley (2000) has argued that reliability may be an inappropriate criteria against which to measure qualitative research and that the use of inter-rater reliability measures only produce an interpretation that has been agreed by two people rather than functioning as a check of reliability.

While the papers included in this review discussed how researcher bias was minimised in selecting themes, for example: ‘*constant reflection and re-examination of the verbatim transcripts*’ (Knight *et al.*, 2003; p213) and ‘*the emerging themes were then cross checked with the text to ensure that the analysis was firmly grounded in the accounts*’ (Campbell & Morrison, 2007; p66), other validation strategies were

also used. Some of the papers had their analyses checked and interpretations validated by the second author or by another member of the research team (Knight *et al.*, 2003; Newton *et al.*, 2007; Pitt *et al.*, 2007; Osborne & Coyle, 2002). Knight *et al.* (2003) state that '*initially interviews were transcribed twice, independently by the principal researcher and by a mental health consumer in order to verify dialogue*' and they later stated that '*the primary analysis was contingent upon the interpretation of the principal researcher, and an independent researcher experienced in IPA methodology conducted external reliability of analysis.*' (p.213).

There is no evidence to suggest that interviewing as a data elicitation technique yields data which are less valid or reliable than other methods (Breakwell, 2006). However, one method of improving validity in qualitative research is to ask the participants for their thoughts on the findings. Only two of the papers reviewed carried this out, Rhodes, Jakes & Robinson (2005) and Campbell & Morrison (2007) who also stated, '*...descriptions of some of the themes were updated in response to this consultation*'. (p.67). However, in an earlier paper by Rhodes & Jakes (2004), reliability was examined by the blind rating of examples and they went on to report kappa coefficients. This reporting of statistics in a qualitative research study seems inappropriate.

Discussion

Interpretative Phenomenological Analysis is increasingly being used within health and clinical psychology and, to date, there have been ten studies investigating the experience of psychosis. These papers were reviewed ; however, it was not possible to convey an understanding of what these papers add to the psychosis literature as a whole, as the research was not brought together in the terms of a meta synthesis. A direct comparison could not be made between the studies as they looked at different aspects of this complex phenomenon. Studies explored experiences of paranoia (Campbell & Morrison, 2007), stigma (Knight *et al.*, 2003), recovery (Pitt *et al.*, 2007), first episode service (O'Toole *et al.*, 2004), group CBT amongst young service users (Newton *et al.*, 2007) and delusional content (Rhodes & Jakes, 2005). Given this diversity of topics, the aim of this review was not to synthesize the findings but instead to attempt a methodological critique of the papers.

The studies in this review varied greatly in terms of the principles of IPA and the extent they followed these recommended principles. They varied in all aspects including; data collection, sample size, presentation of themes, reflexivity and validation. All the studies with the exception of O'Toole *et al.* (2004) used semi structured interviews as their method of data collection and all papers explicitly stated the use of IPA with most referencing Smith *et al.*'s (1999) paper. However, despite the emerging consensus on the use of small sample sizes, the participant numbers varied from four (Osborne & Coyle, 2002) to twenty five (Rhodes & Jakes, 2005).

Moreover, there was a variation within the papers in relation to the discussion of reflexivity and generalisability. The use of excerpts from transcripts has also been emphasised in order to ground the emergent themes within participants account but the papers in this review varied in the extent this was done.

IPA aims to capture and explore the experiences of the individual without testing hypotheses or making assumptions about the meaning of the topic being investigated (Reid, Flowers & Larkin, 2005). Within IPA research, the richness and depth of the data allows researchers to engage with the topic at a level which would be extremely difficult to reach with quantitative data or with less idiographic methods. Qualitative research has been criticised on the basis that it has a tendency to rely on articulate participants, which limits it to those populations who can be heard. However, this conflicts with one of the main aims of qualitative research, which is to allow participants to present their own perspective on the phenomena being studied (Elliot, Fischer & Rennie, 1999). Thus, one could argue that because of the limited voice individuals with psychosis tend to have, and the idiosyncratic nature of each individual's experience and search for meanings, IPA has much to contribute to the psychosis literature. Not only will IPA give this population a voice, but it also attempts to give meanings to their voice. This is especially important for this group, as they are seldom given a chance to convey their experiences.

However, this review found that the reader was only able to obtain a through understanding of the participant's experiences through the studies that had used

smaller sample sizes and grounded the themes within the participant's accounts. In addition, due to the complex nature of psychosis and the heterogeneity within this phenomenon, the use of small, homogeneous sample sizes could be advantageous. Researchers should not attempt to capture the diversity within this population but rather target their needs as individuals and through doing so, IPA fits in well with the National Health Service effort to acknowledge the voice of service users and the increase in patient centred research. In order to improve services, it is important to hear from the individuals that use services and IPA can allow their experiences to be conveyed and understood.

IPA encourages the researcher to enter the individual's world in order to gain an '*insider perspective*'. In order for the researcher to be able to unravel the meaning of the individual's experiences, they need to interpret meaningfully how the participant makes sense of the world. These interpretations are based on the researcher's own understanding, beliefs, expectations and experiences (Smith *et al.*, 1999). Brocki and Wearden (2006) stated that the researcher's perspectives and beliefs should be acknowledged and interpretations made in light of this. However, only three papers within this review explicitly stated this, and thus it was not possible to ascertain if the themes were influenced by this. Perry *et al.* (2007) discuss their own '*struggle*' in trying to find meaningful narratives but in doing so, also the participants' struggle to explain their understanding of their experiences and emphasised the usefulness of engaging in reflective discussions. Being able to stand back and reflect on the narratives in order to find meaning within them is a crucial aspect of the analysis in

IPA as it helps the researcher gain an in depth understanding of the individual's experiences and in turn enables the reader a better understanding.

As stated earlier, in order to have confidence in the quality of qualitative research some way of assessing it is needed, yet on the other hand it is thought that the creative aspects of qualitative research may be suppressed through doing this. Forshaw (2007) asks '*Do we lack the courage of our convictions?*' He wonders why researchers feel constrained by attempting to achieve rigour and the pursuit of replicable and verifiable evidence and why others feel the need to evaluate this. Forshaw (2007) also states that researchers should '*give up trying to do things 'properly' and telling others what our version of properly actually is.*' (p478). Which, some may say, in the true meaning of qualitative research makes perfect sense; qualitative researchers attempt to understand and explore phenomena and do not try to uncover a '*universal truth*' (Lyons, 2007; p4). Thus, perhaps there cannot be a '*proper*' way of doing this and '*thoroughness*' and '*method*' are simply '*restrictions on creativity and invention.*' (Forshaw, 2007; p479).

The author is aware that the present review, which aimed to carry out a methodological critique of IPA studies in the field of psychosis and to evaluate the '*thoroughness*' of IPA within these papers, appears to contradict the above view. Nonetheless, it was felt that whilst criteria should not constrain expression, there remains the important issue of how researchers develop a coherent account which provides a convincing portrayal of individuals' experiences and meanings.

Furthermore, the development of multiple qualitative methods provides researchers with different analytic routes to explore phenomena and the strength of IPA, as opposed to other methods, is that it focuses on homogeneity and developing an understanding of individuals' experiences and the meanings expressed within the data.

However, it has been suggested that if a researcher becomes consumed with using the purest version of a method possible, they can lose sight of what is ultimately important in the research and thus become guilty of '*methodolatry*' – *a slavish attachment and devotion to method*'. (Coyle, 2007; pg 26). This may result in a rather constrained analysis that, if the researcher had explored different analytic routes, could have been enhanced. In saying this, there will be limits to just how much a researcher can adapt a particular method, as they then run the risk of their analysis not being seen as a legitimate example of that method. Coyle (2007) states that '*With experience, researchers can develop a sense of the limitations of a given method and the issues that it does not deal with clearly or well and can develop possible strategies for addressing such limitations in order to answer research questions more effectively.*' (p.27). Therefore, as IPA is a relatively new qualitative method, it may be that the authors of the earlier papers reviewed, which have been reported to be of poorer quality, were actually trying not to be guilty of '*methodolatry*'. However, as IPA has evolved over recent years, what is now reflected is that these papers do not appear to use IPA in the sense it currently exists.

Most qualitative methods, including IPA, Grounded Theory, Narrative analysis and Discourse analysis emphasize the importance of developing an account that is grounded in participants' data. However, there are also significant differences between these approaches. IPA and narrative analysis place significance on language like discourse analysis, but the methods differ in terms of the importance they offer to '*subjectivity and experience of the self and body*' (Crossley, 2007; p133). Discourse analysis does not use an individual's language as a way of gaining access to their psychological and social worlds; instead it prefers to consider individual accounts as behaviours in their own right. Through doing this the ensuing account does not allow the reader to gain a perspective of how and what the individual thinks or feels about their experience. Within IPA the primary concern is to provide an in-depth and detailed description of the participants' lived experiences rather than an explanation of why. In contrast, in Grounded Theory the aim is to develop an explanatory theory on the basis of the data.

Due to the variation within qualitative methods, there is no consensus on the best criteria for evaluation, but according to Coyle (2007) '*the key factors in determining the quality of their research will be the skill and creativity with which they apply the principles of the various methods.*' (p.28).

Conclusion

IPA claims that through purposive sampling a small, homogenous sample, grounding interpretations in the participants' accounts and illustrating themes with quotes from narratives, it can help to convey an understanding of individuals' experience. However, the studies reviewed here varied in the extent they followed the principles of IPA and thus it is difficult to say where the boundaries of methodological flexibility actually lie. Nonetheless, IPA appears to have achieved a place within qualitative methodology and is being used increasingly within health and clinical psychology. It is hoped that this review will contribute to the literature and inform future researchers who wish to carry out qualitative research in the field of psychosis.

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Table 1. Final Search Strategy.

	SEARCH TERMS
1	schizophrenia.mp. [mp=ti, ot, ab, nm, hw, it, sh, tn, dm, mf, tc, id]
2	psychosis.mp. [mp=ti, ot, ab, nm, hw, it, sh, tn, dm, mf, tc, id]
3	delusional mood.mp. [mp=ti, ot, ab, nm, hw, it, sh, tn, dm, mf, tc, id]
4	delusions.mp. [mp=ti, ot, ab, nm, hw, it, sh, tn, dm, mf, tc, id]
5	interpretative phenomenological analysis.mp. [mp=ti, ot, ab, nm, hw, it, sh, tn, dm, mf, tc, id]
6	IPA.mp. [mp=ti, ot, ab, nm, hw, it, sh, tn, dm, mf, tc, id]
7	phenomenological analysis.mp. [mp=ti, ot, ab, nm, hw, it, sh, tn, dm, mf, tc, id]
8	qualitative research.mp. [mp=ti, ot, ab, nm, hw, it, sh, tn, dm, mf, tc, id]
9	5 or 6
10	7 and 9
11	8 and 9
12	1 or 2 or 3 or 4
13	10 and 12
14	11 and 12
15	13 or 14
16	Remove duplicates from 15

Table 2. Summary of Included Studies

First Author & Year	Sample Size	Focus of Study	Method of Data Collection	Summary of Findings	Discussion
Campbell, M.L.C 2007	12 service users	Subjective experience of paranoia.	Semi structured interview	4 themes: 'the phenomena', 'beliefs about paranoia', 'factors that influence paranoia', 'consequences of paranoia'.	Researchers interpretative role discussed prior to & throughout analysis. Copy of interview. Conducted respondent validation. Lack of argument for sampling non-patient group.
Knight, M.T.D 2003	6 service users	Investigation of stigma	Semi structured interview	Super ordinate themes of 'judgement', 'comparison', and 'personal understanding of the (mental health) issue'.	Consideration of potential difficulties interviewing individuals with psychosis. IPA described in detail & compared to other methods to justify use. Analysis described in detail but limited discussion of the researchers' interpretative role. No copy of interview
Newton, E. 2007	8 service users	Young peoples experiences of group CBT for auditory hallucinations.	Semi structured interview	2 super ordinate themes: 'A place to explore shared experiences' and the second was an inductive account of coping with auditory hallucinations.	Researcher's interpretative role explicitly stated & the authors discussed the fit between theory & method and why they used IPA. No copy of interview
Osborne, J. 2002	4 parents of children with schizophrenia	Investigating parental responses to children with schizophrenia & whether or not they can be conceptualized in terms of loss and grief.	Semi structured interview	The perception of loss was not uniform amongst participants.	Explicit recognition of researcher's preconceptions and interpretative role. No copy of interview
O'Toole, M.S. 2004	12 service users	Exploring service users experiences of a first episode intervention	Focus Groups	Key themes: 'human' approach as key to the recovery process, being involved in treatment decisions, flexibility, high nurse to patient ratio, being treated in context, reduction in psychotic symptoms, increased confidence & independence, provision of daily structure.	It was the first qualitative evaluation of user's experiences of a specialist first treatment intervention but used other methods and not exclusively IPA. No copy of topic guide

Perry, B. M. 2007	5 service users	Investigating the personal experiences of participants following a first episode of psychosis and exploring influences on feelings of hope.	Semi structured interview	3 super ordinate themes: ‘ What’s it all about’ ,’banged up’, ‘belonging versus alone’	Very well written and presented. Methodology section described well. Excellent description of IPA and justified use well. Themes well described and embedded in participant’s narratives. Researcher’s interpretative role and reflective process discussed. However, no copy of interview presented.
Pitt, L. 2007	7 service users	Subjective experiences of recovery in individuals who have experienced psychosis	Semi structured interview	3 themes: ‘the rebuilding of self’, ‘the rebuilding of life’, ‘hope for a better future’	User led research and themes illustrated well. Lack of information given on analysis process. No copy of interview
Rhodes, J.E. 2000	14 service users	Correspondence between delusions and personal goals	Semi structured interview	6 super ordinate categories : ‘social’, ‘competence’, ‘experiential base’, ‘material base’, ‘direction’, ‘evaluation’	Acknowledge analysis may be influenced by researcher’s preconceptions. Other methods used, not exclusively IPA. Difficult to follow analysis and results section. Not embedded in participants narratives, authors only present short quotes in table
Rhodes, J.E. 2004	23 service user - 9 were given an additional interview	An attempt to describe and understand the types of ‘reason’ or ‘evidence’ for delusions patients give to support their beliefs during CBT	Detailed case notes and interview	The case notes generated 10 types of evidence including ‘object perception’, ‘thought transfer’, ‘volition’ and 5 further types of evidence from the interviews inc ‘reference to the real’, ‘appeal to motivations’ and ‘avoidance and ambivalence’.	Included individuals who had experienced a range of delusion types (grandiose, persecution etc). Acknowledge analysis may be influenced by researcher’s preconceptions Use of large sample size. Also, don’t exclusively use IPA but also other methods of analysis. Discuss categories rather than themes. Participant quotes seem to be used to evidence their pre determined categories
Rhodes 2005	25 service users	A qualitative analysis of delusional content	Semi structured interview	34 themes which fell into 6 general topic ‘domains’; ‘negative self’, ‘negative interaction’, ‘special self’, ‘identity and relationships’, ‘specific mental experience’ and ‘entities’.	The use of respondent validation was a strength but used a large sample size – not clear whether or not all subject to IPA. No use of verbatim quotes from narratives.

