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A counselling psychology perspective on in-patient settings: considering the relationship of care and depression.

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Declaration

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THE FOLLOWING PART OF THIS THESIS HAS BEEN REDACTED:

Section C: Case Study

Section A: Introduction to the portfolio

1. Overview

The main theme of each part of this portfolio is the depression-dependency relationship and how the nature of this relationship affects the experiences and actions of people as they encounter, engage in and live through the experience of being cared for by others.

Practising as an in-patient counselling psychologist, I became informed of and developed an interest in this relationship. My experiences have made me realise that the depression-dependency relationship might play an important role in the development of difficulties such as negative feelings, powerlessness, frailty, and vulnerability with which a client can be faced. Patients with depression, addiction and personality disorders are among the hardest to help in both primary care and specialist settings (Pearce & Pickard, 2010). Their numbers are also high. Chronic forms of depression are highly prevalent, especially in in-patient settings, and again are considered difficult to treat (Pearce & Pickard, 2010).

Acute illness can change one's sense of self in the world as the lived boundaries of "I can" and "I can't" change with illness, recovery and relapse (Kesselring, 1990, cited in Toombs, 2001). The dependency elements of the depressive experience are evident in all phases surrounding an admission. For example, both before and during an admission there is an acknowledged need for care, which will also play a main role in the discharge phase later on. During an admission patients are placed in a dependent position by being taken care of (e.g. being fed and given medications), while having few realistic housekeeping obligations expected of them in return. What I came to realise in my work as an in-patient psychologist is that dependency is subtle yet profound in the in-patient therapeutic encounter. The exploration and awareness of how the care-receiving process may influence the depressive experience can inform psychotherapeutic practice in a way that allows both the therapist and the client to have a greater awareness of how care may lead to the development or maintenance of dependency and to the consideration of the appropriate therapeutic interventions to deal with them. If as in-patient psychologists our aim is to work towards making the overall ethos of wards psychotherapeutic, then as counselling psychologists involved in the care of in-patient psychiatric clients, we need to be aware of the meanings attached for the person receiving care. We could then manage our clients more effectively in these specific and unique contexts (in-patient units) where the care element is most intensely delivered and felt. At the same time, there is currently an acknowledged need to create mental health services that promote independence and recovery. Therefore, exploring

the phenomenon of receiving care can inform us of how to respond to the different care and dependency needs of our clients, which can play a crucial role in their recovery. I see my role as a therapist not to fit people into an established ideology, but to help them acknowledge the transformative nature of depression and their potential to reconstruct their world by assisting them to generate new meaning and a value base that allows them to find a satisfying way to live in the world.

Each part of this portfolio aims to explore the depression-dependency relationship and its impact on psychological well-being. The research aims to explore this relationship from a systemic perspective; how depressed adults perceive their relationship to care and how this relationship affects the way one experiences the self and the relationship with others. The case study aims to explore this from the perspective of the depressed adult within a 1-1 therapeutic relationship, by looking at the dependency needs of a depressed adult and how these needs affect the development of the therapeutic relationship, as well as looking at their overall impact on the therapeutic outcome. Finally, the literature review aims to explore Cognitive Behavioural Therapy – CBT – as a treatment of depression in in-patient settings.

2. The research

During my training as a counselling psychologist, I worked in community care and managed a small mental health unit. Apart from the therapeutic work that I carried out with the clients, I also maintained a very close collaboration with all the Mental Health (MH) specialists working with these clients. I started developing a holistic perspective of the various agencies a client is surrounded by, including outpatient/in-patient medical intervention, social welfare input, and community care input. My interaction with these services triggered me to consider how such a system impacts mental health conditions and motivated me to reflect on the way(s) clients respond to the attention and care they receive from these different agencies. Upon qualification, I was employed as a counselling psychologist in the National Health Service (NHS), in an in-patient psychiatric unit and working in low-, medium- and high-security wards. This position enabled me to gain a unique viewpoint of the mental health nucleus, and I started reflecting on how the experience of being cared for by others is shaped by and shapes the psycho-synthesis of mental health patients through the assumptions and meanings attached to the term 'care', in terms of both seeking and accepting the help of others. These working experiences gave me a general conception of the mental health system in the UK. Within this overall loop of care with different emergent micro-practices, there is a circularity of a care system with the client at the centre. However, as simple and obvious as this idea is, it cultivated my interest in the meaning of this experience from the client's perspective, and on how it impacts a mental health

condition. In other words, I started reflecting on how the system acts as a systemic force on a mental health condition, specifically in depression.

The product of those reflections resulted in my interest in a broad research area: What is it like to be cared for by others? I opened up this research area to clients, in the form of a focus group that reflected on this question, with the aim of finding out what was important to clients. Conversations and brainstorming sessions with service users on the broader research area of the experience of care helped to inform the interview schedule and questions asked in the one-to-one interviews with in-patient service users.

The theme of dependency stood out as being an important one, in relation to the experience of receiving care, for the clients in the focus group. Service users identified strong parallels between care and dependency in the sense that care can be a response to dependency, in dependency there is a need for care, and that care can itself create or intensify dependency. The input from the focus group helped to finalise and narrow down the research question in which the exploration of the range of meanings embedded in the concepts of both care and dependency became the nucleus of this current research.

Dependency needs of in-patient clients are a dominant and frequent denominator in discussions of medical ward rounds regarding pre-, current and post-hospitalisation phases. It was really challenging and interesting to explore the other side, and by this I mean, how a depressed adult perceives his or her relationship to the care system and the impact of this experience on the depressed individual. On a micro-level is the depressed patient's experiences of interpersonal dependency from significant others, and on a macro-level is the experience of the depressed individual's dependency on a care system.

Klapman (1957), in his reflections on hospitalisation, stated that "if we seek to make hospitalization truly therapeutic we shall not overlook to what extent hospitalization itself conspires with the patient to produce a state which robs him of all incentive…" (cited in Morgan & Johnson, 1957). Half a century later, this statement appeals to me as still having theoretical and practical value. Therefore, on a micro-level, which is the therapeutic work with patients, having a better understanding of what it is like to receive care as a depressed adult might facilitate the practice of psychologists who work therapeutically with depressed adults in in-patient settings. On a macro-level, the exploration of the dependency facets of depression that relate and result in the receipt of care might lead to the desired

goal of reducing the length of admissions and lowering readmission rates. Psychiatric hospitalisation is an expensive modality of care for people with serious mental illness.

3. The case study

As health care moves towards adopting multidisciplinary approaches to practice, counselling psychology should strive to establish its own unique body of knowledge as well as maintain its professional boundaries. When working in NHS in-patient psychiatry as a counselling psychologist, it appears essential to be able to move toward a multiple model, capturing the philosophies of both positivist and non-positivist paradigms, in a triangulated manner. As defined by the *British Psychological Society's Division of Counselling Psychology: Professional Practice Guidelines* (2006), counselling psychology emphasises a "value base grounded in the primacy of the counselling or psychotherapeutic relationship", and within this suggests that we are "not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing" (p. 2). Not assuming one way of knowing has led to counselling psychology being influenced by a variety of positions which are embedded within contrasting epistemologies, including the scientist-practitioner model, reflective-practitioner-model, phenomenology, humanistic values as well as post-structuralism and postmodernism.

This case study is presented from a positivist, medical model stance. The multi-paradigmatic view taken in this portfolio is consistent with and reflects the ethos of counselling psychology. I chose to frame the case study within the medical model approach, so as to bring forth a contrasting reality when working within the NHS. My experience of working within this system involved incorporating and managing the often contrasting meanings inherent in the experience of care in my professional day-to-day practice, as well as in interdisciplinary professional dealings within the context of the hospital. Hence, I selected this particular way of thinking for the case study, which differs from the approach taken in the research and the critical literature review, so as to bring forth this tension for in-patient NHS counselling psychologists, that is, the tension between the philosophical underpinning of counselling psychology, humanistic and existential/phenomenological values, and the power of the medical context.

The case study presents the therapeutic work done by the researcher with a depressed client in an in-patient setting. The patient in question had difficulty coming to terms with the physical and psychological symptoms of a stroke. The main difficulties of my client were to cope with the physical barriers that the stroke left him with, and to adjust to his new reality, a reality dependent on others.

This case study explores the dependency-depression relationship within the therapeutic journey, and considers its impact on the therapeutic outcome.

4. Critical Literature Review

The purpose of the critical literature review is to examine psychological treatments of depression in in-patient settings. An acknowledged challenge when working in an in-patient setting is whether you can work therapeutically, since there is the sense that "the provision of psychological therapy to in-patients is not worthwhile" (Clarke & Wilson, 2009, p. 1). The idea of exploring this particular area came after the many cases of chronic or severe depression I encountered whilst working as an in-patient counselling psychologist. These encounters motivated an internal dialogue between the evidence-based applicability of psychological work with in-patients and the challenges that such work is faced with. Therefore, the objective of this part of the portfolio is to review the literature in this area. Research on psychological treatment of depression with in-patients is not conclusive, with some studies finding clear positive effects (Cuijpers et al., 2011) and other studies finding no significant benefit compared to usual care or structured pharmacotherapy (Cuijpers et al., 2011). This current review focuses on CBT with depressed in-patient individuals.

This portfolio is therefore a manifestation of different ways to deal with the tensions of the philosophical underpinning of counselling psychology, humanistic and existential/phenomenological values and the power of the medical context within the NHS, where a pluralistic stance assimilates the medical model with counselling psychology's value base system.

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Section B: Research

A Qualitative Study of the Experience of Being Cared for by Others, as a Depressed In-patient Adult

We are by our very nature both individuals and dependent creatures, and any plausible account of 'the sheer delight of personal achievement' must make reference to that dependence (Mendus, 1991: 23).