Table 3. Summary of Excluded Studies

First Author & Year	Focus of study	Reason for exclusion of study
Birch, S 2005	The study explored the physical healthcare needs of women with mental health problems using IPA	The study did not explore the women's experience of psychosis but focussed on their physical illnesses.
Knight, M, T,D 2005	The aim of the study was to explore whether community mental health team (CMHT)staff members have considered how stigma may adversely affect the quality of services provided	Interviews were not individuals with psychosis but with members of the CMHT.
Longo, S 2004	The authors used IPA to explore how individuals with intellectual disabilities and their primary carers experience a psychiatric inpatient admission	Interviews were with individuals with an intellectual disability and their carers.
Macdonald, E 2005	The authors aimed to explore individual's experiences of social relationships during the recovery phase of first episode psychosis	The data were analyzed using Colaizzi's (1978) and Moustakai (1994) accounts of phenomenological analysis and not Interpretative Phenomenological Analysis

Major Research Project

An exploration of the experiences of being involved with psychiatric services and psychiatric admission for individuals with psychosis: an interpretative phenomenological analysis

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Abstract

Background: It has been found that patients have expressed favourable attitudes towards hospital settings (Weinstein, 1979) but more recently, evidence from service user feedback has indicated the experience of psychiatric admission can be felt to be neither safe nor therapeutic (Department of Health, 2002). There has been lack of qualitative research exploring individuals' experiences of psychiatric admission in the context of acute psychosis.

Aims: The aim of this study was to explore the experience and perceptions of psychiatric admission for individuals with psychosis using Interpretative Phenomenological Analysis.

Method: Five participants with psychosis who were currently admitted to a psychiatric ward were interviewed using a semi-structured interview.

Results: Three super ordinate themes emerged, which were labelled: "*I feel like a, a prisoner in here...*", "*...my life is in their hands..*" and "*There is an awful lot of stigma put on mental health patients...*"

Conclusions: The emergent themes suggested individuals felt imprisoned, disempowered and experienced a sense of loss due to their admission but also due to their experiences of psychosis. This was also accompanied by a lack of awareness and understanding from others, which resulted in feelings of stigma but acceptance within hospital. The themes are discussed in relation to previous research and current Government and National Health Service (NHS) initiatives.

Declaration of interest: None

Keywords: *psychiatric admission, psychosis, qualitative research, Interpretative Phenomenological Analysis*

Introduction

The experience of psychosis is different for every individual. It can be a distressing and confusing experience and is often associated with changes in perception, hearing voices, hallucinations and delusional beliefs. Furthermore, acute psychosis often results in psychiatric admission, which can be involuntary and coercive, thus adding to an already distressing and disorientating experience. On one hand the Department of Health (2002) has identified psychiatric admission as an essential component of service delivery but, on the other, in a Scottish context, the Delivery Plan for Mental Health (2006) has prioritised the reduction of inpatient psychiatric admission. While there are many excellent inpatient services with dedicated professional staff, there is also unquestionable and compelling evidence, particularly from service user feedback to indicate the experience of psychiatric admission can be felt to be neither safe nor therapeutic (Department of Health, 2002). The positive aspects are seldom written about and personal accounts from individuals with psychosis have rarely been reported.

There is a dearth of literature exploring the experiences of individuals during psychiatric admission. Weinstein (1979) in a review of the quantitative research found that 78.9% of patients expressed favourable attitudes towards hospital settings. Individuals reported that they enjoyed the amenities of the hospital, did not feel restricted and stated that they felt protected and cared for. Importantly, individuals who were admitted voluntarily perceived their experiences in more positive terms than those who were admitted involuntarily, indicating coercive admissions are not necessarily felt to be therapeutic. More recently and in

contrast, Quirk and Lelliott (2001) found evidence of violence, sexual harassment and substance abuse within acute psychiatric wards. They also found that a high proportion of patients within these settings had been detained in accordance with the provisions of the Mental Health Act. The authors also reported evidence of low staff morale and an increasing rate of staff turnover. Goodwin, Holmes, Newnes, & Waltho (1999) have also shown that individuals within psychiatric settings value relationships with staff. Therefore changes in staff and the use of bank and agency staff may lead to a reduction in the quality of care and may hinder the development of a collaborative therapeutic alliance.

These data begin to portray a potentially complex and contradicted picture where for many the experience of acute psychosis is frequently distressing and traumatic (Meyer, Taiminen, Vuori, Aijala, & Helenius, 1999; Frame & Morrison, 2001). In addition, for a significant number the experience of psychiatric admission may also amplify the trauma, via lack of support and therapeutic engagement. On the other hand, the experience of psychiatric admission for those with acute psychosis could buffer the traumatic impact of psychosis. In any case it is highly likely that the meanings derived from the experience are likely to be highly salient to the process of recovery and adaptation. Therefore, understanding recovery from psychosis is a difficult and complex process and we need to take into account not only the experience of psychosis but also the treatment that accompanies it, including psychiatric admission.

The use of qualitative methodology can help us develop a much more detailed understanding of individual experiences as it allows an in-depth account that

quantitative methods cannot readily access. For example, Goodwin et al. (1999) used qualitative methodology and investigated the experiences of individuals in relation to their use of mental health services including inpatient psychiatric services over a 4-year period. Thirteen themes were identified, which included: feelings of institutionalisation, experiences of hospital as a prison, absence of power and control, lack of respect, lack of information regarding treatment and medication, value of having the opportunity to talk and be listened to and being provided with a secure base for recovery. It was clear throughout the study that individuals appreciated their interactions with staff, especially when they felt heard and cared for. However, lack of information remained a source of anger and frustration, as did individuals' perceptions of imprisonment.

In a more recent qualitative study, Laithwaite & Gumley (2007) used grounded theory to explore the experiences of patients with psychosis in a high security setting. The analysis produced two themes common to all individuals' accounts; 'past experiences and adversity' and 'being in hospital and recovery'. Individual narratives revealed that early experiences influenced the individual's stance taken towards hospital. Many participants in the study described dangerous and frightening early experiences. For some, this led them to perceive hospital as a safe place, which removed them from danger they had experienced in the past. However, for others their experience of hospital and admission was frightening and a continuation of the danger and insecurity they had experienced in the past. Furthermore, participants spoke about their relationships with staff as an important factor in the recovery process and this, along with building relationships with other patients and their family, served an important role in redefining their sense of self and self-esteem.

There has been a lack of qualitative research providing an in depth exploration of individuals' experiences of psychiatric admission in the context of acute psychosis. Quirk and Lelliott (2001) found that the limited qualitative research that exists within this area has focussed on clinical practice and on the views of health professionals rather than the individual's experience. Therefore, given the lack of qualitative studies focussing on the experience of psychiatric admission in the context of acute psychosis, the aim of this study was to explore the experience and perceptions of psychiatric admission for individuals with psychosis using Interpretative Phenomenological Analysis (IPA: Smith, 1996).

Through the use of IPA, researchers aim to investigate phenomena from the perspective of those who have experienced them and the aim is to capture and explore the meanings that individuals' assign to their own experiences. Smith and Osborn (2003) state that in IPA research *'there is no attempt to test a predetermined hypothesis of the researcher; rather the aim is to explore, flexibly and in detail, an area of concern'* (p53). IPA is an idiographic approach, which does not attempt to make generalized assumptions or claims about an experience. It has also been said that IPA values the *'voice and perspective'* (Larkin, Watts & Clifton, 2006) of the individual in his or her own right, this is extremely important in a population that seldom have their voice heard and which can be lost through using nomothetic approaches. IPA not only acknowledges the part the researcher plays in accessing and understanding the individual's experience and the interaction between them, but, it explicitly recognizes the influence the researcher's own beliefs can have on the interpretative process.

Furthermore, Kay and Kingston (2002) suggest the use of IPA for research which is of a complex and personal nature. Therefore, it was particularly suited to this study as it would allow the exploration of individuals' experiences of psychiatric admission; an understanding of how individuals make sense of this experience and the meanings it holds for these individuals. IPA is being used increasingly within health and clinical psychology and recent studies have highlighted its potential in exploring the experience of those with psychosis. Studies have included the exploration of experiences following a first episode of psychosis (Perry, Taylor & Shaw, 2007) stigma (Knight, Wykes & Hayward, 2003), recovery (Pitt, Kilbride, Nothard, Welford & Morrison, 2007) and paranoia (Campbell & Morrison, 2007).

Method

Participants

In accordance with IPA methodology (Smith & Osborn, 2003), the aim was to find a small homogenous sample for whom the research question was significant. There is an emphasis within IPA on the use of small sample sizes and it has been suggested that five or six is a reasonable number for a student project using IPA (Smith and Osborn, 2003). Smaller sample sizes allow the researcher to explore the participants' narratives in more depth, allowing for a greater understanding of the participants' experiences, rather than producing a '*superficial qualitative analysis*' which may result from using a larger sample size (Smith & Eatough, 2006; p.327).

Participants were purposively selected from two psychiatric wards in a Lanarkshire hospital. Ward managers and psychiatric nurses identified potential participants.

The inclusion/exclusion criteria, with regards to homogeneity of the sample, were discussed with the main researcher's supervisor and also with prominent figures within IPA. Whilst the study did strive to achieve a homogeneous sample in terms of IPA, this was ultimately complicated through the idiographic nature of the participant's experiences.

Therefore, the key selection criteria required that individuals had experienced psychosis which ultimately led them to being admitted to a psychiatric ward. Furthermore, inclusion required that individuals fulfilled ICD-10 (World Health Organization, 1992) criteria for schizophrenia, schizotypal and delusional disorders (F20-29), a diagnosis of mania with psychotic symptoms (F30.2), bipolar affective disorder (F31.2, F31.5) or mood congruent delusions and hallucinations (F32.3, F33.3). Although diagnostic criteria were used, this does not reflect the principal researcher's language, but rather that of the environment from which the participants were recruited. It was necessary to use this criteria in order to help staff identify participants and to be inclusive of the range of individuals who may have had psychotic experiences.

Individuals were not included if they were under the age of 18 years, had a learning disability, did not speak English as a first language, were acutely psychotic or were unable to give informed consent. Furthermore, individuals from

ethnic minority backgrounds were excluded from the study because it was felt that their cultural and religious beliefs about mental health would merit a study in its own right.

All participants gave written consent to take part in the study. In total, ten individuals were suggested as potential participants. Two refused to participate due to not wanting their interviews audio taped. Three individuals took part in the piloting of the interview and thus five individuals were interviewed as part of the main study.

Participants ranged in age from 33 to 59 years. Participant characteristics at the time of interview are displayed in Table 1.

Insert Table 1 here

Further information on the participants included in the analysis is displayed in Table 2.

Insert Table 2 here

Data Collection

Interviews were conducted by the principal researcher within a private room in the psychiatric ward in the hospital. Interviews lasted between 45 and 80 minutes and were recorded on a digital voice recorder. The interviews were transcribed by the principal researcher, allowing her to become familiar with the transcripts and data

even before the analysis began. All identifying information was removed to preserve anonymity

Interview Schedule

A semi-structured interview schedule was developed through discussion between the principal researcher and supervisor. This was piloted with a subset of the sample (n=3), these interviews were transcribed by the researcher. The pilot was done in order to practice interview technique and to assess the wording and order of the interview questions. The majority of the questions were omitted after the pilot interviews, as, on reflection the researcher felt she had focussed too much on asking the questions and not enough on the person's account and as a result not probing their experiences further.

The researcher discussed the information sheet with each participant before the interview and thus they were aware of the focus of the study. Therefore, it was decided that only one question would be asked. This gave the participant the opportunity to focus the interview on what they felt was important about their experiences and to open up what Smith and Osborn (2003) refer to as '*novel avenues*' as it is these that are the most valuable and are of importance to the participant. In doing so, it was hoped this would allow the researcher to enter their life world rather than forcing them to enter the researcher's.