Abstract

Title: A Qualitative Study of the Experience of Being Cared for by Others, as a Depressed In-patient Adult

Aria Christopoulou: Counselling Psychologist, HCPC Registered Practitioner Psychologist,

Chartered Psychologist, BPS Registered Psychologist

Chapter 1: Introduction

1. Chapter Overview

The current study is concerned with the experience of receiving psychiatric care as a depressed adult. Within the context of adult mental health in-patient services, a number of studies (Escolme & James, 2004; Abeles, Danquah, Wadge, Hodgkinson, & Holmes, 2007; Hurst & Howard, 1988) have identified the concept of patient dependency in many different ways and various techniques and tools have been published aiming to quantify patients' dependencies.

In using the term 'care', the authors refer to the process of people being looked after by mental health professionals while these people are in a psychiatric in-patient unit. The term 'dependency' is used throughout this study to reflect the ways in which an individual relies upon another individual, system, or authority, in the broader sense, and will be further defined later on. As this research project took place in inpatient Psychiatry, which is a medical context, depression at times will be considered in terms of the medical model and as conceptualised within psychiatry and the DSM IV.

At this point the researcher would like to clarify that the term 'depression' has been adopted throughout this study as a convenient way to describe individuals diagnosed as experiencing such a condition, and furthermore that the author does not endorse a positivist view, but instead takes into consideration depression as a mental health experience.

Counselling psychologists enter the NHS system and find an opposing value base to their own. In this medically dominated system people with acute mental health difficulties are perceived as having an illness that needs to be cured and 'treated' with medication, in contrast to the alternative view offered by this study. Whilst counselling psychologists are critical of the medical model, they work in places where the dominant forms of treatment are heavy doses of medication with sometimes devastating side-effects, restraint and Electro convulsive therapy (ECT). This emphasises how complex the in-patient system is, with a complex history, involving complex reasons for what mental illness and distress is, and how the clinicians involved have conflicting underlying rationales which creates different beliefs around interventions and the very structure of the services. The researcher attempts throughout this project to look closely at the details of the depressive experience which are not captured in the traditional, medical model, through a phenomenological lens. By this, the researcher intends to open up a dialogue between philosophy and psychiatry which can offer us a fuller understanding of this human experience, by translating what appear to be inaccessible phenomenological experiences into tangible everyday practice.

This chapter opens with a historical overview of the concepts of care and dependency in the literature from different theoretical frameworks, outlining seminal works and highlighting their relevance to current psychiatric hospitalisation. The objective of the introductory review is to gain a holistic understanding of how the key themes of this current study have been approached in recent times from psychology and other disciplines, as well as how history, culture and society construct care and dependency concepts, how these influences are reflected, and how they inform current in-patient psychological practice. An outline of the aims of the research project follows.

Theoretical discussions in sociology and nursing have been matched by research, providing a rich panel of papers on care and dependency (Chow & Priebe, 2013). However, very little research has been done with a psychological focus on this experience. After my extensive search, no studies were found in the literature. Instead, the phenomenon of care has been approached from different theoretical frameworks and disciplines, mainly from a medicalised-psychiatric nursing or a sociological perspective (Chow & Priebe, 2013). There is rich theoretical work and research that deals with the theme of care dependency in both adult and geriatric care, filed within the nursing literature (Abeles et al., 2007). Taking into consideration the wide range of health care professionals involved in one's care in in-patient psychiatric settings, it is of relevance to inform and be informed of the research of psychologists from different disciplines, and to create common ground that will allow an understanding of how patients interact with and within the care system. Ultimately, this will aid an understanding of how this interaction influences recovery or promotes stagnation in psychopathology in general, and for depression in particular. Nonetheless, findings from a number of nursing and sociological studies are relevant to the current research and therefore have been included in this review.

The literature review identified the following broad areas of investigation that are of relevance and significance to this study. These are a) the phenomenon of care dependency, b) the experience of mental health hospitalisation, and c) the link between depression and dependency. The literature reveals a wealth of research on the phenomenon of experiences of care during psychiatric hospitalisation and care dependency with in-patient adults from the nursing field, but a serious lack within psychology. No studies were found with a focus on the phenomenon of receiving care from an adult service user perspective, or from a psychological perspective with an explicit psychological focus.

A three-part search strategy was employed. Initially, six major computerised publication databases were searched: PsychArticles, PsychInfo, MedLine, PubMed, Cinahl and SocialSciSearch. Search terms included: 'Psychiatric Hospitalisation', 'care' 'dependency', 'depression', 'Service-User Experiences'; along with additional terms, 'Psychological Impact' and 'in-patient hospitalisation', to refine the search. These terms were also combined with the methodology type that included "interpretative phenomenological analysis" or "IPA" or "phenomenological analysis" or "qualitative research". Of the papers identified, abstracts of those most relevant were reviewed. Referenced papers containing any of the relevant search terms were also reviewed.

2. Experience of care during psychiatric hospitalisation

Once a patient is admitted to a hospital setting, it is acknowledged that there is a need for this person to be cared for by others. On a societal-macro level, welfare dependency implies high levels of government expenditure and the loss of potential tax revenue (Cabinet Office, 2010). On an individual-micro level, psychiatric hospitalisation can be a very intense experience, impacting a person in multiple ways and levels.

Research on this intense experience has focused on different areas and aspects of hospitalisation, for example, the therapeutic potentiality of wards, their physical and social environment, and their safety, violence and restriction (Mellesdal, 2003; Owen, Tarantello, Jones & Tennant, 1998), the effectiveness of different types of in-patient care (Xenitidis et al., 2004) , and the psychological effects of psychiatric in-patient care, such as stigma, self-esteem and identity (Painter, 2008; Lynch et al., 2005). Satisfaction, survey and outcome research on in-patient care have highlighted some important issues for patients relating to the daily life of the hospital stay, such as boredom, coercion and lack of privacy (Barker, 2000; Leavey, King & Cole, 1997), but have also been criticised as offering little insight into the patients' world, as such research is often small in scale, lacking rigour and limited in scope (Quirk & Lelliott, 2001). Most papers have mainly used clinician-led measures, focusing on diagnosis prognosis and treatment issues, investigating the experience of mental illness and hospitalisation as a whole, rather than psychiatric hospitalisation and the experience of care per se. Therefore, it can be said that the meaning of the experience of care during hospitalisation has been overlooked.

Quirk and Lelliot (2001), in their review of research evidence about life on psychiatric wards and focusing on the experience of patients in acute settings, found that most prior research emphasised the professionals' perspective and focused on clinical practice, therefore offering a poor

understanding of the meaning of in-patient care to its recipients. In the studies they reviewed, they identified five methodological approaches: 'participant observation, discourse/conversation analysis, in-depth or semi-structured interviews with patients, questionnaire surveys of patients and one-day "snapshot" observational methods' (Quirk & Lelliot, 2001, p. 6). They noted that most UK studies in the 1990s used quantitative and questionnaire survey methods, focusing on the nurse-patient relationship (Higgins & Hurst, 1999), the lack of contact with professionals, the appreciation of humane qualities in staff (Leavey et al., 1997; Rogers & Pilgrim, 1994), and criticism of the physical environment and ward conditions in in-patient life (Barker, 2000; Quirk & Lelliot, 2001; Higgins & Hurst, 1999). The authors concluded that such research, although useful, provides little insight into everyday institutional processes and contextual influences that shape how acute psychiatric care is delivered and experienced by its recipients. They further pointed to the need for systematic, comparative qualitative investigation of in-patient care to explain the nature of patient care within its dynamic institutional context, modelled on earlier qualitative studies, and conducted from a social science research perspective. Therefore, key qualitative studies that provide insight into psychiatric in-patients' subjective experience were reviewed in some detail and placed in the context of wider bodies of research. These are presented below.

Qualitative studies during the 1990s mainly focused on specific aspects of acute ward life, such as the nature of staff-patient interaction and patient satisfaction (McDonald, Sibbald, & Hoare, 1988; Hansson, 1989). There were some noteworthy qualitative studies in the literature during the 90s that studied aspects of the subjective experiences of patients, usually in relation to specific demographic or diagnostic groups, such as in the Barker, Lavender and Morant (2001) study, McNally (1997), Corin (1990, 1998), or other studies using hermeneutics and ethnography studies like Cohen's, (1992), Estroff's, (1995) and Wiley's, (1989) (all cited in Davidson 2003, p. 16).

Even though the 2002 NICE Guidelines suggest encouraging clients to write and tell their own accounts of their admission to hospital, there is still a substantial lack of studies within psychology, which strengthens the necessity of the present study. Again, nursing studies dominate this research area. In the literature review the researcher identified a plethora of studies relevant to the experience of care during hospitalisation, from patients' and nurses' perspectives within the nursing field.

Kapborg and Bertero (2003) used qualitative content analysis to study the nature of the concept of caring from a student nurse's perspective, and identified three categories of caring: doing – namely the physical presence of nurses with patients; being – their mental presence; and professionalism –to do with a nurse's competence. Qualitative research on the experience of care and hospitalisation has mainly reported negative findings in relation to identity, and suggests that this experience may have a detrimental effect on self-concept, dignity, and on the self-esteem of in-patients. Roe and Ronen's

(2003) study used a grounded theory approach to qualitatively investigate the subjective experience of people admitted to hospital with psychotic experiences, and the troublesome aspects of the psychiatric stay. The main themes identified were: a sense of passivity that generated self-doubt and a loss of sense of self, confrontation with the personal meaning of hospitalisation and loss of how they were previously perceived by others, losing the 'ease' of meeting basic environmental demands, loss of self-esteem, and transition problems. The authors concluded that the process of becoming a psychiatric in-patient made "a powerful statement about one's limited competence and capacity for independence" (Roe & Ronen, 2003, p. 332). However, other studies report a balance between positive and negative findings. Miedema and Stoppard's (1994) qualitative study of the subjective experience of in-patients identified two important themes with their female participants, firstly, the need to seek asylum and thereby have respite from everyday responsibilities which led, secondly, to feelings of being controlled by others, coercion and powerlessness. Similar findings in relation to autonomy and restriction are reported by Johansson and Lundman (2002), who described the experience of involuntary hospitalisation where patients reported being protected and cared for, but also felt that their physical integrity and human value were violated (Johansson & Lundman, 2002).

Research has also demonstrated positive aspects of compulsory care, such as finding a refuge and being freed from everyday responsibility (Thomas & Pollio, 2002; Famham & James, 2000). In Roe and Ronen's (2003) study, being freed from responsibilities was reported by patients as passivity, created by their inactive status during a hospital stay and producing a sense of hopelessness and helplessness (Roe & Ronen, 2003). This is explained by Seligman's (1975) notion of 'learned helplessness' whereby the loss of personal control during hospitalisation may lead to learned helplessness in terms of lowered motivation, decreased self-efficacy, and resulting in a spiral of depression.

Later qualitative studies, again within the nursing field, have investigated staff attitudes toward patients in psychiatric care (Deans & Meocevic, 2006; Gibb, Beautrais, & Surgenor, 2010; Husum, Bjørngaard, Finset, & Ruud, 2010; Pollard, Gelbard, Levy, & Gelkopf, 2008) and patient experience of particular types of care (Johansson, Skärsäter, & Danielsson 2009; Lilja & Hellzén, 2008; Määttä, 2009; Thibeault, Trudeau, d'Entremont & Brown, 2010). However, most of these studies stem from Scandinavian countries, and hence are only briefly mentioned, as this thesis is looking at the UK mental health system.

Berg, Skott and Danielson (2006), in an IPA study on the meaning of the caring relationship, gave an understanding of the phenomenon through the illumination of nurses' and patients' thoughts, feelings and actions in the nursing care proceedings. The patients interviews identified themes such as:

competence, lack of continuity, strain and vulnerability, while the nurses' themes from the interviews were those of competence and striving (Berg et al., 2006). The same authors conducted another study by qualitatively looking at both patients' and nurses' experiences of the caring relationship in hospital. This IPA study with seven nurses and six patients identified themes for both of these groups. Themes from the patients' side were: maintaining dignity – using one's own competence and being cared for by the team; feeling vulnerable – being cared for in a strained relationship and being exposed; and acquiring personal caring relationships. Themes from the nurses' side were: a purposeful striving – using one's own competence and being aware of limitations; an arduous compassion-giving care in a strained situation; and being aware of what is needed (Berg & Danielson, 2007). Though this study implicates the importance of an understanding of how contextual circumstances create the foundation of the caring relationship, methodologically it used participant observation with nurses' field notes, and again was conducted in a Swedish medical context.

Enarsson, Sandman and Hellzén (2011), in a hermeneutic analysis focusing on patients' perceptions, investigated the lived experience of receiving care based on a common staff approach, again within the nursing field. Their results revealed the themes of: discovering that you are subjected to a common staff approach, becoming aware that no one cares, becoming aware that your freedom is restricted, and feeling safe because someone else is responsible.

The study carried out by Enarsson et al. chose to focus on a common staff approach, which meant that in situations where a patient challenges the internal order of the ward, the staff try to correct the patient's behaviour by applying a common approach to them, which has been formulated and implemented by all staff for all their individual patients. In doing this, staff members negotiate with each other to reach an agreement on how to behave towards individual patients. However, as mentioned above, this study was conducted in northern Europe and so represents a very specific medical culture, therefore its findings might be culture specific. In addition, one should keep in mind that this common staff approach is not a properly formulated care plan, but a strategy that the staff employ to control a patient whenever they feel exposed and pressured by the patient's actions. The aim of this study was, therefore, to illuminate the reader on the meanings of a common staff approach when applied to the caring of in-patients in psychiatric care, as narrated by the patients, and not on the patients' lived experiences of receiving care.

Finally, Gilburt, Rose and Slade (2008) qualitatively studied service users' experiences of psychiatric hospital admission in the UK, using a participatory approach, and exploring the process and themes which define the user experience of hospitalisation. Relationships formed the core of service users'

experiences. Three further codes were treatment, freedom and environment, which defined the role of the hospital and its physical aspects. Themes of communication, safety, trust, coercion, and cultural competency contributed to the concept of relationships (Gilburt et al., 2008). Though the service users of this study were not current patients, but had previous experiences of psychiatric admissions, it nevertheless explored the experiences of admission to acute psychiatric hospital from the perspective of services users, identifying the central role of relationships in the patient experience. Furthermore, their accounts clarified the important elements of relationships and how these inform patient experiences. Jones et al. (2010) explored the experiences of 60 service users on acute in-patient psychiatric wards in England, with a particular focus on their feelings of safety and security, and found that while the majority of service users felt safe in hospital and felt supported by staff and other service users, psychiatric wards were still perceived by many as volatile environments with elements threatening their sense of security, such as aggression, bullying, theft, racism and the use of alcohol and drugs on the ward (Jones et al., 2010). This study involved a large number of participants, and though it focused on issues of security and safety, it provided us with a good understanding of issues around aggression within wards, through the nursing field.

What seems to transpire is that within nursing research there is an attempt to explore, identify and develop meanings of hospitalisation experiences and grasp the experience by the two parties involved in the care relationship – giver and recipient. However, by definition this line of research lacks the psychological depth of what is it like to be cared for. Recent studies in psychology have yielded some important results about the experience of hospitalisation. For example, Lilja and Hellzén (2008) described patients' experiences of hospitalisation using a qualitative, content analysis approach. Themes that emerged from patients' narratives were: being seen as having a disease, striving for a sense of control in an alienating and frightening context, succumbing to repressive care, meeting an omniscient master, and care as a light in the darkness (Lilja & Hellzén, 2008). Furthermore, the use of narratives in in-patient care has provided useful information. In Duncan et al.'s (2005) paper, in-patients on two wards at the Maudsley Hospital in South London were given the opportunity to write their own narratives of how they came to be admitted to hospital. This allowed clients to reflect back upon their journey up to their admission, with the use of narratives as a therapeutic device, allowing the multidisciplinary team to appreciate the perspectives of service users and perhaps to reveal areas that could be improved on in the admission process and client care (Duncan et al., 2005).

As a continuation of the studies using narrative work, Whittall and Allie (2011) used content analysis to develop a narrative project on an acute psychiatric ward, in order to determine whether the process of creating a narrative impacted upon the therapeutic relationships between staff and clients (Whittall

and Allie , 2011). Narratives are a way in which people can derive meaning from events by retelling their story as they place their experiences in chronological order (p. 34). This study showed how psychological interventions can improve the quality of care and psychological mindedness throughout a hospital's workforce, by including particular examples of good practice such as: the formulation of informing during acute pathway care, reflective practice for staff groups, the use of a systemic perspective and the use of narratives on an acute ward.

Finally, Painter (2008) qualitatively explored adolescents' experiences of psychiatric hospitalisation with reference to the possible psychological impact of the experience. Her grounded theory revealed that the core category was of living in an 'alternative reality' while admitted to hospital. Two contributing factors to this experience were reported: feelings of disconnection from their normal reality, significant others and everyday life; and the existence of hospital rules and daily routines in combination with loss of freedom and privacy that contributed to a feeling of restriction. Identity management was also a main theme, in terms of patients protecting, adjusting and accepting their identity during admission (Painter, 2008). Apart from these studies, which focused on the experience of hospitalisation, there is a significant lack of psychological qualitative research into the experience of being cared for by others. It is an overlooked area and Rose (2001) suggests that this perhaps reflects the scepticism among mental health professionals over information gathered from clients especially about the care they receive, considering this to be symptomatic of their mental health difficulties.

Furthermore, the lack of qualitative research used to explore the experience of being looked after whilst admitted to hospital highlights the need for further qualitative research to be conducted from the service-user perspective. Such research should also explore the involvement of the care component of hospitalisation on the depressive experience in general. In this way, the participant's subjective experience of being cared for can allow for the integration of their illness, health and recovery status. The author of the current study believes it is important to understand the dynamics that may be involved during the process of care, from a psychological perspective. To view depression in this context may provide a deeper understanding of the complexity of being part of a mental health care system that can offer a framework that delineates the relevant aspects of context, coping and the resources needed to enhance recovery-oriented services.

2.1 Conceptualisations of dependency

Dependency is a broad and ambiguous construct, in Booth's words (1986), "an elusive notion" (p. 11). The term 'dependency' is used throughout this study to reflect the researcher's interest in the ways in which, and extent to which, an individual is relying upon another individual, system, or authority, in the broader sense. Dependency can be conceptualised as a psychological state, a personality trait, a personality type that is vulnerable to psychopathology, or as a distinct personality disorder (Pincus & Gurtman, 1995). The researcher's understanding and the way she defines dependency throughout this research has been influenced by Weiss (2002), who noted that the term patient implies a dependency-reliance on others – "giving oneself over to a process that is bigger and more powerful than the individual" (Weiss, 2002, p. 10). He further acknowledges that psychological literature and clinical theories are situated within, and contribute to, a culture that idolises self-reliance, and "pathologises" dependency. He concludes that psychological theory and practice on patient dependency is situated within a broader socio-cultural context, where in western culture we tend to honour independence and look down on dependence as a weakness, or a dangerous vulnerability.

The researcher's understanding of the concept treats dependency as a relational experience, which changes during the course of individual development and also during the course of one's care. It has been argued that there exist different levels of interpersonal relatedness ranging from maladaptive to more adaptive forms (Schulte, Mongrain & Flora, 2008, p. 342). Consequently the exploration of aspects of dependency as a need to depend upon another, such as a care giver, a professional, a hospital, a system, and that leads to an in-patient admission, can help us to better delineate its connection with psychopathology.

3. Care – dependency as conceptualised in other disciplines

3.1 In sociology

Research on care came forward during the 1970s, mainly stemming from feminist academics, in the form of theoretical writing and empirical research that explored the position of women in relation to both the family and the state, regarding the provision of extensive unpaid care (Fine & Glendinning, 2005). During the 1980s, the issue of care was conceptualised in the context of sexual division of labour by feminine scholars and research focused on the so-called 'burden of care', mainly documenting the side effects of the care-giving process experienced by women, such as stress, limitations and the emotional impact of this. This resulted in a process of the formalisation of care work; we can evidence the emergence of the care giver's movement and the establishment of compensation and support through health and the social welfare system, in the form of a care giver's

advocacy organisation, and policy initiatives that responded directly to the concerns of the care giver with various support programs aimed directly at this population (Fine & Glendinning, 2005).