I am really interested in finding out about your experiences of being admitted to hospital. I would really like to learn more about your experiences and get a detailed understanding of the experiences that you have had and what they have meant to you. Like I said in the information sheet there are no right or wrong answers and it is basically your perspective that is important to me that I want to hear about. So maybe you could start of by telling me a little bit about yourself?

Probes and specific questions were used where necessary to encourage participants to elaborate on what was being said. The following probes were used during the interviews:

Can you tell me more about?

How did you feel about that?

What did that mean for you?

Can you tell me a little bit more about that?

In order to access elicited specific episodic memories, participants were asked questions such as “*can you give me a specific example of what you mean?*” or “*can you tell me about a particular experience that would describe that*”. In order to encourage reflection on their experience, participants were also asked questions such as “*thinking about that now...*”

The pilot interview data was not used in the analysis. The final sample for analysis therefore consisted of five participants.

All five interviews were conducted before the researcher began transcription. Transcription took approximately 6 hours for every 1 hour of interview. Once all interviews had been transcribed, the researcher started the analysis process, which was completed over the course of 6 weeks.

Analysis

The analytic method within IPA is not prescriptive and allows for creativity within the process of analysis. Due to the subjective nature of the focus of this study, the researcher chose to use an individual approach when analysing the transcripts (Smith, Jarman & Osborn, 1999). Each individual transcript was

therefore treated as an individual case-study, with the same analytical steps applied to each transcript in turn.

The transcript was read several times to become as familiar as possible with the account. Significant and interesting responses were noted in the left hand margin. Emerging themes were then noted in the right hand margin of the transcript; these were listed and the researcher attempted to make connections between the emerging themes and 'cluster' them together. Throughout this process, the researcher made sure the themes remained grounded within the transcripts. The themes were then arranged into super ordinate and sub themes, which appeared to most accurately, represent the participant's narrative. These themes were illustrated by participant's verbatim quotes and, in doing so, the researcher moved between the emerging themes and the participant's transcript in an iterative, cyclical way. This process was repeated for each transcript. Similarities were only looked for after themes emerged for each individual transcript, this allowed the researcher to maintain the unique aspects of each individual's experiences. Overarching superordinate themes were then identified. Smith et al. (1999) suggest that this approach works best for smaller studies.

Reflexivity

The emergent themes are grounded in the participant's narratives, however, IPA is dependent upon and potentially biased by the views of the researcher (Smith, 1995). Thus, it is inevitable that the researcher's biases and pre-existing beliefs will be influential during the analysis process. Reflexivity is a necessary aspect of IPA, in order that the researcher's perspectives are made clear and interpretations

made are in light of this. In this study it is important to note that the principal researcher was a trainee clinical psychologist who had experience of working with individuals with psychosis in an inpatient setting. She had also facilitated a therapeutic talking group, during which individuals had discussed negative experiences including their feelings and thoughts about being on the ward. This made the researcher more aware of the emotional impact of these experiences. The researcher had found this emotionally distressing but, through the process of reflecting on her own feelings, she was able to contain this and, in turn, this shaped her decision to conduct this study and ultimately work within this area.

It was hoped to carry out respondent validation, to reduce any bias and to ensure that the emergent themes were clearly linked to the individuals' experiences and not to the researcher's own beliefs but this was not possible due to time constraints. However, an independent researcher, also using IPA, read a subsample of the transcripts. This was in order to verify the themes identified by the researcher and so that there was '*rich evidence*' (Smith & Osborn, 2003; p.73) within the transcripts to support the themes identified. This process also ensured that any significant themes were not overlooked by the researcher. During the analytic process, the researcher also discussed themes with her supervisor in order to strengthen her reflexivity throughout the analytic process and to ensure that she was not influenced by her own beliefs and conceptions. The comments and reflections were incorporated into the presented analyses.

Results

The themes that emerged during the analysis of each participant's transcript were compared to portray what were felt to be the most significant experiences. Three super ordinate themes emerged, which were labelled: *"I feel like a, a prisoner in here..."*, *"...my life is in their hands.."* and *"There is an awful lot of stigma put on mental health patients..."* Labels were chosen because they were felt to signify the true meaning of each theme and it was attempted to use the participants' own words to label the themes. This was done to keep the themes grounded within the participants' experiences.

The superordinate and subthemes are presented in detail, and extracts are presented from the transcripts to illustrate each theme further. While the quotations have been selected to best illustrate the theme under discussion, since the themes are interlinked the quotations may also inevitably reflect this. The researcher's words are shown in bold text within the extracts.

Superordinate Theme 1

"I feel like a, a prisoner in here..."

(Jean, Pg13:403)

This theme captured participants' intense feelings of being imprisoned and entrapped in hospital. The language used by the participants suggested a strong sense of being dominated and feeling powerless. It was also felt that participants felt this way not just about admission to hospital but also about their lives and

being powerless against the diagnosis given to them. The participants shared the opinion that the mental health professionals had too much power and disagreed with their authority to detain them. This appeared to make these individuals feel helpless, with little say in their lives and as though they were being punished. The following extract also conveys a sense of isolation felt

“I had no idea what section 18 meant, so it was a bit of a shock to me, when they read it out to me and there were about 3 of them, they sat in the ambulance and I felt like a prisoner as if - - kinda just even if I had somebody to talk to, I just felt like I had nobody to talk to.....” (Jean, Pg12:356-358)

The use of words such as ‘*liberating*’, ‘*freedom*’ and ‘*locked up*’ suggested that participants felt trapped on the ward.

“....its just trivial things I get locked up for and that’s 3, that’s 3 months went by and its like whoosh - -do you know what I mean.” (Robert, p14:459-460)

This ‘*freedom*’ was sought not only in the wider context of being discharged from hospital, but also within the ward. The constant observations the participants found themselves under on admission made them feel restricted.

Probably - - the first two days or the first week when you are on constant obs is quite demanding on you cos you are not going out the ward ehh basically you need to through the back for some fresh air and that but after you get the freedom of the ward and you get to go upstairs and you get to go to the shop and back, its liberating you know, it’s something we look forward to and all the patients look forward to it, I look forward to it, being able to get back out, go upstairs and have a cup of coffee or that, that’s what we always look for. (Ryan, Pg17:492-497)

The sense of being punished and being powerless was highlighted in the following extracts, where participants compared being admitted to hospital to being treated like a criminal. This reflected that participants felt they were being treated like individuals who are discriminated against in society because of the choices they have made in life, such as criminals and drug addicts. In contrast, these participants were being treated like this through no choice of their own but due to a diagnosis given to them and a decision made, not by them, to be admitted to hospital. Thus, further emphasising feelings of unfairness, lack of respect and an injustice at being treated in this way.

“Even junkies, junkies with, junkies with big criminal records and attempted murders and all get treated better than, better me, know what I mean.” (Robert, Pg9:279-280)

“...what they are basically sayin is that the psychiatrist has got more right to have you lifted off the street than any other person cos even the police would come and interview you before charging you with a crime but it feels as if you are treated like a criminal with the police involvement. (Ryan; Pg13: 376-378)

It was even reflected that prison may have been a better option, emphasising participant's dislike of being in hospital further. The following extract conveys that the experience of hospital felt never-ending for them. With a prison sentence they would be released eventually but it appeared that these individuals feared readmission, leading them to feel hopeless and disempowered.

“..... as they say they are keeping me in here for 6 months because I wouldn't take the medication. I have to take the medication and I'm detained against my will, I mean it's just like a prisoner. I feel as if, if I had committed a crime and I would've went into prison and done my time and come back out and ehh - - I would still be able to make decisions for myself ehh. . . . (4secs) if I had committed a crime - -I would have still got less time in prison than what I have in the hospital.” (Jean, Pg13:406-411)

With a prison sentence, if an individual does not commit a crime they will not be imprisoned, and thus it seemed that participants felt that there was more justice involved in this decision. Whereas, for these individuals a sense of injustice was felt and that they need someone to ‘fight’ for them. The fear of readmission was heightened further through feeling that their voice is not heard and not having anyone to speak for them.

“I think that’s a voice that should actually be addressed by somebody actually specifically designed to work and fight for patients i.e. a lawyer that’s trained in psychology or psychiatry....” (Ryan, p15:439-440)

It was thought that participants felt not heard because of their diagnosis and being thought of as having an illness

Language such as ‘I have to’ and ‘they tell me’ emphasised the power differential felt by participants, which seemed to be accompanied by feelings of anger and loss.

“The quality of life I had, I lost the life I had cos of the medication. They tell me I hear voices, I’ve never heard a voice in my life so why should I take medication for something I’ve never had. If I hear voices fair enough but why give me medication, I’ve never heard a voice in my life.” (Jean, Pg5:137-140)

The following excerpt shows that Justin felt that he had to go into hospital because, when he refused, the police were called. He appeared to submissively accept this, further emphasising a sense of dominance.

".... I felt well your home's your home ain't it, nobody wants tae come in, and then they suggested that ehh if you don't come in we will bring the police in and they came in and they brought me in - - eh, which is - - one of they things ain't it. (Justin, p6:167-169)

Despite their dislike of being in hospital, participants seemed to accept their situation. On reflection, it was felt that this may have been because they felt that there was nothing they could do to change this or their diagnosis.

'So basically I'm stuck with paranoid schizophrenia on my records and nobody believes, nobody will believe a word you say, know what I mean.' (Robert, p11:359-360)

This further emphasised their sense of being powerless and feelings of entrapment. They expressed a fear that if they did disagree or refuse, they would be sectioned, leaving them feeling trapped, which further impacted on their lives and feelings of loss.

Well basically I'm just stuck in this system - - that's life, know what I mean. There's nothing I can do about it, I just need to bide my time until I get out, get on with my life, know what I mean. (Robert, pg7:217-219)

Thus, this superordinate theme captured some of the meanings attached to having psychosis and being admitted to hospital, which included participants feeling disempowered, entrapped and coerced. This is intertwined with the following theme of *'my life is in their hands'*.

Superordinate Theme 2

‘..my life is in their hands..’

(Jean, Pg9:287)

This superordinate theme captured the feelings of loss experienced by participants on being admitted to hospital. During the course of analysis it was clear that their experiences varied greatly and the way in which these participants made sense of their admission differed. However, a sense of loss emerged for all participants. This included loss of freedom, independence and autonomy, loss of employment and loss of being able to drive. Essentially the loss of their life the way they knew it and more importantly their identity. Moreover, the loss felt was not only due to the admission but also their experiences of having a diagnosis of psychosis. The loss experienced was accompanied by feelings of anger by some participants but for others acquiescence.

The following extract reflects the loss of independence and also highlights the restrictions felt.

What does it mean to you being in here?

It's wasted my life, its really a wasted life.... I mean they are making decisions for you, they are telling you when to go to bed, when to get up and - - you have to ask them if you want to go out for a walk, can I go out for a walk. They are takin, they are takin that - -all away from you and while you are in here life is going on out there and I should be out there getting on with my life. (Jean; 413-418)

These restrictions meant that participants were unable to live their lives the way they would choose to, because of the admission, but also because of the diagnosis

given to them. They felt limited in what they could do through not being able to work, not being allowed to drive or go on holiday and the regular attendance expected at clinic appointments and groups. It appeared that these restrictions may have contributed to the loss felt.

“I like to think that the more authorities that we give a mental health team to help us, i.e. to re housin us, applyin for things then the more they have go to dae with your life, I mean I don’t mind visitin Doctor (Name) once every month for a - - a review and involvement with my CPN after a period of time but I don’t want them every week in my face and crowdin out my life and I find that mental health teams tend to crowd out your life quite a lot if you allow them to.....I mean I absolutely hated the mental health team emm because of their forceful attitude upon you.... a lot of people have got - - have got social workers - - ,they have got CPN’s, they have got psychiatrists, they have got hospital visits and a lot of folk actually spend all their lives involved in mental health, 90% of it, whereas I like to think that maybe a small percentage is mental health...”(Ryan; pg7:184-206)

The above extract also conveys a sense that due to the accumulation of appointments because of their diagnosis, participants felt that they were not able to live their lives the way they would like to.

The loss of employment is reflected within participants’ transcripts. They emphasised that through the loss of their job their financial security would also be affected, this, in turn, would affect their quality of life. A sense of disappointment was felt as work was obviously an important aspect of their lives. Moreover, this disruption to their employment was not only due to the admission but also because of their illness.

“...my doctor does’nae agree that I should be working - - he feels that I’m not well enough to work and I disagree with this. I feel I need to work...

Is work quite important to you?

Well, I worked all my days and it is quite important, I like to get out - - Earning ehh money reasons, financially better off, I like company, I enjoy working. I just enjoy out working ehh - (Jean, Pg1:18-28)

However, Justin attempted to accept and understand this through comparing mental health difficulties to physical health difficulties.

“Well, a bit of a come down for me, you know, well no a come down but obviously if your no well then you cannae work its just like anybody else, its just like somebody else havin maybe heart problems or another part of their body you know ehh your mind is no different from anywhere else, you know, your mind can be effected just like your heart or your leg, you know.” (Justin, Pg5:125-128)

Whereas, Ryan expressed his anger at being banned from driving because this affected his business plans. Thus, this linked in with the loss of employment and lack of financial security felt by participants, which would impact negatively on their quality of life.