3.2 In nursing

Within the nursing field, the notion of care dependency originates from the work of Dorothea Orem, who worked towards the development of a theoretical self-care framework from 1970s until 2001. Her work within nursing is known as the Orem model. The philosophy of this model lies in the fact that all patients wish to care for themselves. It is mainly used in rehabilitation and primary care settings and has a foundational role regarding nursing practice generally. This model explains the relationship between the nurse and the client, where nurses devise systems to care for clients at different dependency levels, by explaining the link between self-care, self-care demands and the self-care agency (Orem, 2001). In this model, Orem (1980) addresses the concept of health by saying that "health and healthy are terms used to describe living things… [it is when] they are structurally and functionally whole or sound…includes that which make a person human, operating in conjunction with physiological and psychophysiological mechanisms and a material structure (biologic life) and in relation to an interacting with other human beings (interpersonal and social life)" (Orem, 1980, pp. 118-119). She also addresses the concept of care dependency by differentiating self-care as "activities that individuals initiate and perform on their own behalf in maintaining life, health and well-being" (Orem, 2001, p. 43) and dependent care as the "activities that responsible… persons initiate and perform on behalf of socially dependent persons" (Orem, 2001, p. 515). The patient-nurse relationship has been a common theme in research and a central element of nursing practice (Shattell, 2004). However, as Boggatz, Dijkstra, Lohrmann, and Dassen (2007) state in their analysis of the meaning of care dependency criticising the Orem model, "if nursing is interested in patient autonomy and participatory decision making, it would be useful to have an idea of care recipients' point of view" (p. 562). In a recent review of nurse-patient interaction in in-patient psychiatric wards, it was concluded that despite evidence of the benefits of therapeutic nurse-patient interaction, reports of low activity and social engagement for patients have remained stable for 35 years and limited nursing time is spent in direct contact with patients (Sharac et al., 2010). The 'care receiving/care-giving process' has been explored within the nursing literature, mainly qualitatively, and predominantly from the nurse's perspective, while qualitative studies that focus on what is known about psychiatric in-patient care place much emphasis on clinical practice and the worlds of professionals, which highlights the need for in-depth interview studies involving the patient's understanding of the meaning of in-patient care to these people (Quirk & Lelliot, 2001).

3.3 Dependence on care

When considering care dependency, psychological needs are implied, so a closer examination of this concept is required. Strandberg and Jansson (2003) conducted research on the meaning of dependency on care from both nurses' and patients' perspectives and concluded that it is a particular form of dependency – dependency on a person who is able to give care. Dijkstra, Buist and Dassen (1998) defined nursing-care dependency as "a nurse-patient relationship resulting from a person's decrease in self-care and simultaneous increase in dependency on nursing care whenever needs must be satisfied" (p. 144). However, other authors have defined care dependency as a relationship that is not dependent on level of need and whereby care givers may even impose their support and make a person more dependent (Gignac & Cott, 1998), depending on whether individuals define their situation as dependent or if someone in their environment does so (Van den Heuvel, 1976). Maslow's description of needs is as a driver of human behaviour that aims to avoid deficits (Maslow, 1943), and other authors in line with this description define care dependency as a disadvantageous condition implying powerlessness and unmet needs (Ellefsen, 2002).

The phenomenon of care dependency has been explored both from the care giver's as well the recipients' point of view, with comparisons of the two viewpoints. An important point to consider is whose perspective or judgement is more appropriate; that of the health care professional or that of the recipient of the care. Comparing the views of care recipients and professional care givers, for example, shows the subjective nature of the term. Studies have shown that professionals identify more dependency than their clients (Morrow-Howell, Proctor, & Rosario, 2001). Other studies have come to the conclusion that the meaning of dependency from the care recipient's perspective is associated with themes such as constraints, loss of freedom and powerlessness (Nordgren & Fridlund, 2001; Ellefsen, 2002; Strandberg & Jansson, 2003). On the other hand, nurses perceive care dependency as a burdensome responsibility that evokes feelings of guilt, insufficiency and worry in an attempt to cope with the demanding task of balancing between helping and not helping too much (Strandberg & Janson, 2003, p. 84). Boggatz et al. (2007) attempted to tackle the above issue by analysing both recipients' and givers' conceptualisations of the phenomenon of care dependency in order to reach a shared meaning for both recipients and givers of care. They based their review analysis on three kinds of papers: studies that offered theoretical understandings of care dependency; qualitative studies within nursing attempting to understand the phenomenon from either care recipient or giver; and studies that measured dependency with different instruments. They concluded that "care dependency is a subjective, secondary need for support in the domain of care to compensate a self-care deficit

while each side may assess them in a different way, therefore allowing different perceptions of the same phenomenon" (p. 568).

Undoubtedly, service users with intense dependency needs are experienced negatively by professionals (Chow & Priebe, 2013). Dependency needs of in-patients can be defined as an individual's need to be dependent on a particular service when they are not able to live alone, when they lack a social support network and when they are too acutely unwell to care for themselves. Thus, when patients have lived for prolonged periods in restricted environments they can become dependent on receiving care from these services and consequently become institutionalised. Pearce and Pickard (2010), in their philosophical reflections on clinical practice, acknowledge that clinicians for their part need to hold service users responsible and accountable for behaviour if they are to improve and recover, and offer a conceptual framework suggesting that the key to avoiding this trap is to link responsibility fundamentally to the idea of agency, and to distinguish it clearly from ideas of blameworthiness and blame (Pearce & Pickard, 2010).

In a review of difficult patients in mental health care, dependency on care was found to be the second reason for perceived patient difficulty (Koekkoek, van Meijel, & Hutschemaekers, 2006. A patient with severe unmet dependency needs will project a lack of stable self and basic trust onto the care giver (Neill, 1979; Powers, 1985; Groves, 1978; Groves & Beresin, 1998; Fiore, 1988). This leads to the patient being seen as a difficult one – demanding and clinging – by the care giver, which will make the interpersonal relationship difficult. On the contrary, good patients are described as reasonable and thankful of the care given (Koekkoek et al., 2006). It seems that dependency needs of patients influence the meaning of the care-giving situation, which can also influence the quality of care. As we see, patient dependency on care becomes problematic for nursing practice, which is reflected in the amount of research on this topic in the nursing field. However, this phenomenon remains important to all health care professionals and therefore a psychological exploration of this phenomenon would be of benefit to all health care professionals, as well as psychologists. In our day-to-day clinical practice we make differential judgements about patients who need to develop their capacity for autonomy or the capacity for a mature dependency. Undoubtedly, excessive dependency on the part of the patients can become a significant problem in any therapeutic encounter.

4. Institutionalisation and the sick role / Patient-hood

The concept of total institutionalisation proposed in the 1960s by Goffman states that people with mental illness learn to conform and adapt to the expected social role of 'mental patient' in accordance

with the institutional structure. Consequently, the person's self-identity is embedded in the role of passive and compliant 'mental patient'. Chow and Priebe (2013) suggest that a more recent way to understand institutionalisation in psychiatry is in terms of the relationship between staff members and patients and elaborate on the fact that this is not dependent on the services provided, as even in community treatment teams or supported housing contexts staff and patients engage in obligatory close relationships (Chow & Priebe, 2013). This point suggests that there is a risk that mental health patients might also be subjected to new forms of institutionalisation, even in community-based services (in the context of the process of closure or downsizing of large psychiatric hospitals and the establishment of alternative mental health care in the community), where these in fact have the opposite aim of 'deinstitutionalisation'. They further state that institutionalisation in modern psychiatry is displayed in terms of policy and legal frameworks, in terms of clinical responsibility and paternalism, or is understood as patients' response to institutional care.

Back in the 1950s, Klapman observed that "…if we seek to make hospitalization truly therapeutic we shall not overlook to what extent hospitalization itself conspires with the patient to produce a state which robs him of all incentive…" (cited in Morgan & Johnson 1957). Thirty years later, Yalom very sharply stated that "…for many patients, the hospital setting augments and legitimizes the emergence and the surrender to dependency feelings. Patients are placed in a dependent position by being fed, by having minute attention given to their physical needs, by having few realistic housekeeping obligations expected of them in return. Consequently, dependency will be very evident in the in-patient therapeutic encounter, and the therapist must develop methods of counteracting these dependent cravings" (Yalom, 1983 p. 103).

In social theory, the Parsonian assumptions underpinning the 'sick role' theory are dominant ones, in which persons internalise a social definition of themselves which then serves as a guide for their future behaviour. What it means to be a 'patient', how one becomes a patient and, especially, what one is to do upon becoming a patient are themes that have been well described and widely accepted in sociological terms. Yet there remains a gap between psychological theory and exploration in terms of the patient role. The changes that the concept of patient-hood has undergone during the last decades and the possible hidden expectations of illness gains held by patients impact the ways the institution of medicine manages the changing demands for services, which are also impacted by the economic context of the time. If one considers the new reform in the United Kingdom, whereby the aim is to create less dependent forms of care, then the meanings and standpoints that the experience of receiving care represents must be recognised as a lived experience of people who define themselves in this role in relation to each other and the mental health system.

5. Recovery, culture and mental health

At the forefront of mental health policy and service delivery is the recovery based model of care, which is viewed in clear opposition to institutionalisation (Wirt, 1999). According to Anthony (1993), recovery is "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness..." (Anthony, 1993, p.4) From the recovery perspective, institutionalisation is conceptualised as learned helplessness a loss of motivation and functioning when a person feels he or she has no control over his or her environment (Seligman, 1975). In relation to dependency, Deegan (1988) challenges the traditional values of independence and self-sufficiency in rehabilitation programs and with people having enduring mental illness arguing that the emphasis on achieving 'independence' can exacerbate their sense of limitations and deter recovery (Deegan, 1988).

In Western industrial societies, independence is associated with being able to do things for oneself, to be self-supporting and self-reliant. Health and illness as well as their management are part of a wider cultural system closely associated with social control by professions and the state. Culture is a "particular, important and materialized form of relationship" (Brudny, 2004, p. 41). UK culture and the mental health care system, as it has been formed to date, have a specificity of context that cannot be taken as a general rule. Slade (2011), for example, after comparing recovery-focused mental health services in Australia, New Zealand, Canada and the USA stated that he was "convinced of the need to question deeply embedded culturally based beliefs that inadvertently promote dependency and impoverish people's expectations". According to Slade, "the challenge is to move beyond the view that a good patient is a compliant one, who does what the professional says because the professional knows best" (Slade, 2011). But what does this mean to the counselling psychologist who works within such a mental health system? In his work Slade conceptualises system dependency by acknowledging the fact that the system does indeed promote dependency, even within the recovery model as it was endorsed in 2005 by the National Institute for Mental Health in England (NIMHE) as a possible guiding principle of mental health service provision (NIMHE, 2005).

The challenge for mental health services in the UK is to move beyond a narrow focus of symptom reduction into helping people to build satisfying, meaningful and valued lives (Perkins, 2012).

This change is reflected in the mental health strategy 'No Health Without Mental Health' (Department of Health, 2011) which defines key outcomes as enabling people to gain: "a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live". In other European Union countries, mental health care systems are formed differently, and therefore the way the system influences the 'person with depression', and indeed all mental health conditions, will be different, both qualitatively and quantitatively. The ideas behind recovery are supported in England by various Department of Health policies which aim to promote self-management of long-term conditions and 'choice'. These include The Expert Patient (Department of Health, 2000); Our Health, Our Care, Our Say (Department of Health, 2006a); and the Commissioning framework for health and well-being (Department of Health, 2007a).

Although 'Promoting independence' has been a central theme of recent United Kingdom health and social care policy development (Secker & Membrey, 2003), Slade, Amering, & Oades (2008) stress that even though the recovery approach has gained traction in mental health policy throughout the English-speaking world change must work in practice if it is to be sustained (Slade & Oades, 2012).

As a general rule, when the sick role gets legitimised, the agreement that an individual is ill usually results in intrapersonal conflicts between a patient's childlike dependence on services and significant others, and their adult state of independence. In a project for the development of recovery facilitating mental health systems, it was found that one of the factors that hinder recovery is the paternal /maternal orientation of a system that promotes dependency (Slade, 2009). Such an orientation, which is like 'adult babysitting', harms the potential for recovery and promotes instead a dependency among consumers, which is the antithesis of recovery. Many systems are infantilising and dependency-engendering by not supporting the development of self-responsibility (Onken et al., 2004, p. 12. It is through this rationale and perspective that dependency becomes salient for the psychologist working in in-patient settings, and it is this factor that distinguishes this study from the general postmodern policy inclination towards creating independent mental health services. This study aims to throw light on the care process and dependency needs that the process itself might create.

5.1 Research on dependency and depression

The link between depression and dependency is an established one (Bornstein & O'Neill, 2000). However, when a disorder has been diagnosed, professionals are often inclined to view the set of behaviours accompanying the disorder, either symptoms or maintaining factors, as wholly

compulsive (Pearce & Pickard, 2010, p. 831). There is a range of medical conditions, depression being one of them, where the core symptoms or maintaining factors include actions and omissions: voluntary behaviours over which the patient has some degree of control (Pearce & Pickard, 2010, p. 831). In changing behaviour that appears symptomatic or maintaining of a medical condition, a patient directly affects the experience.

Most health care professionals treat the dependency needs of their patients as part and parcel of their diagnosed depression that have to be addressed, either by exposure to more responsibility, or by diminishing responsibility and duties until the patient is deemed able to cope. In any case, there is a mediating role to be performed by professionals in particular and the care system in general. This is an obvious routine encounter among patients and professionals in psychiatric/mental health hospitals but as Barbour (2000) intimates, it is exactly such routine and obvious situations that need to be investigated, as any significant insight can be hidden from view due to the society's familiarity with such routine encounters. Recovery from these conditions requires a change in the core or maintaining behaviours. Given that these behaviours are actions and omissions (Pearce & Pickard, 2010, p. 831) patients must and can decide to behave differently, and have the will to do it. Therefore, the 'sick role' may play a part in obscuring the fact that recovery can fundamentally depend on the patient's own active effort and will (Pearce & Pickard 2010, p. 831), as well as the system's and professionals' orientation, by moving from a deficit-based to a strengths-based approach to care (Rapp & Goscha, 2006) and by avoiding dependency-creating relationships and deficit-focused assessments as the antidote to any professional tendency to assume responsibility by using coaching skills for supporting partnership relationships (Slade, 2009).

High levels of interpersonal dependency have been linked to a variety of psychopathologies (Bornstein, 2005). Among the most well-established of these links is the dependency-depression relationship (Bornstein & O'Neill, 2000, p. 464; Birtchnell & Kennard, 1983; Blatt, D'Afflitti, & Quinlan, 1976; Overholser, 1992. Previous research on clinical and non-clinical populations has found a significant positive relationship between dependency and the level of depression, where excessive dependency has been linked to being both a risk factor and a complication of depression (Blatt, Zohar, Quinlan, Zuroff, & Mongrain, 1995; Bornstein, 2005, McBride & Bagby, 2006; Mongrain & Leather, 2006). In addition, the dependency-depression relationship has been found in children, adolescents and adults, as well as in clinical and non-clinical populations (Bornstein, 1994).

As a result, a multitude of research has focused explicitly on the quantification of interpersonal dependency and a multitude of interpersonal dependency measures, and scales have been developed

from a variety of theoretical perspectives in the last decade. Widely used are Hirschfield's Interpersonal Dependency Inventory (Hirschfield, Klerman, Gough, Barrett, Korchin, & Chodoff 1977), the dependency factor of the Depressive Experiences Questionnaire (Blatt, D'Afflitti, & Quinlan, 1976), and the Dependency subscale of the Personal Style Inventory (Robins, Ladd, Welkowitz & Blaney, 1994). In clinical literature, there is a large current of research focusing on statistical means of assessing dependency along two dimensions: content (measuring different types of dependency), and format (which involves different ways of measuring dependency). Studies have used objective measures, which involve self-report questionnaires, behavioural measures and interview ratings, and which have long-term retest reliability. Yet, these are more susceptible to self-presentation biases, while others, including dependency scales such as the TAT-derived dependency scales and dependency content on the Rorschach test, make use of projective measures (Bornstein, 1996).

Although such findings can be of value in a statistical sense, the quantification of the link between interpersonal dependency and depression does not amplify our understanding of the practical implications this link might suggest in the case of institutional treatment and care. In other words, it does not and could not provide insight into the intricate structural components and behavioural correlates of dependency and the consequences of dependency on depression, in order to have implications in clinical in-patient practice with dependent depressed adults in terms of treatment process and outcome. Such conceptualisation of dependency appears to be one-sided, and does not provide insight into the psychological meaning of dependency and the processes involved in becoming dependent. This idea is echoed in the work of Weiss (2002) on the role of dependency in psychotherapy, who suggests that the reason that this occurs (i.e. the pathologising of dependency) stems from "our linear understanding of the relationship between dependence and independence, in other words, that dependency is something you have to 'get over' in order to be truly independent and that becoming independent means no longer being dependent" (p. 8).

Within dependency, there exists a web of psychological stances, such as excessive psychological self-reliance, dependency as a relational experience, or an impaired capacity for dependency. These variations can be lost if we consider dependency and independence as two poles in a linear mode. A qualitative exploration of the experiences of depressed service users being cared for by others (i.e. mental health care professionals) within in-patient psychiatric settings will thereby throw light on the important link between care and depression. This in turn will aid in a better understanding of the involvement of the care component of hospitalisation on the depressive experience and thereby contribute to the provision of appropriate services for these individuals.

The author believes that the qualitative exploration of the experience of being looked after might be a promising line of research that might signal important implications for psychological clinical practice within this population. An understanding of this experience will help elicit themes that have relevance to depression and caring as a result of the care-receiving experience offered by health care professionals in particular, and the health care system in general. A gap therefore exists between the experience of being looked after by mental health professionals and how this care influences the depressive experience.

5.2 Contemporary context: The burden of care and relevance to psychological practice

No group of chronic diseases burdens the world more than mental illnesses (World Health Organization (WHO, 2008). Complex social and economic forces have placed patient autonomy at the centre of medical ethics (Tauber, 2003). This is reflected even in the UK's labelling of those who use services; patients have increasingly become clients, service users, consumers (Tauber, 2003), terms that overlap and have often been used interchangeably within the UK. This shift in terminology conjures up differing identities, and identifies differing relationships and differing power dynamics, thereby highlighting their assumptive worlds and the relationships the terms suggest and signify.

More than one in four working-age adults, that is 10.6 million people in the UK, do not work (Cabinet Office, 2010). The 2009 NICE update on depression urges us to consider the wider social implications regarding depression, stating that the benefits system in its current form adversely affects the work incentives for those who most need an incentive to work. The report recognises a "dependence upon welfare and benefits resulting in loss of self-esteem and self-confidence; social impairments, including reduced ability to communicate and sustain relationships during the illness and longer term impairment in social functioning, especially for those who have chronic or recurrent disorders" (NICE, 2009, p. 17). Since the 10-year programme of reform of mental health care was launched in 1999 in the UK, over 650 strategies, frameworks, guidelines, guidance notes and protocols have been issued, with a funding increase of 58 per cent spent between 2001/02 and 2009/10 (Mental Health Strategies, 2010). Despite the shift to community-based health care, in-patient care services continue to consume the greatest proportion of the mental health budget with 80 per cent of the NHS's total expenditure on adult mental health services directed towards in-patient care. Between 1997 and 2007 the number of psychologists working in MH rose by 69% (The King's Fund, 2012) and while historically in-patient psychiatric wards mainly consist of practicing clinical psychologists, the number of counselling psychologists who work in psychiatric settings has also increased.