“I was absolutely fizzing mad at the psychiatrist for banning me.....driving is a privilege but for some folk it’s a necessity and for myself, if I wanted to start up a business it would be a necessity.....” (Ryan, pg4:112- 115)”.

Jean’s loss is encapsulated in the following extracts, where she described having her life ‘taken’ from her. To be told your life never existed and is all in your mind must have been extremely difficult, and there is a sense of anger and frustration which, beneath it appears to be a great deal of sadness and sense of loss. However,

this was not just experienced on admission but has been throughout her experience with psychiatric services.

Everything I say nobody believes me, it's all made up, my full life is just blanked out. My life for me ehh I have'nae been married, I've never ehh, I've no got a son, I've no got a family even my grandpa does'nae exist, my full life is as if it hasn't existed so all I've done was worked as a machinist in (city name) and everything else is cut out. They have given me - - they have took away - - my full life. . . (Jean, Pg16:479-482)

The use of the word 'we' in the following extract suggested Robert saw himself as part of a group, united through this experience of admission, on which individuals want to have their voice and opinions heard. It also highlighted that participants would prefer to choose whether or not they want to go to hospital and would appreciate the opportunity to organise themselves before being admitted. It was felt that this would make them feel valued, empowered and respected.

I've had difficult experiences down here emm generally not with the staff, just generally the psychiatrist or a CPN or somebody comin down to let me know my rights whereas basically we do know our rights fae day one but it's just we are no getting the right voices concerned, we are no getting right through to the right people concerned that we want more rights. We want the right to refuse to come down to hospital unless we are guaranteed a certain period of time. I mean I thought when I was asked to come down voluntary for a month then I was comin for a month voluntary but I was comin for a month voluntary but then after that it was a forceful emm stay against my wishes, whereas I felt I was lied to. (Robert; p15:420-427)

The loss of respect felt is further highlighted by Jennifer through an invasion of privacy.

Losing the mirror was immaterial; it was the manner in which it was done. I feel as if my dignity has been shot to bits enough without - - I wouldn't do it. I believe to treat others as I would treat myself and I would never go into anyone's - - I think its bad enough my wee luggage bag but to go into my personal handbag - - and when they move my things, everything was just thrown everywhere with such disrespect, you know, I was very upset about it. (Jennifer, Pg16: 485-490)

Participants also conveyed the sense of injustice they felt about their medication, they expressed the wish to either be able to refuse to take medication or choose their own. Jean felt that she had no choice and sadly described her life as:

"...a life of drugs...." (pg12,382)

Being autonomous, privacy, employment status and being able to drive affects the way an individual sees themselves and losing these will no doubt affect an individual's life. Thus, it was felt that all of these factors contributed to a loss of identity felt by the participants, which was accompanied by resentment towards mental health professionals but for some a submissive acceptance. Although, the emotions felt by participants were different, it was felt that they resulted from feeling powerless and dominated and feeling that there was nothing they could do to change the decisions made. Furthermore, it is not possible to consider the loss experienced on admission in isolation. The losses experienced throughout the participant's career of illness also need to be acknowledged as they are all intertwined and may be exacerbated by one another.

Superordinate Theme 3

“There is an awful lot of stigma put on mental health patients”

(Ryan, pg8, 217)

Despite variation between individual experiences, all participants conveyed the stigma experienced. Within this superordinate theme, two sub themes emerged: *“You have got a broken wee bit of your mind, how can you describe that?”* and *“...we are all the same in here...”*

The subthemes attempted to capture the stigma experienced due to others’ lack of awareness and understanding. It was felt that this made the admission and also their diagnosis harder for participants to accept, as they were then viewed differently by others. However, these individuals found acceptance within hospital because of a shared understanding.

Sub Theme 1

“You have got a broken wee bit of your mind, how can you describe that?”

(Jennifer,pg10:313)

This sub theme highlights that participants felt discriminated against because of a general lack of awareness and understanding of mental health.

“I don’t think, sort of, people realise how many folk actually have got mental health problems, you know. Whereas just depression or stress is still, it’s still a mental health problem, you know.” (Ryan;p11:325-327)

The label used to describe this subtheme conveys that participants found it difficult to explain how they felt to others. This is further emphasised through the frustration felt because it was perceived that individuals will only get empathy from people if they are physically unwell.

‘...like a lot of society, if you are not bleeding and are not in physical pain, there is nothing wrong with you, snap out of it.’ (Jennifer, Pg2:54-55)

Similarly, the following extract also conveys this frustration and gives a sense that Jennifer was experiencing pain, albeit not a physical pain, but for her this pain was equally distressing. This may have been intensified by others’ lack of empathy and understanding.

‘perhaps if I started screaming and relaying all that was in my mind, they would empathise with me more but that isn’t me. I am a quiet person who learned at a very early age to suffer in silence. So I may appear ok, yes I can talk, yes I can walk, no I’m not bleeding and no I’m not in physical pain, so am I ok? (Jennifer, Pg9:268-271)

Furthermore, the following quotes show that these individuals felt they were viewed differently by others because of their experiences.

“.....even when you go home ehh and you talk to the neighbours and that and they start talking to you as if you are no well.. “(Jean, 371-372).

The anger felt was emphasised through the use of the derogatory language.

“.....a lot of other folk think that everybody’s a looney....”(Ryan; pg8:218)

This also linked to the earlier theme of feeling like a prisoner and being made to feel like a criminal. On reflection, it appeared that being viewed differently by others also impacted on these individuals' loss of identity. This seemed to result in the need to try and prove their sanity and not to be what others view them as.

".....you need to prove your sanity all the time, know what I mean." (Robert,pg11:338)

The following extract reflects that, because of the stigma surrounding mental health difficulties, individuals did not feel accepted. Justin came to the decision that he would no longer hide his mental health difficulties, despite not being accepted. Through reflection it was felt that this lack of acceptance may impact further on these individuals' sense of self and identity. Thus, the feelings of loss and disempowerment could be intensified.

"....it's a bit of a taboo subject mental health problems and a lot of people don't want to talk about it you know. Which I think, its more and more now, more people are, but see now I just tell people that I suffer, you know, fae mental health problems and that's it and if they don't accept you, they don't accept you, that's just - - that's just up to them you know.." (Justin, p8:217-221)

Thus, individuals felt discriminated against and different not only because of the admission to hospital but also their diagnosis.

Sub Theme 2

“....we are all the same in here...”

(Jennifer, Pg10:312:319)

This subtheme encapsulates the acceptance participants found in hospital. This was due to a shared understanding they had with other individuals. It was felt that the participants were able to relate to other individuals in hospital and that learning they were not alone in experiencing such phenomena increased their knowledge and their self esteem.

The following quotes illustrate that participants only felt understood if others had also been through similar experiences as them.

“I, I think you really need somebody to go through, through the same, same type of thing as you - - or similar tae what you have went through before you realise.....” (Justin, Pg8:208-209)

They gained an understanding in hospital as they could identify with other individuals and didn't feel judged, which made them feel accepted.

“.....I feel that the patients are sometimes your best pals rather than people outside, you know, and I get on a lot better with patients than I do with friends outside.” (Ryan, Pg8:223-224)

Despite the negative feelings expressed about having being given a diagnosis and having to be admitted to hospital, participants showed their resilience through trying to find positives in what was felt to be a difficult experience. Participants felt accepted in hospital, they felt understood as Jennifer stated;

In here, I feel safe to interact - -

Why is that?

Because we are all the same in here.

and what does that mean for you to be in here with people that are the same?

They can't judge me - - they can't judge me. I would never judge them, the only judge is god - - never judge another human being.....we are all the same, we all need fixed - - (Jennifer, Pg10:312- 319)

This emphasis on being the same as others shows that she does feel different, further emphasising the perceived stigma felt of being in hospital. Also, for Jennifer there is an aspect of feeling broken and not being 'whole' (Pg10;293) and the meaning of being in hospital for her was to get 'fixed'. This was thought to be an interesting analogy and the idea of needing 'fixed' makes one feel that she felt incomplete or damaged through her experiences of her illness.

Justin felt that he was able to further his own knowledge about mental health while in hospital and the realisation that he was not alone in experiencing such phenomena was an important one for him. This also highlighted the acceptance he felt while in hospital, through being with individuals that have had similar experiences.

"I feel as if when you are in here you - - you actually learn a bit more, you know.

Like what?

Well -- I think when you are in an environment with people, it opens your mind up, you are in with the same people. There was a guy that was just in, he has just been discharged and some of things he says was exactly the same as what I was goin through you know ehh and I was like that I cannae believe how much what he is sayin coincides with what I, what I was and he was a single guy too and he stayed himself and I says that's really, you know, its unbelievable that - - the same things he's sayin was exactly the same as I was, I was experiencing, you know - -Ehh and you learn a lot about other people ..." (Justin, Pg7:181-189)

The use of ‘*that world out there*’ in the following excerpt suggests that he differentiates between the world inside the hospital and the one outwith, further emphasising feeling different. Furthermore, it seems as though he had preconceptions about the types of individuals’ who are affected by mental health problems and would be in the world of the hospital ward, and these beliefs were challenged when he was admitted.

“...the actual meeting people aswell, you know, seeing what they, what everyone else is going through cos when you are out in that world out there you don’t know half of what is happening to people. I mean I did’nae really know this place existed, I knew there was a psychiatric ward but I did’nae - I thought it was meant to be mainly for people - - you know but there’s all walks of life it could happen to. It does’nae, it does’nae ehh - - discriminate against anybody, anybody could end up with mental health problems. It opens your eyes up to see the amount of people that’s in here, fae young girls, young guys to elderly guys, you know and elderly women, you know all walks of life. (Justin, Pg11:300-306)

Discussion

This study explored the experiences of psychiatric admission for five individuals using Interpretative Phenomenological Analysis (IPA). The participants had experienced psychosis and, at the time of interview, were admitted to a psychiatric ward. The themes that emerged were in relation to participant’s experiences of admission but also being involved with psychiatric services due to their diagnosis and having a mental health difficulty. Three super ordinate themes emerged and, while each theme was reported separately, in order to fully appreciate the participants’ experiences, the themes are best understood within the context they provide for each other. The theme “*I feel like a, a prisoner in here...*” reflected

feelings of being imprisoned and entrapped, which in turn influenced the loss felt by participants, captured in the theme “...my life is in their hands..”. The theme “*There is an awful lot of stigma put on mental health patients...*” conveyed the stigma experienced due to others’ lack of understanding and awareness of mental illness. The narratives revealed in this study can be interpreted in light of a number of different frames; the policy context, for example current government and National Health Service (NHS) initiatives, the clinical context and the context of psychological theory.

The recent Scottish Government policy document ‘Delivering for Mental Health’ (DFMH, 2006) has committed the health service in Scotland to assess individuals’ experiences of recovery and the degree to which policy expectations are being met in terms of equality, social inclusion, recovery and rights. A key aspect of this is the principle of reciprocity Mental Health (Care and Treatment) (Scotland) Act (2003), which states that there is an obligation for health and social care authorities to provide safe and appropriate services for individuals who have to comply with a programme of care. Furthermore, these principles state that individuals should be fully involved in all aspects of their assessment, care and treatment. The current study has highlighted that individuals with psychosis who are admitted to hospital do not always feel this way.

The theme “*I feel like a, a prisoner in here...*” captured feelings of entrapment, imprisonment and disempowerment. These feelings were not only due to having to be in hospital but also at being given a diagnosis which they didn’t agree with. Individuals conveyed a sense of being forced to go into hospital and a lack of

involvement in decisions. Furthermore, this lack of control and autonomy appeared to affect individuals' sense of self and self esteem, and this was evidenced through participants' self comparison with criminals and drug addicts. This theme was in line with previous research in this area. For example, Perry, Taylor & Shaw (2007) also found that participants felt trapped and powerless. In addition, Thornhill, Clare & May (2004) found similar themes when they interviewed individuals who described themselves as recovered or recovering from psychosis. Their study showed that individual narratives fell into 3 groups; narratives of escape, enlightenment and endurance. The narrative of escape indicated that patients viewed being admitted to hospital as being in '*a prison*' (p188) and wanting to escape from the hospital and unwanted treatment.

Furthermore, the loss felt by participants in this study was conveyed through the theme "*...my life is in their hands..*". It is important to note that these feelings of loss were in relation to their mental health difficulties and admission to hospital. This included a sense of loss of freedom, independence and autonomy and essentially a loss of their identity. It was felt that being able to make their own decisions was important for participants and not being able to do so influenced their feelings of disempowerment and loss of autonomy. Previous research has emphasised the importance of increasing an individual's sense of control in the early stages of recovery from psychosis, to reduce the sense of entrapment and humiliation which can lead to depression and suicide (Birchwood & Iqbal, 1998).

Participants also spoke about the lack of understanding and awareness of mental health difficulties, which led to them feeling different and not accepted. Knight,

Wykes & Hayward (2003) found that participants experienced both public and self stigma, *'...public stigma is evident through prejudice and discrimination, from a plethora of sources including family, friends, society, police, and mental health professionals. Self-stigma reveals similar prejudice, lowered self-esteem, and an ongoing struggle for acceptance within social cliques.'* (p218). This experience was also described by participants in this study, who felt that others, including their family and friends, did not understand them and lacked empathy. One participant also spoke about being discriminated against and victimised by the police and the staff within the ward. Furthermore, participants expressed experiencing what Knight et al. (2003) refer to as 'self-stigma'. They felt misunderstood and not accepted by other individuals who had not shared similar experiences. It is possible that the inclusion of peer support workers (DFMH, 2006) could help address misconceptions and prejudices about people with mental health difficulties.