Government policy increasingly recognises the importance of creating a mental health system that promotes independence, in which staff will see the ultimate goal of their work as being to help people maintain or regain independence (DoH, 2012). However, one can easily challenge whether this is the current in-patient outlook today. As described by Downing (1958), "many mental patients are not motivated to leave the hospital which contains them. By prolonged hospitalisation, they become so dependent on the hospital that leaving causes severe anxiety. If discharged they act in such a way that they are returned back. In many instances, they react to the possibility of discharge or release with behaviour that ensures their continued restraint" (cited in Verma, Chaudhury, & Patkar, 2017 p. 44). Though this was over 50 years ago, the current situation for chronic mentally ill patients does not appear to be far from Downing's depiction.

As in-patient psychologists (counselling /clinical), we deal on a daily basis with the challenge of our patients' dependency needs. However, this is an area that is under-researched within the psychology field and the literature on dependency needs within in-patient care is not strong. A considerable number of the clients who seek our help may be admitted, or may be facing an imminent admission, or will have experienced psychiatric in-patient care at some point in time. Thus, a focus on understanding the components of the experience of being cared for will enable in-patient psychologists to better understand our patients' in-patient experiences, as well as offer an understanding of the impact of these components on their overall mental health. Such an understanding could move discussion and analysis from abstract statistics relating to satisfaction rates, quality of life levels and recovery models, to a direct focus on the process of care which is being carried out within a system of medical and social care. It seems salient to deal with the depressed individuals' needs by working towards the exploration and understanding of the experience of being looked after by services, as this might even help towards reducing hospitalisation stay and potential costs for the NHS. As psychologists, the need to understand the experience of receiving care, and our ability to work and understand the impact of care on the overall mental health of our patients, will be paramount. In-patient psychiatric care is one of the most important forms of care for vulnerable clients, and it is hoped that an understanding of the dynamics that shape the experience of hospitalisation will offer us a psychologically informed account of the components of care.

Reviewing the relevant literature, it became apparent that there were few psychological qualitative studies exploring the experience of care of in-patient depressed clients. Psychological research mainly adopts the evidence-based research approach into the efficacy and effectiveness of psychological interventions (Oestrich, Austin, Lykke, & Tarrier, 2007; Quijpers et al., 2011). Perhaps the lack of

psychological qualitative research with in-patients can partly be explained by the challenges to the research process within a clinical setting, and the methodological difficulties encountered because of individual and contextual factors, such as those of patients, staff and organisations.

Issues such as the lack of time for involvement, experiencing difficulty in obtaining ethical approval and the anxiety experienced concerning the vulnerability of the client group, seem to lead to the difficulties faced in engaging in-patients to take part in counselling psychology research.

5.3 Rationale and objectives of current study

As shown from the review of literature exploring the experience of care, the majority of studies that explored the critical 'care receiving /care-giving process' were mainly conducted from within the nursing profession and predominantly from the nurse's perspective. There was a considerable lack of studies within psychology that looked at the experience of receiving care and being looked after by mental health professionals. As highlighted above, while there is a large body of literature dealing with the concept of dependence and the dependent personality, little has been written about the phenomenology of dependence on psychopathology. Issues addressed in the literature mainly deal with the definition, measurement and classifications of dependency. As there appears to be a gap in literature of psychological studies focusing on the experience of being cared for by others during psychiatric hospitalisation, it may be reasoned that our understanding, as counselling psychologists and mental health professionals working in psychiatric in-patient settings, would be enhanced by a study that aims to describe and interpret the experiences that patients diagnosed with depression have of being cared for by others and discuss these experiences through the framework of psychological theories. Furthermore, this study's unique contribution is that it focuses on the more fundamentally humane phenomenon of 'being looked after'.

The following two broad research topic areas emerged from the review of the literature. The first concerns in-patients' own sense of being cared for and supported by the hospital's treating teams and how this experience influences the way they experience themselves, their goals and aspirations in life. The second concerns the impact of the experience of care on the course of depression. Since depression usually results in impaired social, emotional and cognitive functioning, how the element of care of an admission is influenced, whether it be by encouraging or discouraging unhealthy and destructive patterns of interpersonal relatedness towards an institution, such as when exhibiting dependency to care, is of relevance to all psychologists working in in-patient units. Both research

areas engage in the meanings and beliefs that participants conveyed about themselves and others when cared for during their time in hospital. With the emergence of large numbers of counselling psychologists involved in the care of in-patient psychiatric clients, we need to be aware of exactly what it means to be the person receiving care, so that we can work more effectively with our clients in these specific and unique contexts (in-patient units) and where the care is most intensely delivered and felt. Moreover, exploring the phenomenon of receiving care will provide us with information on how to respond to the different care needs of our clients, which in turn will play a crucial role in an individual's recovery.

This study's unique contribution is that it focuses on the care, as understood and experienced from the service user's perspective. It therefore seems appropriate to employ a qualitative methodology, aiming to offer insights into how a given person, in a given context, makes sense of a given phenomenon (Smith et al., 2009). In general, this study explores the lived experience of being cared for and the meanings attached to the phenomenon of care from the perspective of people who have been admitted to hospital whilst not feeling well. Thus, conducting a qualitative study that would allow these participants to communicate their experience of receiving care would seem to be the optimal approach. Such an approach would thereby allow for the care giver's access into the patients' world so as to better understand their experience and how it can have a relevance to the depressive experience. As people who have the experience of been admitted to hospital receive an intense input of care in acute in-patient settings, the author believes that the phenomenological exploration of this experience, within the context that emerges, will offer an enriched perspective of the experience of being looked after. The question that emerge from these considerations are: What does it mean to be cared for?

Chapter 2: Methodology

1.   Chapter overview

This chapter presents the rationale for the present study and the philosophical assumptions underlying the research process. It outlines the epistemological and methodological position of the study, as well as the personal and professional position of the researcher in relation to it.

2. Development of qualitative research in psychology

Psychology was described as an archetypal quantitative science as early as the nineteenth century, when objective measurement and identification of psychological variables of statistical associations were dominating research (Yardley, 1997). This was in tune with the mainstream account of science dominant at that period; the privileging of the biomedical model of ill health and health-related matters, whereby all triumphs were attributed to scientific knowledge of physiology, biology and epidemiology.

However, during the 1960s this established view of science was questioned for its aims and methods by both natural and social scientists, which led to a paradigm shift. This was triggered by an appreciation of the role played by psychosocial influences on health. It is the application of behavioural principles to health problems that gave rise to the field known as 'behavioural medicine', from which the discipline of health psychology emerged. There was a new shift towards understanding developmental processes at different levels of the human 'system', from the biochemical to the socio-cultural, which resulted in the 'biopsychosocial model' (Engel 1977, cited in Yardley, 1997, p. 5)

Health psychology, like most other branches of psychology, initially followed and adopted the methods of biomedicine, holding on to the importance of the comparison of groups and statistical analysis (Murray & Chamberlain, 1999). Over the past decade and a half, scientific and medical journals, such as the UK's *British Medical Journal*, have acknowledged that a qualitative approach can highlight important areas of health research (Biggerstaff & Thompson, 2008). Qualitative research became increasingly popular in health-related fields and the nursing field in particular saw qualitative research as a type of inquiry appropriate and relevant to its work. This shift may be credited to the holistic and person -centred nature of the qualitative approach in understanding human experience, a necessary component for health professionals who focus on caring, communication and

interaction (Holloway & Wheeler, 2002, p. 19). Since the 1990s the use of qualitative psychological research has become more widespread (Holloway & Wheeler, 2002, p. 9), enabling health sciences researchers to explore questions of meaning, identify what hinders and what facilitates change, and examine institutional and social practices and processes (Starks & Trinidad, 2007).

2.1 Benefits of qualitative research

Qualitative approaches have specific distinctive characteristics that render their applicability to psychological research ideal. One of the advantages of qualitative research is its ability to capture a client's perspective of health care, therefore enabling professionals to understand how clients perceive heath care services by focusing on participants' feelings, meanings and experiences (Bryman, 2001). A qualitative approach is more appropriate when studying complex situations in which the relevant factors are not initially apparent. More specifically, in psychiatry, where the patient's perspective is involved, rather than adopting a reductionist view of the patient in order that different elements can be measured, a qualitative approach allows preservation of complexities, so that their nature can be explored and better understood (Buston, Parry, Livingston, Bogan & Wood, 1998, p. 197).

Another benefit of qualitative research is the emphasis on the context-bound nature of experiences, that is, the idea that experiences cannot be free from time and location. Qualitative research allows for the study of people within naturally occurring settings, creating open systems in which conditions develop, to interact and give rise to a process of ongoing change. In this respect "participants' and researchers' interpretation of events itself contributes to this process" (Willig, 2001, p. 9). This holistic nature of qualitative methods allows the elucidation of the contextual conditions under which the phenomena of the study occur. The phenomenon of care and how it can create, influence or maintain dependency among depressed adults within psychiatric hospitals is quite the contextualised process, unfolding in specific settings. The sensitivity of qualitative approaches to the context of the research and how it influences participants' behaviour allows researchers to immerse themselves in the subjective nature of the participants' social reality and gain an 'insider's view' of the topic under investigation. Furthermore, qualitative (as opposed to quantitative) approaches share distinctive features that are very important and fit well with this research; open and exploratory research questions versus closed hypotheses, unlimited, emergent descriptions versus predetermined choices or rating scales (Elliott & Timulak, 2005) and the in-depth exploration of people's experiences in research areas where there is little known or the existing literature is not moving forward, or when a research topic is highly complex (Barker, Pistrang, & Elliott, 2002). The open-ended questions can

be specifically useful with in-patient psychiatric participants as they allow participants the opportunity to respond in their own words as opposed to choosing the fixed responses offered by quantitative methods. This makes the data more meaningful and salient to the participant as well as providing the researcher with responses that are rich and explanatory in nature. Finally, the style of interaction between the researcher and the participant in qualitative approaches is usually more flexible, which can be most useful when working with psychiatric in-patients.

Moreover, qualitative approaches allow for the investigation of phenomena from a new perspective, by learning from the direct source in which phenomena are situated, rather than from pre-existing theories or knowledge (Shaw & Gould, 2001), which have a great appeal within the context of the national service frameworks and therefore fit well within the current NHS agenda of taking a 'patient-centred perspective' and listening to the voices of service users. As this study focuses on the individual subjective lived experience of the phenomenon of care receiving, and how this is experienced by depressed individuals, the utility of a qualitative approach was seen as ideal for this particular study.