Peer support workers could bring a unique perspective and set of skills as they will be trained members of the staff team with personal experience of mental illness. One of the positive findings from this research was that individuals valued the acceptance they felt within hospitals and this appeared to be due to a shared understanding with other individuals in hospital. Thus, peer support workers are in an excellent position to offer insights into service users' experience of services, transitions and the journey to recovery. Furthermore, this could also open up avenues of employment for individuals with psychosis, and this has been highlighted as important by individuals.

For example, in the current study, loss of employment appeared to mean loss of a valued role and also loss of relationships with others. Participants felt that being able to work gave them something to do and was a way to socialise and interact with others. The losses experienced through unemployment served to exacerbate feelings of entrapment in hospital and within their diagnosis further. This was also highlighted in the Perry et al. (2007) study, where participants described the importance of work to '*prevent isolation and segregation from others*' (p788). The new role of peer support worker may therefore influence feelings of hope, self esteem and help individuals on their journey to recovery and in rebuilding a sense of identity that they feel they lose on admission.

Furthermore, the emergent themes can also be interpreted in the context of psychological theory as the work of Birchwood et al. (2000) has raised the importance of conceptualising psychosis and its attendant experiences as a life event. As a life event, psychosis brings with it a number of important dimensions including shame (e.g. the sense of stigma and embarrassment felt by service users in relation to their psychosis), humiliation and entrapment (e.g. coercive detention and other involuntary experiences), and loss (e.g. loss of friends, social supports, cherished ideas and ambitions). These themes, as described by Birchwood et al., have their routes in Gilbert's (1992) work on development of depression. These dimensions of psychosis strongly overlap with the themes apparent in this study and provide insight into the challenges of emotional recovery following psychosis. For example, processes of mourning and grief may provide an important basis to understand the feelings of anger and loss experienced by some of the participants.

In terms of the clinical implications of this research, Birchwood, Iqbal, Chadwick and Trower (2000) found that 36% (n= 28) of individuals recovering from acute psychosis developed depressive symptoms in the year following their acute episode. Those participants who developed post psychotic depression (PPD) were more likely to attribute the cause of psychosis to themselves, perceive greater loss of autonomy and valued role, and perceive themselves as being entrapped and humiliated by their illness than those without PPD. Rooke and Birchwood (1998) found that participants with depression, who appraised their psychosis as uncontrollable and trapping, experienced more compulsory admissions and greater loss in employment status compared with those participants without depression. More recently, Karatzias, Gumley, Power and O'Grady (2007) found that 44.9% (n = 62) of participants had at least one current co-morbid anxiety or affective disorder. Psychological co-morbidity was predicted by lower levels of functioning, more negative appraisals of entrapment in psychosis and lower levels of self esteem, including feelings of self blame, shame and humiliation. It is possible therefore that anxiety and depression may occur in response to individuals' appraisals of their illness as being persistent and uncontrollable, socially stigmatizing and resulting in feelings of defeat and alienation. The current study highlighted that psychiatric admission and coercive measures could exacerbate these feelings and associated emotional distress, which may be an important focus of psychological therapy.

Further clinical implications highlighted include the importance of collaboration with service users. The feelings of dominance and disempowerment conveyed by

participants suggest that individuals value being treated with respect and being included in decision making, thus this should be promoted in relationships with mental health professionals. Especially as this should promote recovery rather than individuals feeling controlled and coerced. Individuals are central to their own care, treatment and recovery and thus should be involved in the design and delivery of services.

The feeling of acceptance related to being in hospital is concordant with Yalom's (1995) therapeutic factors of group work. For example, the participants reported experiencing universality through learning they are not the only ones experiencing difficulties and also the instillation of hope through not being alone, being accepted and feeling as part of a group. Moreover, a recent study by Newton, Larkin, Melhuish & Wykes (2007) found that group CBT for young people who were experiencing distressing auditory hallucinations was beneficial as they saw it as a source of therapy, information, and support. Thus, this highlights the benefits group work may have within the hospital environment, in promoting universality and group cohesion (Yalom, 1995). This is also in keeping with the recovery model, empowering patients and instilling hope.

Service user forums such as Asylum and Mind have found that individuals in crisis want someone to talk to and to help them to make sense of their experiences (Clarke & Wilson, 2009). Participants in this research also valued being listened to and thus may benefit from talking therapies such as cognitive behaviour therapy (CBT). The National Institute for Clinical Excellence (NICE) guidelines (2002) recommend *“Psychological treatments should be an indispensable part of the treatment options available for service users and their families in the effort to*

promote recovery” (NICE Schizophrenia Guidelines 2002 p16). Furthermore, Clarke & Wilson (2009) state that therapy has a place in an inpatient setting but acknowledge this will not be easy and poignantly use the analogy of *‘the sandcastle model of working’*(p.198): through some success a sandcastle is built but, as acute wards are ever changing, *‘the tide comes in and sweeps it away’* (p.198). They emphasise the importance of keeping building as the service users do not have the luxury of leaving the beach. Future research could look into developing a more durable *‘sandcastle’* and the benefits of this for service users and also the inclusion peer support workers.

Reflection on the development of the interview schedule

This research held a great deal of importance for the researcher as it was imperative that it be completed in order for the researcher to obtain the doctorate in clinical psychology. Due to this, through conducting the pilot interviews, the researcher realised that her own anxieties were over shadowing the interviews. She was not listening to the participants ‘voice’ or experiences. The researcher felt she needed to ask the questions on the schedule and had to obtain answers. If the participants spoke about anything not within the interview schedule she would bring them back to the original question and not allowing the participants to open up ‘novel avenues’ (Smith & Osborn, 2003). This only became apparent once the pilot interviews were transcribed and discussed by the researcher and her supervisor. It was therefore felt that in order to do justice to the participant’s experiences and to allow their voice to be heard, the interview schedule would only be one question, as stated below, but with potential probe questions that could be asked depending on what was said by the participant.

I am really interested in finding out about your experiences of being admitted to hospital. I would really like to learn more about your experiences and get a detailed understanding of the experiences that you have had and what they have meant to you. Like I said in the information sheet there are no right or wrong answers and it is basically your perspective that is important to me that I want to hear about. So maybe you could start of by telling me a little bit about yourself?

This would allow the researcher to focus on what was being said during the interview rather than worrying about having all the questions answered or about the participants discussing something not expected.

The researcher also came to the realisation that she cannot separate the clinical aspect of her role from the researcher as they are both equally as important. She thus conducted the interviews as both, allowing the participants to talk about their experiences, all the while listening and asking questions for further elaboration in order to explore their experiences of psychiatric admission, making sense of these and allowing them to open up ‘novel avenues’ if they wished.

Limitations

IPA studies aim to sample a homogeneous sample; however, despite attempts to do so, this was complicated due to the complex nature of psychosis and the heterogeneity of experiences within this phenomenon. This was highlighted in Table 2 which showed that each participant’s experience and life histories were unique and idiographic. Thus, one could state that it may be impossible to achieve

a truly homogeneous sample of individuals whom have experienced psychosis. Therefore, for this study individuals who had experienced psychosis and had been admitted to a psychiatric ward were recruited and results should be interpreted with this in mind.

It could be suggested that the small sample size is a limitation of this study as this limits the generalisability of the results. However, IPA is committed to the analysis of small numbers and the aim is to explore subjective experiences rather than produce generalisable results. Whilst an IPA analysis may not attempt to achieve generalisability, neither should it merely be the retelling of participants' narratives (Brocki & Wearden, 2006), but should include a level of interpretation from the researcher. Moreover, the emergent themes are the author's interpretations of the participants' experiences and it may be that someone else would interpret them differently, as there can be infinite interpretations of any given text. As discussed earlier it had been hoped to carry out respondent validation to ensure the themes found were true to the participants' experiences. Unfortunately this was not possible due to time constraints. However, it is hoped that through the robustness of the analytic process the interpretations of the narratives are true to the participants' experiences. The themes were discussed with the researcher's supervisor, another IPA researcher, the author focussed on reflexivity throughout and the themes have been grounded in the participants' accounts.

Conclusion

In summary, this is the first IPA study exploring experiences of psychiatric admission for individuals with psychosis. The emergent themes suggested individuals felt imprisoned, disempowered and experienced a sense of loss due to their diagnosis and on being admitted to hospital. This was accompanied by a sense of lack of awareness and understanding from others, which resulted in feelings of stigma but, in turn, a feeling of being accepted within hospital.

This study has highlighted some of the positive and negative aspects of psychiatric admission experienced by individuals and thus, IPA fits well with the National Health Service (NHS) drive towards increasing patient centred research and hearing the voice of the service user. This study attempted to provide a detailed account of participants' experiences of psychiatric services and it is hoped that this information will be useful for broadening our understanding in clinical practice, as well as suggesting areas for further research. It is not claimed that these themes are generalisable but it is hoped they will provide some insight into the experience of psychiatric services for individuals with psychosis.

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Table 1. Participant characteristics at time of interview.

<i>Participant</i>	<i>Gender/Age</i>	<i>Relationship Status</i>	<i>Diagnosis</i> (Taken from medical file)	<i>Detained/ Voluntary</i>	<i>Number of Admissions</i>
Justin	M/42	Single	Schizophrenia	Detained	2
Ryan	M/33	Single	Schizophrenia	Detained	3
Jean	F/55	Single	Treatment Resistant Schizophrenia	Detained	>5
Jennifer	F/42	Single	Psychotic Depression	Voluntary	2
Robert	M/34	Single	Paranoid Schizophrenia	Detained	>5
<i>Pilot Interviews</i>					
David	M/37	Single	Paranoid Schizophrenia	Detained	>5
Michael	M/50	Married	Schizo-affective disorder	Voluntary	>5
Sean	M/59	Single	Schizophrenia	Detained	3

Table 2. Information on participants included in analysis

Participant Name	Information on Participants
Justin	Justin was 42 years of age, single and living on his own since he mother died a few years ago. He had always worked and employment played an important factor in his life. Justin attributed his diagnosis to his job and stress, he worked in security. He thought people were talking about him and plotting against him. He also felt being on own at home contributed to his paranoia and feeling under threat. He tried to cope on own but eventually had to seek help, he tried to speak to his family but as they didn't understand he saw his doctor. He was diagnosed and prescribed medication. Prior to admission, he refused to increase his medication and decided to stop it as he felt he no longer needed to. He was therefore, detained under the Mental Health Act.
Ryan	Ryan was 33 years of age and single. He was unemployed but used to work as a gardener. He had hoped to take up HGV driving but had been banned because of his diagnosis; he didn't feel consulted in this decision and was very angry about it. He has had conflicts with his doctors and disliked mental health teams/psychiatrists due to the authority they have over his life. Ryan was against his admission and feels his voice was not heard. He preferred to stay within the community rather than having to be admitted. Ryan reported not having the support of his family and felt his friends are more supportive.
Jean	Jean was a 55year old widow. Her husband died when she was in her 20's, she was pregnant at the time, the baby unfortunately died. However, she had been told that none of this happened. She asked her lawyer to get a 2 nd opinion but he took the doctors word over hers. She hoped to hope to prove them wrong. She lived with her mother up until she died a few years ago. She was finding it difficult to find work and doesn't agree with the doctor's decision that she shouldn't be working. Work was important to Jean, not only for the financial element and the effect that this would have on her quality of life but also because of the social aspect. She was detained because she was not taking her medication but felt she didn't need as when she does it affects the quality of her life.

Jennifer	<p>Jennifer was a 42 year old single mother; she lives alone with her dog. Her mother died when she was a child and her father was abusive. Jennifer's husband died in the early 90's and she had been on her own since. This was her second admission to hospital (voluntary). She believed her 'breakdown' was triggered by stress at work but her 'underlying problem' was her relationship with her father. Jennifer would hear her father's voice and had conversations with him that she would like to have had while he was still alive. She felt she did not deserve to be in hospital as others are in more need and she shouldn't complain about anything and accept the care she was given. Jennifer experienced a lack of acceptance from others and was in denial of her own difficulties due to a fear of others finding out. However, she felt accepted in hospital.</p>
Robert	<p>Robert was a 34 year old single male and lived with his parents. He didn't agree with his admission and felt the doctors didn't know what they were doing and the medication doesn't work. Ryan didn't think there is anything wrong with him but that others are out to cause him trouble. He also felt that he was targeted by people because of his diagnosis and that they take advantage of the fact that he will admitted because of it and that there was nothing he could do about it. He referred to hospital as 'being locked up' and felt 'stuck in the system'. He knew he would 'have to' go into hospital as if he refused the police would be called.</p>

**ADVANCED PRACTICE I
REFLECTIVE ACCOUNT**

**Doubts and enlightenment: Reflection on running a psychiatric
inpatient group**

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Abstract

It has been said that reflective practice writing is not a process of thinking reflectively about issues within practice, and then using writing to record those thoughts, but of consciously *not* thinking, while allowing the hand to express and explore that which needs expressing and exploring (Bolton, 2003). The following account is my attempt to allow my experiences of running a group on a psychiatric inpatient ward to replay themselves and in doing so allowing my feelings and thoughts to emerge. I have used Boud, Keough & Walker's (1985) model while writing this reflection. This model uses a continual process of reflection and I feel that it has allowed me to be more open to reflection without inhibiting me. While doing so, I have become more aware of the gradual shift in my own perceptions of my role as a trainee clinical psychologist which I hope to take forward into my future career.

ADVANCED PRACTICE II
REFLECTIVE ACCOUNT

Safe Haven? I think not!

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Abstract

Reflection was a relatively new process for me at the beginning of my final year of training, but it is a process I have now embraced and enjoy. The following account developed through a discussion with a colleague on the gap in services for young individuals and my passion for working within a child and adolescent mental health service. I have used Borton's (1970) framework for reflexive practice in writing this reflective account. This framework is based on the need to identify, make sense of and respond to real life situations using three basic questions: what, so what and now what? Through this process I have become more aware that I will be facing issues of service need and provision in my future career. It has further developed my understanding of the role of a clinical psychologist especially in the drive towards New Ways of Working (2008).

APPENDICES

Pages

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IPA Guide

Developed from criteria generated from A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology (Brocki & Wearden, 2006).

Title of paper reviewed:
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1. DATA COLLECTION

What were the methods of data collection?

- Use of exemplary method for IPA (Smith & Osborn, 2003), semi-structured interviews using open-ended questions and non-directive style.
- OR Alternative methods and justification e.g. focus groups, written narratives, email interviews.
- Use of participant diaries? ‘An excellent alternative to providing a narrative account for analysis’ (Brocki & Wearden, 2006).

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How was the design of the interview presented?

- Were examples of prompt questions given or ‘minimal probes’ presented?
- OR copy of the interview.
- How was the interview constructed? E.g. on basis of theory or existent writings?
- How was the approach to data collection described?
- Did the design ensure that the approach to analysis was flexible in-depth exploration ‘without an attempt to test a pre-determined hypothesis of the researcher’ OR without ‘preconceived ideas?’ (Smith & Osborn, 2003).

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How was the researcher’s interpretative role in analysis discussed at this stage? (Smith, 1996)

- E.g. role of preconceptions, beliefs and aims

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2. SAMPLING

Was sample size in accordance with the aims of IPA analysis?

- E.g. large data sets may result in the loss of potentially subtle inflections of meaning (Collins & Nicolson, 2002).

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How was purposive sampling conducted?

- E.g. 'The aim is to select participants in order to illuminate a particular research question.'
- How did sampling support the analysis? Do the authors present a position on the consideration of generalisability?

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3. ANALYSIS

How was the IPA approach defined?

- E.g. use of IPA specifically stated? OR ‘inductive interpretations using phenomenological framework’. Was Smith’s (1999) paper described as a way to define the approach?

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Themes:

- Evidence of theme representation in transcripts
- How was theme selection discussed e.g. ‘the eloquence with which one participant summarises the point others sought to say in more words and less precisely’ (Brocki & Wearden, 2006) Or ‘manner in which theme assists in the explanation of other aspects of the account’
- How was researcher biased minimised in selecting themes e.g ‘a final rereading of the original transcripts to ensure that interpretations were grounded in participants’ accounts’ (Collins & Nicolson, 2002)
- Were excerpts from transcripts presented to provide a ‘grounding in examples’ and as ‘central to IPA?’

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How was the analysis process described?

- Detailing aspects of analysis.
- Was the absence of a detailed formulaic procedure for IPA acknowledged?
- How did the researcher evidence moving from the ‘descriptive to the interpretative?’
- How were theoretical preconceptions brought by researchers discussed?

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Validation:

- How were analyses checked and interpretations validated by others?
How was this open to discussion if validation was not completed?

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Reflexivity: The interpretative role of the researcher:

- How is the explicit recognition of the interpretative role of the researcher in IPA (Smith et al, 1999) acknowledged? N.B. even if it is not mentioned outright.

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Fit between theory and method adopted:

- How did researcher reflect on the usefulness and appropriateness of utilising IPA with their data set?

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How has the study adapted the method to the study of participants suffering from psychosis?

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Please note below if the papers reviewed was of particularly high quality in any of the areas above or in other additional areas.

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Instructions for Authors

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relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content.

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Style and References. Manuscripts should be carefully prepared using the aforementioned *Publication Manual of the American Psychological Association*, and all references listed must be mentioned in the text. Within the text references should be indicated by the author's name and year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if there are more than two authors (Wykes *et al.*, 1997). Where several references are quoted consecutively, or within a single year, the order should be alphabetical within the text, e.g. (Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g. (Marks, 1991a).

The reference list should begin on a separate page, in alphabetical order by author (showing the names of *all* authors), in the following standard forms, capitalisation and punctuation:

a) For journal articles (titles of journals should *not* be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A controlled trial. *Magnetic Resonance Imaging*, 18, 351–355.

b) For books:

Powell, T.J. & Enright, S.J. (1990) *Anxiety and Stress management*. London: Routledge

c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In G.Parry & F. Watts (Eds.), *A Handbook of Skills and Methods in Mental Health Research* (pp. 75–89). London:Lawrence Erlbaum.

Illustrations should *not* be inserted in the text. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Figure 3). The appropriate position of each illustration should

be indicated in the text. A list of captions for the figures should be submitted on a separate page, or caption should be entered where prompted on submission, and should make interpretation possible without reference to the text. Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied.

Tables should be typed on separate pages and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should *not* be used.

Accepted papers. If the article is accepted, authors are requested to submit their final and revised version of their manuscript on disk. The disk should contain the paper saved in Microsoft Word, rich text format (RTF), or as a text or ASCII (plain) text file. The disk should be clearly labelled with the names of the author(s), title, filenames and software used. Figures should be included on the disk, in Microsoft Excel. A good quality hard copy is also required.

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Major Research Proposal

How does the experience of psychiatric admission inform the recovery perspectives of service users with psychosis: an interpretative phenomenological analysis

Ifaf Asghar

Summary

The Department of Health (2002) has identified psychiatric admission as an essential component of service delivery; however, in a Scottish context the Delivery Plan for Mental Health (2006) has prioritised the reduction of inpatient psychiatric admission. There is a lack of qualitative research providing an in depth exploration of individuals' experiences of psychiatric admission in the context of acute psychosis. Therefore, the aim of this study is to explore the experience and perceptions of psychiatric admission for individuals with psychosis.

Objective: To develop an understanding of individuals' experiences of psychiatric admission. To explore individuals' interpretations and understanding derived from their experiences of psychiatric admission and to consider how their interpretations and understanding might enlighten how we understand the importance of the experience of psychiatric admission in recovery.

Design: An interview based study using Interpretative Phenomenological Analysis (IPA) to analyse qualitative data. The aim of IPA is to capture and explore the meanings that individuals' assign to their own experiences.

Method: Semi structured interviews will be conducted with 8-20 individuals who have experienced psychosis and either be currently admitted to a psychiatric inpatient setting within Lanarkshire or have been admitted to and subsequently discharged in the previous 1 year.

Expected Findings: This study is expected to elicit individual experiences of admission to an inpatient psychiatric setting and enable us to establish the meanings individuals attach to their experiences. The study is expected to give us a greater understanding of the experience of psychosis, admission and recovery from the individual's point of view.

Practical Applications: This study will inform how we understand psychiatric admission from a psychological point of view and will highlight positive and/or negative experiences of psychiatric admission. In addition, the study will explore the utility of this methodology for future studies and will highlight areas that could be explored in future research.

Introduction

The experience of psychosis is different for every individual. It can be a distressing and confusing experience and is often associated with changes in perception, hearing voices, hallucinations and delusional beliefs. Furthermore, acute psychosis often results in psychiatric admission, which can be involuntary and coercive, thus adding to an already distressing and disorientating experience. On one hand the Department of Health (2002) has identified psychiatric admission as an essential component of service delivery but on the other, in a Scottish context, the Delivery Plan for Mental Health (2006) has prioritised the reduction of inpatient psychiatric admission. However, while there are many excellent inpatient services with dedicated professional staff, there is also unquestionable and compelling evidence, particularly from service user feedback to indicate the experience of psychiatric admission can be felt to be neither safe nor therapeutic (Department of Health, 2002). The positive aspects are seldom written about and personal accounts from individuals with psychosis have rarely been reported.

There is a dearth of literature exploring the experiences of individuals during psychiatric admission. Weinstein (1979) found that the majority of patients expressed favourable attitudes towards hospital settings. Individuals reported that they enjoyed the amenities of the hospital, did not feel restricted and they felt protected and cared for. Importantly, individuals who were admitted voluntarily perceived their experiences in more positive terms than those who were admitted involuntarily, indicating coercive admissions are not necessarily felt to be

therapeutic. More recently, Quirk and Lelliott (2001) found evidence of violence, sexual harassment and substance abuse within acute psychiatric wards. They also found that a high proportion of patients within these settings had been detained in accordance with the provisions of the Mental Health Act. The authors also reported evidence of low staff morale and an increasing rate of staff turnover. Previous research has shown that individuals within psychiatric settings value relationships with staff (Goodwin, Holmes, Newnes & Waltho, 1999); therefore changes in staff and the use of bank and agency staff may lead to a reduction in the quality of care and may hinder the development of a collaborative therapeutic alliance with staff.

Katsakou and Priebe (2006) reviewed 18 studies on the outcomes of involuntary hospital admissions in general adult psychiatry. They found that patients show significant clinical improvements after involuntary treatment and their assessments of involuntary admission and treatment was positive. Furthermore, more participants reported positive views, in retrospect, than did those expressing negative views on the justification of their involuntary admission, their initial need for hospital treatment and their perceived benefits from treatment. A significant proportion, however, did continue to express negative views in the self reported outcomes.

Recent research has shown that aspects of psychiatric admission and psychosis have been linked to the development of psychosis related post-traumatic stress disorder (PPTSD); (McGorry, Chanen, McCarthy, Van Riel, McKenzie & Singh, 1991; Meyer, Taiminen, Vuori, Aijala, & Helenius, 1999; Frame & Morrison,

2001; Priebe, Broker & Gunkel, 1998; Shaw, McFarlane & Bookless, 1997). There has been a lack of consensus as to what aspects of admission are specifically traumatic. Some studies have argued that the experience of psychotic symptoms are primarily responsible for traumatic reactions (Frame & Morrison, 2001; Meyer *et al.*, 1999), while other studies have argued that the use of coercive treatment methods may be causal and the involuntary detention of individuals may also be partly responsible (Frame & Morrison, 2001; McGorry *et al.*, 1991).

Preibe et al. (1998) assessed post traumatic reactions in relation to reported involuntary admissions. More than half of the participants (57%, $n = 60/105$) reported one or more involuntary admissions in the past. The frequency of PTSD was similar in both groups; participants with involuntary admission (48%, $n = 50$) and in participants without involuntary admission (56%, $n = 59$). A total of 51% ($n = 54$) of participants fulfilled the criteria for a PTSD diagnosis; however they found that frequency of PTSD symptoms were not associated with aspects of involuntary admission but they were highly correlated with auditory hallucinations and visual hallucinations. Furthermore, Meyer et al. (1999) found that psychotic symptoms were generally more traumatic than involuntary hospitalisation or application of coercive measures. Chisholm, Freeman and Cooke (2006) found that lower levels of support and a greater perception of perceived helplessness at the time of admission and prior history of stressful life experiences predicted the severity of PTSD.

Birchwood, Iqbal, Chadwick and Trower (2000) found that 36% ($n = 28$) of individuals recovering from acute psychosis developed depressive symptoms in the year following their acute episode. Those participants who developed post

psychotic depression (PPD) were more likely to attribute the cause of psychosis to themselves, perceive greater loss of autonomy and valued role, and perceive themselves as being entrapped and humiliated by their illness than those without PPD. In an earlier study, Birchwood and Iqbal (1998) found that PPD was associated with the perception of being unable to prevent or control psychotic relapse or the fear of psychosis itself; crucially these meanings are likely to be grounded in episodic memory.

Rooke and Birchwood (1998) found that participants with depression, who appraised their psychosis as uncontrollable and trapping, experienced more compulsory admissions and greater loss in employment status compared with those participants without depression. More recently, Karatzias, Gumley, Power and O'Grady (2007) found that 44.9% (n = 62) of participants had at least one current co-morbid anxiety or affective disorder. Psychological co-morbidity was predicted by lower levels of functioning, more negative appraisals of entrapment in psychosis and lower levels of self esteem, including feelings of self blame, shame and humiliation. Anxiety and depression may occur in response to individual's appraisals of their illness as being persistent and uncontrollable, socially stigmatizing and resulting in feelings of defeat and alienation. It is possible that psychiatric admission and coercive measures may exacerbate these feelings.

The data begin to portray a potentially complex and contradicted picture where for many the experience of acute psychosis is frequently distressing and often traumatic. In addition, for a significant number the experience of psychiatric

admission may also amplify the trauma via lack of support and therapeutic engagement. On the other hand the experience of psychiatric admission for those with acute psychosis may buffer the traumatic impact of psychosis. In any case it is highly likely that the meanings derived from the experience are likely to be highly salient to the process of recovery and adaptation. Therefore, understanding recovery from psychosis can be a difficult and complex process and we need to take into account not only the experience of psychosis but also the treatment that accompanies it including psychiatric admission.

The use of qualitative methodology can help us develop a much more detailed understanding of individual experiences as it allows an in depth account that quantitative methods cannot readily access. For example, Goodwin et al. (1999) used qualitative methodology and investigated the experiences of individuals in relation to their use of mental health services including inpatient psychiatric services over a 4-year period. Thirteen themes were identified which included feelings of institutionalisation, experiences of hospital as a prison, absence of power and control, lack of respect, lack of information regarding treatment and medication, value of having the opportunity to talk and be listened to and being provided with a secure base for recovery. It was clear throughout the study that individuals appreciated their interactions with staff, especially when they felt heard and cared for. However, lack of information remained a source of anger and frustration, as did individuals' perceptions of imprisonment.