2.2 Epistemological stance

The primary foundation and anchor for qualitative research methods is the constructivist-interpretivist paradigm (Ponterotto, 2005). According to Ponterotto, the philosophical paradigm of a researcher will guide them to philosophical assumptions about the research and to the selection of tools, instruments, participants, and methods used in the study (ibid). Filstead defines a paradigm as a "set of interrelated assumptions about the social world which provides a philosophical and conceptual framework for the organized study of that world" (Filstead, 1979, p. 34).

This study employs principles of a constructivist approach. Constructivist theory is concerned with how individuals create systems in order to meaningfully understand their worlds and experiences (Raskin, 2002). On an ontological level, the constructivist approach assumes a relativist ontology: one which accepts that there are multiple, constructed realities, and rejects a single, true reality. As a result, there are multiple meanings of a phenomenon in the minds of people who experience it, as well as multiple interpretations of the multiple realities (Ponterotto, 2005). On an epistemological level, this approach maintains a subjectivist position whereby reality is socially constructed, and gives a central role to the interaction between the researcher and the participant, in order for the meaning of the participant's experiences to be understood. Interpretation, therefore, plays a key role in this process. On an axiological level, the constructivist paradigm advocates that the researcher's values

and experiences cannot be separated from the research process, and maintains a naturalistic set of methodological procedures (Ponterotto, 2005; Lincoln & Denzin, 2005).

The epistemological stance adopted by the researcher is aligned to contextualism, which holds the position that all knowledge is local, provisional, and situation-dependent (Madill, Jordan, & Shirley, 2000; Charmaz, 1995; Jaeger & Rosnow, 1988). This approach can be described as "an epistemological concern with the context specificity of meanings" (Henwood & Pidgeon, 1994, p. 231), which also recognises the existence of multiple realities that are based on people's experiences in context (e.g. Henwood, 1997). The underlying philosophy of IPA purports that there is no objective reality to be uncovered, but aims to capture the experience of individuals as they themselves have constructed it, whilst also acknowledging the influence of social constructions on individual meaning-making.

The implications of how this influences this research process is seen not only in the acknowledgment of the importance of the context in which the data will be analysed, but also in the way that the researcher's interpretation of the meaning of a particular phenomenon in a particular context will be communicated. There is emphasis on the researcher's personal involvement in the research process within a particular context and how this is construed by the researcher's training, experiences, practice and biases regarding the phenomenon of investigation. From a phenomenological perspective, contextualism formally recognises the interaction between the researcher and the participant, acknowledging the historical, contextual and power imbalances within the relationship, whilst encouraging transparency and reflexivity (Mays & Pope, 2000).

3. Phenomenology as the study of persons-in-context

Qualitative research methods include diverse approaches. The most established, well-used methods are phenomenology, ethnography, discourse analysis, grounded theory, and interpretative phenomenological analysis. There is a common thread that runs through all these approaches; they employ meaning-based rather than statistical forms of data analysis (Elliott & Timulak, 2005). However, there are many differences among them, both in terms of methodology, theoretical underpinnings and subsequently methods of analysis. For example, the goal of phenomenological research is to describe the meaning of the lived experience of a phenomenon while grounded theory aims at developing an explanatory theory of basic social processes.

According to Carter and Little (2007), all methodologies have an epistemic content which shapes the objectives, research questions and design as much as this epistemic content is also shaped by objectives, research questions and design (Carter & Little, 2007). This study is concerned with the lived experience of receiving care as a person with a depressive experience, and attempts to explore the beliefs and feelings that individuals bring to this experience. In particular, the study explores the meanings attached to the phenomenon of care. It considers how the participants' experience affects their sense of self, as well as the way they perceive their relationship with others. The questions that emerge from these considerations are: What does it mean to be cared for by others? How do depressed individuals think and feel about themselves and others as a result of this experience?

Phenomenological inquiry seeks to "answer two intrinsically interrelated questions: what is the phenomenon that is experienced and lived, and how does it show itself?" (Fisher, 1978, p. 175 cited in Toombs, 2001) Phenomenology's emphasis on individuals' experiences of the world appeals to this particular psychological research, as it allows the researcher to explore the diversity and variability of human experience (Willig, 2001). Phenomenology as a qualitative research approach is based on the philosophy of the nineteenth and early twentieth centuries, and originates from the ideas of the mathematician and philosopher Husserl (1859-1938) and basic principles further enriched by his pupil Martin Heidegger (1889-1976) who focused on ontological questions of meaning and lived experience.

The fundamental concept of phenomenology is intentionality, the idea that consciousness is always directed towards something other than itself. While Husserl focused on the cognitive processes of the intentional act, Heidegger dedicated himself to the existential aspects of the human being, where the concept of intentionality is expanded in order to include the relation between the person and the world. For Heidegger, such relatedness is "a fundamental part of our constitution". Heidegger fundamentally rejects the Cartesian divide between subject and object, implying that our very nature is to be there – always somewhere, always located and always amidst and involved with some kind of meaningful context (Larkin, Watts, & Clifton, 2006). In this context of human life it is we who decide what counts as real and what does not. In phenomenological terms "it must be stated that the entity as an entity is in itself and independent of any apprehension of it; yet, the being of the entity is found only in encounter and can be explained, made understandable, only from the phenomenon exhibition and interpretation of the structure of the encounter" (Heidegger, 1985, in Larkin et al., 2006). This suggests that individuals exist in a lived world rather than in isolation, signifying that an individual's involvement in the lived world influences their perspective on their live and experiences.

Heidegger holds that the phenomenological mission is to make manifest what is hidden in ordinary everyday experience, by approaching and dealing with any object of our attention in a way that "it is allowed to show itself as itself and not according to the researchers' pre-conceived assumptions and expectations" (Larkin et al., 2006, p. 108). This study aims to reveal aspects of the care phenomenon in the depressive experience. Heidegger (1962), in his *Being and Time*, concluded that all experience is grounded in "care" and that To Be in the world in an authentic existential pretext is to be "careful" (Stainer, 1978). "Care" is the Being of *Dasein*, the Nature of Human Being, that fundamental structure that underlies each and every human existence. As my starting point is Heidegger's statement that human beings have the ability to give meaning to their world. This Heideggerian perspective "what it means to be a person in the world" shaped the philosophical and conceptual framework of this research.

3.1 Rationale for Interpretative Phenomenological Analysis (IPA)

Phenomenology, the study of what an experience is like, has been a major influence in the development of Interpretative Phenomenological Analysis (Smith, 1996; Smith & Osborn, 2003). Interpretative phenomenological analysis is an approach that is well situated to the contextual paradigm described above, and is shaped from Heideggerian phenomenology.

Interpretative Phenomenological Analysis (IPA) and the social constructionist version of Grounded Theory are two qualitative methods that employ a contextual constructionist approach (Willig, 2001), both aiming to emphasise and explore the subjective perception of an individual and concerned with understanding what participants' think / believe. However, Grounded Theory was initially founded to study social processes that account for phenomena, while IPA is a specific psychological research approach, aiming to give insight into psychological processes and thus allowing a detailed understanding of the quality and texture of individual perspectives (Willig, 2001). Smith (1996) states that "access to a participant's personal world is both dependent on, and complicated by, the researcher's own conceptions which are required in order to make sense of that personal world through a process of interpretative activity" (p. 264). This is salient for this study, as although the main concern of the researcher is to attend to themes that were important to participants, interpretation can be informed by direct engagement with existing theoretical constructs (Larkin et al., 2006).

Other approaches, such as discourse analysis, which have parallels with phenomenology in that they emphasise the social origins of meaning and the role of culture and language in shaping individual experiences, were considered (Neimeyer & Raskin, 2000). However, phenomenologically based

approaches see experience as more than a construction shaped within the linguistic constraints that culture provides, therefore placing more emphasis on the role of the individual (Eatough & Smith, 2006). The present study utilised phenomenology and IPA. This approach was felt to fit best as it involves "exploring the lived experience of the participant and/or understanding how they make sense of their personal and social world" (Smith, 2003, p. 3). IPA aims to obtain an insight into another person's thoughts and beliefs in relation to the phenomenon under investigation. In particular, it aims to create knowledge about the way people think about this phenomenon. This study attempts to explore the lived experience of receiving care as person with depressive experience who is admitted to hospital, and how the beliefs and feelings that individuals bring to this experience affect their sense of self, as well as the way they perceive their relationship with others. Therefore, it is reasoned that IPA is the most appropriate methodology with which to gain an insight into this phenomenon.

Heidegger's philosophical position contrasts with Husserl's position in that reality and experience are socially constructed and thus presuppositions are unable to be removed or suspended because they "constitute the possibility of intelligibility or meaning" (Ray, 1994, p. 120). Therefore, an important difference among approaches that have been influenced by Husserl and his phenomenological perspective, and those that employ a Heideggerian perspective, according to the latter, it is not possible to differentiate ourselves entirely from our experience, since all experiences can only be understood in terms of one's history and the social context of the experience. IPA places emphasis on the interpretative role of the researcher in the research process, by acknowledging and utilising the impossibility to remove previous knowledge and perspectives though necessitating the need to be aware of these and ensuring that they are not obscuring /biasing the research.

The interpretative framework that IPA employs is of great importance and consequence. It not only allows for the description of the experience but also for the exploration of the participant's personal perceptions. The intentional interpretation of IPA suggests the inclusion of the introduced themes addressed by participants, but also addresses the interpretation of psychological states as indicated in the narratives that participants offer (Smith & Osborn, 2008). IPA "maps closely the complex reality of psychological processes" (Smith, 2004, p.44). This is required to allow for a multidimensional understanding of the person's experience of care that goes beyond common sense awareness, leading to a more informed and nuanced practice.