Koivisto, Janhonen and Vaisanen (2003, 2004) used a phenomenological approach to explore the experiences of individuals recovering from psychosis who described admission as '*shameful and frightening*' (p227). Individuals'

experiences of being helped during their admission were also explored. Participants reported experiencing both positive and negative aspects of hospital care. The peaceful environment of the hospital and the feeling of safety were amongst the positive aspects. However, some participants felt that the hospital environment was '*turbulent and insecure*' (p273). Thornhill, Clare and May (2004) interviewed individuals who described themselves as recovered or recovering from psychosis. The study showed that individual narratives fell into 3 groups; narratives of escape, enlightenment and endurance. The narrative of escape indicated that patients viewed being admitted into hospital as being in '*a prison*' (p188) and wanting to escape from the hospital and unwanted treatment. However, a key element of the enlightenment narrative was '*a sudden or gradual dawning of understanding of self and the experience of psychosis*' (p189), which brought with it a new perspective on the experience of psychosis. This was also accompanied by spiritual insight for some of the participants of this study and they reported that coming to an understanding of their illness was crucial to their journey to recovery.

In a more recent qualitative study, Laithwaite and Gumley (2007) used grounded theory to explore the experiences of patients with psychosis in a high security setting. The analysis produced two themes common to all individuals' accounts; 'past experiences and adversity' and 'being in hospital and recovery'. Individual narratives revealed that early experiences influenced the individual's stance taken towards hospital. Many participants in the study described dangerous and frightening early experiences. For some this led them to perceive hospital as a safe place, which removed them from danger they had experienced in the past.

However, for others their experience of hospital and admission was frightening and a continuation of the danger and insecurity they had experienced in the past. Furthermore, participants spoke about their relationships with staff as an important factor in the recovery process and this, along with building relationships with other patients and their family, served an important role in redefining their sense of self and self-esteem.

In conclusion, there has been a lack of qualitative research providing an in depth exploration of individuals' experiences of psychiatric admission in the context of acute psychosis. Quirk and Lelliott (2001) found that the limited qualitative research that exists within this area has had a focus on clinical practice and on the views of health professionals rather than the individual's experience. Therefore, given the lack of qualitative studies focussing on the experience of psychiatric admission in the context of acute psychosis the aim of this study is to explore the experience and perceptions of psychiatric admission for individuals with psychosis. The objectives of the proposed study are: 1) To develop an understanding of individuals' experiences of psychiatric admission; 2) To explore the individuals' interpretations and understandings derived from their experiences of psychiatric admission and 3) To consider how individuals' interpretations and understandings might enlighten how we understand the importance of the experience of psychiatric admission.

Aims

The proposed study aims to develop an understanding of how experiences of acute psychiatric admission inform the recovery perspectives of individuals with psychosis

Plan of Investigation:

Design

Interpretative Phenomenological Analysis (IPA) will be used. Through the use of IPA, researchers aim to investigate phenomena from the perspective of those who have experienced them. The aim of IPA is to capture and explore the meanings that individuals' assign to their own experiences. Smith and Osborn (2003) state that in IPA research 'there is no attempt to test a predetermined hypothesis of the researcher; rather the aim is to explore, flexibly and in detail, an area of concern' (p53). Therefore, it is particularly suited to this study as it will allow us to explore individuals' experiences of psychiatric admission, understand how individuals made sense of these experiences and what meanings the experience holds for the individual. Furthermore, Kay and Kingston (2002) suggest the use of IPA for research which is of a complex and personal nature.

Importantly, IPA also acknowledges the part the researcher will play in accessing and understanding the individual's experience and the interaction between them. It employs the use of a 'double hermeneutic' which is the researcher making sense of the interviewee making sense of their experiences (Smith, 1996).

Smith, Jarman and Osborn's (1999) definition of IPA clearly describes its purpose as an analytical tool:

"The approach is phenomenological in that it is concerned with an individual's personal perception or account of an object or event as opposed to an attempt to produce an objective statement of the object or event itself. [. . .] Access [to the participant's personal world] depends on, and is complicated by, the researcher's own conceptions and indeed these are required in order to make sense of that other personal world through a process of interpretative activity. Hence the term interpretative phenomenological analysis is used to signal these two facets of the approach."

(Smith *et al.*, 1999: 218-219)

Methodological criteria for carrying out analysis in IPA have been developed by Brocki and Wearden (2006) and will be adhered to during the research process. This includes evaluating the analysis, acknowledging the role of the researcher and reflections on the analysis process.

Participants and Recruitment

'IPA researchers usually try to find a fairly homogeneous sample. IPA....., through purposive sampling, finds a more closely defined group for whom the research question will be significant. How the specificity of a sample is defined will depend on the study; in some cases, the topic under investigation may itself be rare and define the boundaries of the relevant sample. In other cases where a less specific issue is under investigation, the sample may be drawn from a population with similar demographic/socio-economic status profiles'.

(Smith & Osborn, 2003:54)

The researcher will attempt to purposively sample participants who are between 18 and 65 years, have experienced psychosis (see inclusion criteria below) and either be currently admitted to a psychiatric inpatient setting within Lanarkshire or have been admitted to and subsequently discharged in the previous year. The participants will include men and women, first time admissions and those with a previous history of hospital admissions.

Participants will be recruited via advertisements and also through referral via clinical psychologists, consultant psychiatrists, and psychiatric nurses working within Lanarkshire.

Inclusion and Exclusion Criteria

Inclusion will require that patients fulfil ICD-10 (World Health Organization, 1992) criteria for schizophrenia, schizotypal and delusional disorders (F20-29), a diagnosis of mania with psychotic symptoms (F30.2), bipolar affective disorder (F31.2, F31.5) or mood congruent delusions and hallucinations (F32.3, F33.3). All participants will be between 18 and 65 years inclusive and will have experienced psychiatric admission in the previous 1 year.

With the patient's consent, the researcher will liaise with the patient's key worker or doctor to confirm that the patient has a diagnosis of schizophrenia or similar and check that involvement in the research study will not affect the patient's treatment and that there are no pertinent clinical risk factors. If the key worker or doctor feels participation in the study would be detrimental to the patient's treatment stage, the patient will be excluded from the study.

Individuals under the age of 18 years, individuals with a learning disability, individuals who do not speak English as a first language, individuals who are acutely psychotic and those unable to give informed consent will also be excluded from the study. Furthermore, individuals from ethnic minority backgrounds will be excluded from the study, this is because their cultural and religious beliefs about mental health would merit a study in its own right.

Research Procedure

Participants will be recruited via advertisements and via referral from clinical psychologists, consultant psychiatrists or psychiatric nurses. The study will be advertised via an advert (See Appendix 2.2) that will be displayed in the psychiatry wards at Wishaw General Hospital. The advert will include a tear-off slip which the patient can either place in a secure box within the reception area, hand to their keyworker or send to the researcher. By returning the tear-off slip, the participant will be made aware that they are consenting for the researcher to contact their key worker or doctor to ensure that participation in the study does not interfere with any treatment that they may be receiving or that there are not any other pertinent clinical risk factors that would prevent the participant from taking part.

Individuals who express an interest in participating in the study will be provided with an information sheet once the key worker or doctor has confirmed that it is appropriate for them to participate. Informed consent will be obtained prior to participation. Written informed consent will be obtained before each interview and also to record and transcribe the interviews. Participants will be informed that they can withdraw from the study at any time. To ensure confidentiality the data will be anonymised.

Data will be collected using a semi-structured interview. The questions, based on the main aims of the study, will be open-ended to encourage participants to talk about their experiences. The interview schedule will be piloted with a subset of

the sample (n=3). This will be carried out to gain a sense of the appropriateness of the wording of the interview questions and any changes required will be made before carrying out the rest of the interviews. The researcher will be watchful of her own assumptions and views and will try to not allow this to influence the interview. The interview will be flexible and probes and specific questions may be used where necessary to encourage participants to elaborate. Throughout interviewing, emphasis will be placed on establishing rapport, with the aim of trying to understand the participant's perspective.

Participants will be interviewed by the researcher, within the hospital or health clinic. The researcher will not be doing home visits. Participants will be informed that they can stop the interview at any time, take a break or return to the interview at a later time. Each participant will be interviewed at least once and the interviews will last no longer than 1 hour at any one time. Participants may be interviewed on more than one occasion if it is felt necessary, in order to get a fuller understanding of their experience. The number of interviews conducted with each participant and the duration of the interviews will be flexible to suit each participant's needs. One hour of tape will take approximately 6 hours to transcribe; it is unable to state how long the analysis process will take as it is an iterative process.

The researcher will keep a reflective diary and will keep a note of any thoughts after each interview, in order to enhance personal reflexivity (discussed below).

Justification of sample size

The number of participants cannot be accurately predicted before commencing the study, however, data collection will continue until a point where the researcher feels that no more significant information/themes are continuing to emerge during coding. It has been suggested that for good qualitative research submitted for a Doctorate in Clinical Psychology thesis, a sample of between eight and twenty participants is desirable (Turpin, Barley, Beail, Scaife, Slade, Smith & Walsh, 1997).

Settings and Equipment

Interviews will be conducted across hospitals and health clinics in Lanarkshire and within areas that are convenient for the participants. Interviews will be recorded on a Sony digital voice recorder (ICD-V60 512mb). Interviews will be transcribed by the researcher and a computer with qualitative software (N-Vivo) will be used to aid analysis.

Data Analysis

The interpretative phenomenological analysis will proceed according to a series of recognised steps. Each interview will be read and then reread to become as familiar as possible with the account. Any significant and interesting responses will be noted in the left hand margin. The researcher will then return to the beginning of the interview transcript and each line of text will then be analysed

for thematic content and this will be noted in the right hand margin. The initial notes and thematic content will be grouped together; emerging themes will be identified and given a title. This will continue throughout the transcript. The emerging themes will then be listed on a sheet of paper and connections between these themes will be looked for. The researcher will attempt to make connections, if any, between the emerging themes. This process will be carried out with each participant's interview transcript. The emerging themes from each interview will then be examined together and the main themes identified (Smith *et al.*, 1999).

An independent researcher, also using IPA, will be asked to read a random selection of transcripts. This will be in order to verify the themes identified by the researcher and that there is '*rich evidence*' (Smith & Osborn, 2003; p.73) within the transcripts to support the themes identified. This process will also ensure that any significant themes are not overlooked by the researcher.

Personal reflexivity

In IPA research the analysis is the result of the interactions between the participants and the researcher. It is considered to be phenomenological (participants account) and interpretative (researchers interpretations of the participants' account). In order for the researcher to be able to unravel the meaning of the participants' experiences the researcher will need to interpret meaningfully how the participant makes sense of the world. These interpretations are based on the researchers own understanding, beliefs, expectations and experiences (Smith *et al.*, 1999). Therefore, personal reflexivity involves reflecting upon the ways in which our own beliefs, values and experiences will

have shaped the research. It also involves the researcher thinking about how the research may affect and may change us, as individuals and as researchers (Willig, 2001).

IPA requires reflexivity from the researcher who is expected to explicitly present his or her own perspectives (Willig, 2001). The researcher will reflect upon the interaction between her and the participants involved in this study. The researcher will also acknowledge any beliefs and experiences that may have the potential to bias her interpretations of the interview transcripts. In depth notes will be recorded in a reflective journal after each interview. Notes will also be made during the interview including non verbal behaviours, any comments made that will not have been recorded and any apparent contradictions in what the interviewee says or pertinent incidents that occur will also be noted.

Validity and Reliability

The purpose of a qualitative study is to elicit in-depth knowledge about the phenomenon under investigation, not knowledge that can be generalized. Therefore, the findings of this study may not have the same significance in other situations or contexts.

This study aims to produce a rich and in-depth understanding of service user's experiences of psychiatric admission and the findings will provide a foundation upon which further qualitative research can be carried out in the future.

Health and Safety Issues

Researcher safety issues

The researcher will not conduct home visits. Interviews will be conducted within health settings where there is a clear health and safety policy. The health and safety policy will be followed at all times. Managerial support will be obtained prior to conducting the interviews.

Participant safety issues

Due to the emotive nature of the information discussed, care will be taken to ensure that participants do not experience high levels of distress during the interview. Participants will be asked to assess their own comfort levels using a five-point likert scale before, during and after the interviews to monitor any changes. If at any point during the interview, the participant becomes distressed, the researcher will stop the interview and attend to the participant's distress. The researcher will stay with the participant until the distress is reduced. However, if the participant continues to be distressed the researcher will obtain the participant's consent to involve another member of clinical staff and seek further assistance. The participant's key worker and Consultant Psychiatrist will also be contacted.

Ethical Issues

This study will follow the ethical considerations described by Elmes (1995), i.e. participants should be fully informed about the research procedure and give their consent to participate before data collection takes place; there should be no

deception of participants in the study; they should be informed about the full aims of the study prior to data collection and complete confidentiality should be maintained regarding any information about participants acquired during the research process.

Therefore, each participant will be given an information sheet outlining details of involvement in the study and informed consent for participation, recording and transcribing of interviews will be obtained prior to participation. They will be informed that they are free to withdraw from the study at any time and also withdraw their data from the study at any time. The participants will be given the opportunity to read the interview transcripts prior to analysis to ensure they feel that it is an accurate reflection of their experience. The information obtained will remain confidential and only used for the purpose of this research and will not be shared with anyone else for any other use. The audio recording of each interview will be stored securely at the researcher's main base, within a locked filing cabinet. The interview transcripts will be password protected. No patient identifiable information will be recorded and a coding scheme will be used to identify participants. Consent to use and publish anonymised quotations will also be sought.

The participants will be informed of the limits of confidentiality and if there is a disclosure of risk to the participant or their intention to harm others the researcher will inform their key worker or Consultant Psychiatrist. Also, if at any point during the interview, the participant becomes distressed, the researcher will end the interview.

Financial Issues

A Sony ICD-V60 512mb Digital Voice Recorder will be borrowed from the Department of Psychological Medicine.

Timetable

30 th March 2007	Hand in Final Proposal
16 th July 2007	Re-submission of amended proposal
14 th September 2007	Re-submission of amended proposal
November 2007	Ethics/Management Approval
December 2007	Recruitment
March 2008	Complete recruitment
April 2008	Complete Data Analysis
Beginning of June 2008	Final Draft to Supervisor
1 st August 2008	Submit

Practical Applications

1. To inform how we understand psychiatric admission from a psychological point of view
2. To highlight positive and/or negative experiences of psychiatric admission
3. To aid the development of a users experience of psychiatric admission questionnaire
4. To feed back users perspectives and experiences of psychiatric admission into improving services
5. To highlight areas that could be explored in future research

Ethical and Management Approval Submissions

Ethical approval will be requested from the Lanarkshire Ethics Committee before beginning the study. Managerial approval will also be requested from the Lanarkshire Research and Development Department before beginning the study.

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How do you feel about your recent hospital admission?



I am a Trainee Clinical Psychologist and I am conducting a research study in the field of psychosis and psychiatric admission. I am interested in speaking to individuals who have experienced psychosis. I would like to learn more about your experience of being admitted to hospital.

What is the research study about?

This research is about developing an understanding of individual's experience of psychosis and psychiatric admission to hospital. Everyone's experience of being admitted to hospital will be different. I would like to find out about your experience of being admitted to hospital and if you think being in hospital helped you or not.

What is psychosis?

Psychosis involves having unusual experiences which may include hearing voices when there is no-one there, seeing and feeling things that other people do not. Individuals may also hold strong beliefs that are not shared by others. It can often result in psychiatric admission but everyone's experience is different and unique.

Why is this research important?

If we learn more about your experience of being admitted to hospital, it may help us make changes and develop services.

What is involved?

I will aim to meet you at the hospital or at your local health centre and I will ask you about your experience of psychosis and admission to hospital. There are no right or wrong answers. It is your experience that I would like to hear about. With your permission I will tape record this session.

What happens next?

If you are interested in taking part please complete the tear-off slip below and hand it to your keyworker. In order to ensure that your participation does not get in the way of any ongoing treatment that you may be receiving, I'd like to contact your keyworker. If your keyworker feels that your involvement in the research will not interfere with your ongoing treatment, I will contact you to arrange a meeting to talk about what is involved in the study and answer any questions that you may have.

Please take and complete a slip if you are happy for me to contact your keyworker in the first instance. Thank you for taking the time to read this advert and I hope to have an opportunity to find out more about your experiences.

**Miss. Ifaf Asghar (Trainee Clinical Psychologist),
Hartwoodhill Hospital, Dept. of Clinical Psychology**

**Contact Number: 01501 824 571
Email: hospitaladmissionstudy@googlemail.com**

Name Address
Telephone No.....(optional)
Keyworkers name Keyworkers base / Contact No.....
Signature.....(I agree that you may contact my Keyworker)
For office use: Psychiatric Admission Study - Please contact Ifaf Asghar, Trainee Clinical Psychologist, Hartwoodhill Hospital, 01501 824 571



Department of Psychological Medicine, University of Glasgow
NHS Lanarkshire



Exploring individuals' experiences of psychiatric admission

Information Sheet

My name is Ifaf Asghar and I am a Trainee Clinical Psychologist. I would like to invite you to take part in a research study. I am interested in learning about experiences of psychiatric admission from those individuals that have experienced psychosis. (Insert name of referrer) suggested you may be able to help me with this study.

Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask me if there is anything that is not clear or if you would like more information. You can contact me on the following number **01501 824 571** or you can leave a message and I will get back to you as soon as possible.

What is the research about?

This research is about psychosis and psychiatric admission. The experience of having psychosis is different for everyone. It can be a distressing and confusing experience and it is often associated with unusual experiences such as hearing voices or unusual beliefs such as believing that you are being persecuted. It can often result in psychiatric admission and this can sometimes be involuntary. Importantly everyone's experience of being admitted to hospital will be different. I would like to find out about your experience of being admitted to hospital and if you think being in hospital helped you or not.

Why have I been invited?

I am asking people who have experienced psychosis and have been subsequently admitted to hospital to take part in this study.

Do I have to take part?

No. It is up to you to decide whether or not you want to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. The consent form is a way of making sure you know what you have agreed to. If you decide to take part you are still free to withdraw at any time and you do not have to give a reason. This will not affect the standard of care you receive.

What will happen next?

If you would like to take part please tell the person who gives you this information sheet and I will get in contact. Or you are welcome to contact me directly on the number above.

If you decide to take part you can contact me and we can meet to have an initial chat. You can decide where we should meet; this can be at the hospital or at your local health centre. You are welcome to meet first with a family member or your key worker. If you still want to take part you and I can meet again and have a discussion about your experience which will last about 1 hour, but this is flexible, depending on how you find the experience. We may meet on a second occasion but this is also up to you.

What does taking part involve?

When we meet I will answer any questions or concerns you may have. I will ask if the meeting(s) can be recorded on a digital recorder. I will show you the equipment and demonstrate how it works before starting recording. You are free to stop the recording at any time during the interview(s).

I will then ask about your experience of admission to hospital. Importantly there are no right or wrong answers. It is your perspective that I would like to hear.

Why are the interviews being recorded?

I need to record the interviews to carefully understand your experiences and our conversation. All information will be kept strictly confidential. During our conversation I will check with you that I have understood correctly, and later I will provide you with written feedback to further check I have understood your perspective.

What happens to the information?

Your identity and personal information will be completely confidential and known only to the researcher Miss Ifaf Asghar. The information obtained from the audio tapes will remain confidential and stored within a locked filing cabinet. The data are held in accordance with the Data Protection Act, which means that we keep it safely and cannot reveal it to other people, without your permission.

What is the down side?

It is possible that our meeting(s) may cover topics that are difficult or distressing for you to talk about. However if you do not want to continue you can end the interview at any time. You can take a break at any time. I would like to meet at a time when your key worker is available, so afterwards if you want you can speak with someone who knows you about our meeting.

What are the possible benefits of taking part?

There are no direct benefits to you of taking part. The information we learn from this study will help us plan future research and develop services.

What will happen to the results of this study?

If you wish, I will provide you with a summary of the results of the study. The final results and conclusions of the study will be published in a scientific journal and will form part of my qualification in Clinical Psychology. Your identification will not be included in any publication.

Who has reviewed the study?

This study has been reviewed by the Department of Psychological Medicine to ensure that it meets important standards of scientific conduct and has been reviewed by NHS Lanarkshire Research Ethics Committee to ensure that it meets important standards of ethical conduct.

What if I wish to complain?

If you are unhappy about any aspect of the study and wish to make a complaint, please contact Ms. Shona Welton, Head of Patient Affairs on 01698 245002

Thank you very much for reading this and for any further involvement with this study.

A study exploring individuals' experiences of psychiatric admission

Researcher: Miss Ifaf Asghar

Consent Form

Please initial box

I confirm that I have read and understand the information sheet dated 01/11/2007 (version 1) for the above study and have had the opportunity to ask questions

☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

☐

I understand that sections of my medical notes may be looked at by the research team where it is relevant to my taking part in the research. I give my permission for the research team to have access to my records.

☐

I understand that the researcher will have access to my personal details including my address so that she can send me a copy of the research findings. I understand my personal details will not appear in the research report.

☐

I understand that the interview will be tape recorded solely for the purposes of the research study as described in the Participant Information Sheet date 01/11/2007 (version 1)

☐

After the interview has been transcribed, and all names, places and identifiers have been removed I understand that the researcher may publish direct quotations

☐

I agree to take part in the above study.

☐

Name of Participant

Date

Signature

Researcher

Date

Signature

3 Copies: 1 copy to be given to the participant, 1 to be kept by the researcher and 1 to be put in the participant's case notes.

Appendix 2.5

Lanarkshire Local Research Ethics Committee

Lanarkshire NHS Board
14 Beckford St
Hamilton
ML3 OTA

Telephone: 01698 281313

Facsimile:

20 December 2007

Ms Ifaf H Asghar
Trainee Clinical Psychologist
University of Glasgow
Department of Psychological Medicine
Division of Community Based Sciences,
Academic Centre,
Gartnavel Royal Hospital,
1055 Great Western Road,
GLASGOW G12 0XH

Dear Ms Asghar

Full title of study: **How does the experience of psychiatric admission inform the recovery perspectives of service users with psychosis: an interpretative phenomenological analysis**

REC reference number: **07/S1001/103**

Thank you for your letter responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application	5.5	05 November 2007
Investigator CV	1	01 November 2007
Protocol	2	08 December 2007
Covering Letter	2	08 December 2007
Interview Schedules/Topic Guides	1	01 November 2007
Advertisement	2	08 December 2007
GP/Consultant Information Sheets	2	08 December 2007
Participant Information Sheet: PIS (2)	1	01 November 2007
Participant Information Sheet: PIS	1	01 November 2007
Participant Consent Form: PCF	2	08 December 2007
Response to Request for Further Information		
Supervisors CV	1	01 November 2007

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from <http://www.rdforum.nhs.uk/rdform.htm>.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

Here you will find links to the following

- a) Providing feedback. You are invited to give your view of the service that you have received from the National Research Ethics Service on the application procedure. If you wish to make your views known please use the feedback form available on the website.
- b) Progress Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
- c) Safety Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
- d) Amendments. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
- e) End of Study/Project. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nationalres.org.uk .

07/S1001/103	Please quote this number on all correspondence
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With the Committee's best wishes for the success of this project

Yours sincerely

MRS. P. CONWAY
SECRETARY TO THE GROUP

Enclosures:

Standard approval conditions [SL-AC1 for CTIMPs, SL-AC2 for other studies]

Site approval form

Lanarkshire Local Research Ethics Committee

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

REC reference number:	07/S1001/103	Issue number:	0	Date of issue:	20 December 2007
Chief Investigator:	Ms Ifaf H Asghar				
Full title of study:	How does the experience of psychiatric admission inform the recovery perspectives of service users with psychosis: an interpretative phenomenological analysis				

This study was given a favourable ethical opinion by Lanarkshire Local Research Ethics Committee on 20 December 2007. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.

<i>Principal Investigator</i>	<i>Post</i>	<i>Research site</i>	<i>Site assessor</i>	<i>Date of favourable opinion for this site</i>	<i>Notes ⁽¹⁾</i>
Ms Ifaf Asghar	Trainee Clinical Psychologist	NHS Lanarkshire	Lanarkshire Local Research Ethics Committee	20/12/2007	

Approved by the Chair on behalf of the REC:

..... (Signature of Chair/Co-ordinator)

(delete as applicable)

..... (Name)

Lanarkshire Primary Care NHS Trust

Ms I H Asghar
Trainee Clinical Psychologist
University of Glasgow
Department of Psychological Medicine
Division of Community Based Sciences, Academic Centre,
Gartnavel Royal Hospital,
1055 Great Western Rd,
GLASGOW
G12 0XH.



Research & Development Office,
Strathclyde Hospital,
Airbles Road,
Motherwell,
ML1 3BW.

24th December 2007
Phone/FAX 01698 245196/245091

Ref LAPP757
Ethics 07/S1001/103

Dear Ms Asghar,

Conditions of Management Approval to undertake the project:
" How does the experience of psychiatric admission inform the recovery perspectives of service users with psychosis: an
interpretative phenomenological analysis "

I am pleased to inform you that you have management approval to undertake the above study in NHS Lanarkshire (Primary Care Division). As the Chief Investigator for the study you are subject to the following requirements:

- 1 You have approval to undertake research activities relating to non-commercial NHS Research & Development under the terms of Scottish Executive Research Governance Framework for Health and Community Care ("Approved Research Projects"). (see CSO website: www.show.scot.nhs.uk/cso) Local Research Governance monitoring may involve audit of your research at some time in the future.
- 2 You must have a favourable ethical opinion for your project, you must comply with any conditions imposed by the ethics committee and any amendments made to an ethics committee should also be notified to the Research & Development Office.
- 4 Within NHS Lanarkshire you are responsible to Ms A. McMullan and are required to comply with Good Clinical Practice, Research Governance and Ethics Guidelines, Health & Safety Laws, Data Protection Act 1998 and all other Policies and Procedures as laid down by NHS Lanarkshire.
- 5 You must ensure that all confidential information is maintained in secure storage. You are further obligated under this agreement to report to the NHS Lanarkshire Data Protection Office and the Research & Development Office infringements, either by accident or otherwise, which constitutes a breach of confidentiality.
- 6 This agreement is in relation to the above study and will be effective from the date of this letter to 31st August 2008.
- 7 You must send brief annual reports followed by a detailed final report and summary to the R&D office in hard copy and electronic formats.

Best wishes with your project.

Yours sincerely,

Dr J. M. Gaukroger
Research & Development Manager



(See Appendix 1.2)