IPA is attentive to cognitions, treats the individual as a "cognitive, linguistic, affective and physical being" (Smith, 2008, p. 54) and presumes a connection between the way people communicate, think and feel. This element of IPA is of paramount importance with individuals in in-patient settings

whereby the critical state of an acute mental health patient can mean they sometimes present their conversational partners with a perplexing range of behaviours and challenges to normal social interaction. The interpretative feature of IPA allows researchers to engage this population in qualitative research.

3.2 Interpretative Phenomenological Analysis

Phenomenology, hermeneutics and idiography are the three theoretical perspectives that have been combined in IPA, offering a distinct approach in the field of phenomenological inquiry (Smith et al., 2009). IPA is connected to the principles of phenomenology as it attempts to understand how people make sense of their lived experiences, placing salience upon social, historical and cultural perspectives, emphasising that individuals exist in a lived world, therefore signifying that experience is not only individually situated but also bound up with and dependent upon relationships with others, coloured and shaped by society, history and culture (Eatough & Smith, 2008). This phenomenological emphasis of IPA is very important to this study, given that people's experiences of mental health care are deeply personal at a micro-level, whilst at the same time influenced and constrained by societal constructions of 'what is' and 'what should be' at a macro-level.

Hermeneutics, the theory of interpretation, is the second theoretical underpinning of IPA. This theory acknowledges the complexity of the relationship between the interpreter and the interpreted by highlighting that the researcher's interpretations are inevitably influenced by the conceptual lenses through which they make sense of the world. Smith and Osborn (2008) discuss that in IPA a double hermeneutic is involved. At the first level the participant offers their interpretation of the phenomenon. At the second level, the researcher attempts to understand how the participants are trying to make sense of their world. This interpretation is therefore influenced by the participant's ability to verbalise their thoughts and experiences, as well as the researcher's own conceptions as they attempt to assess the participant's experiences. This double hermeneutical move within the IPA research process allows a "balance of 'emic' and 'etic' positions in IPA" (Reid, Flowers, Larkin, 2005, p. 22). These two conceptual frameworks, the emic, the particular, often referred to as the insider's point of view and the etic, the general, representing external constructs employed by outsiders), are viewed as complementary perspectives in IPA and not as dichotomised ones. IPA researchers work on an idiographic level – the individual level – and are "committed to the painstaking analysis of cases rather than jumping to generalisations" (Smith & Osborn, 2008, p. 54). In IPA, as in other emic approaches, the emphasis is on systemic relationships in a specific culture (Pike, 1962, cited in Green, 1962, p.215). Thus, "the readers of an IPA study may make links between the findings of an IPA study, their own personal and professional experience, and the claims in the

extant literature". (Smith & Osborn 2008, p. 56). Furthermore, IPA integrates two stances of interpretation, namely a hermeneutics of empathy (Ricoeur, 1970) and a hermeneutics of suspicion (Ricoeur, 1970) or questioning (Smith, Flowers, & Larkin, 2009). Hermeneutics of empathy refers to the researcher's attempt to understand the participants' interpretation of their experience from an insider's perspective (Conrad, 1987), thus "gaining a fuller understanding of what is being expressed" (Willig 2017, p. 278). Hermeneutics of suspicion refers to the interpretation of a text through the use of psychological and theoretical concepts, whereby "interpretation is done top-down, generated on the basis of a 'suspicious' attitude which aims to reveal a deeper meaning beyond the surface" (Willig 2017, p. 277).

Therefore, the analysis chapter of this study is comprised of this double hermeneutical move within the IPA research process, whereby the author moved through deeper levels of interpretation and focused on the participants' texts. In this way, the author utilised the hermeneutics of empathy first and then followed it up with a separate hermeneutics of suspicion or questioning; a critical engagement aided by theoretical perspectives "in ways which participants might be unwilling or unable to reveal themselves" (Eatough & Smith, 2008, p. 189).

Furthermore, Smith (2004) has argued that both modes of hermeneutic engagement – empathic engagement and a hermeneutic of suspicion, of critical engagement – can contribute to a more complete understanding of the participant's lived experience. Thus, Smith maintains that IPA occupies a "centre-ground position" whereby it is possible to combine a hermeneutic of empathy with a hermeneutic of questioning "so long as it serves to 'draw out' or 'disclose' the meaning of the experience" (Smith et al., 2009, p. 36). Therefore, the strategy employed in the current study, which is the use of both modes of hermeneutic engagement, is not in tension with the theoretical underpinnings of IPA and phenomenology, as "IPA requires a combination of phenomenological and hermeneutic insights" (Smith et al., 2009, p. 37) as long as is it "principally based on a reading from within the terms of the text which the participant has produced" (p. 37).

Finally, at times, the language used could be seen as 'objectifying' language, however, this does not represent the way the author understands and approaches mental health experiences. It is used rather as a necessity that portrays and incorporates how mental health is depicted in in-patient psychiatric clinics, where the medical model, accompanied by objective, medical language, is the predominant one. Therefore, it was necessary to use a more medicalised language at times when describing inclusion criteria, and when referring to the way the NHS diagnoses patients, depicting in a way how the participants are accustomed to be perceived whilst staying in hospital. Furthermore, most research in in-patient psychiatry has been conducted through a medical stance, so when describing other

research findings the language used has remained medicalised. The use of such language is mainly in the 'suspicious' section rather than the 'empathic' one.

Chapter 3: Method

1. Chapter overview

This chapter provides a detailed description of the research process of this study. It describes the different stages of the process: the ethical approval process, the rationale for the use of a focus group in the interview construction, the recruitment phase, the interviews and the analysis employed.

2. Rationale for using a focus group

Many means of data collection have been used in psychological research, among them interviews, diaries, electronic dialogues, postal questionnaires, and real and non-real time computer-mediated communication. However, IPA's idiographic commitment has made in-depth individual interviews the best means of accessing rich, detailed, first-person accounts of experiences for data collection when working within this approach (Smith et al., 2009, p. 56).

More recently, researchers have made use of focus groups alone as a mean of data collection, or combined data from focus groups with that from individual interviews (Tomkins & Eatough, 2010). The rationale behind such mixed methods of collecting data is the attempt to form an experiential perspective as such a group discussion may elicit more experiential reflections than with a one-to-one interview (Palmer, Fadden, Larkin, & de Visser, 2010, p. 100). However, such use of focus group interviews over individual interviews has been criticised, mainly due to their non-compatibility with IPA's idiographic component; focus on shared understandings can lead to a neglect of idiosyncratic experiences (Flowers et al., 2001, in Palmer et al., 2010, p. 115). This is why the researcher, following the idiographic commitment of IPA, made use of a focus group only as a means of data generation and not as a means of data collection. Therefore focus group material was used to generate ideas for broader areas of interview questions, and not as a substitution of one-to-one individual interviews.

All studies found in the literature which made use of a focus group have done so in their data collection as an alternative to individual interviews, and none were found to make use of focus groups during their data generation phase. This study attempted to utilise the use of a focus group in a novel manner. The client's role has been increasingly recognised as a key one in the modernisation of mental health services. The opportunity to investigate phenomena from a new perspective by learning from those who are experiencing it, rather than from pre-existing theories or knowledge (Shaw & Gould, 2001), seemed optimal to the researcher, and has a good fit with the current NHS agenda of

taking a 'patient-centred perspective' by listening to the views of service users (Reid, Flowers & Larkin, 2005).

2.1 Focus / advisory group

The principal researcher involved a service user's research group in the process of identification of areas for the broader research question of what it is like to be cared for. The results of this consultation were used for the creation of the interview schedule, particularly in relation to the strengths and limitations of in-patient care, dependency needs, service user aspirations and staff expectations in relation to care. Consulting service users to create the general topic guide of interviews was deemed by the researcher as a step that could ensure a smooth research interaction and the creation of questions that were important to the service users. This focus group did not entail the participants who were to be interviewed but an already existing service user-led research group, which was facilitated by both service users and project staff, with the aim of helping with the development of questions to be asked at the interviews.

The researcher initially conducted a search through available potential groups, and identified one natural group that consisted of current and former service users whose role was to carry out research and consultation work for mental health service commissioners and providers. This advisory group was recruited through the Patient Liaison Officer of the region's Care Trust, in order to give direction to the interview schedule process, from a patient's perspective. The recruited group was active in local patient groups and used to talking about their experiences with health care issues. The administration officer of this group was contacted by the researcher, the desire of the researcher for this group to actively contribute towards the creation of the interview schedule was explained, and the purpose of such use and the suitability of the group was also discussed. A subsequent meeting was organised.

The main purpose of the advisory group was to give advice on what seemed important to them in relation to the researcher's area of interest, offering their views on aspects of psychiatric hospitalisation and their experience of receiving care. Discussions had to do with the patients' experience of hospitalisation, such as what happens in terms of their sense of self when an individual feels unwell and gets admitted to hospital, and what are the positive and negative sides of being cared for by others.

The purpose of the focus group was to explore service users' perspectives on in-patient care experiences. The researcher approached and held the discussion within the group's regular meeting place, a mental health resource centre, in order to create a safe and supportive environment that group members felt comfortable with. At the meeting, the research area was briefly presented by the researcher, and a dialogue about this experience emerged. A discussion of what service users thought would be important to be included in the interview schedule took place. Service users were asked to put forward their ideas in relation to the themes of their experience of care and hospitalisation i.e. the positive and negative sides of their experiences. From the issues discussed, themes were identified, that were then used to inform the interview schedule. The interview schedule was thus developed using incorporated feedback from the group, and consisted of four broad categories: patient's experience during hospitalisation, care and being cared for by others, feeling dependent, experience of self in relation to others.

Phenomenology, in its search for the essential structure of a phenomenon or experience, is also concerned with part-whole relations (Tomkins & Eatough, 2010), and therefore the researcher chose to use a focus group in order to generate the interview schedule concerning the areas highlighted that appeared relevant to the group's experiences of their past hospitalisation. The researcher noted down what individuals in the group were saying and looked for connections between areas discussed. Then the researcher grouped these areas together according to similarities in content and focus of interest. The areas that emerged through the group's discussions of this experience operated as an overall thematic summary of the individuals' (service users') positioning in relation to this experience, thereby establishing interview questions contextualised in the structural system of the institutional setting of the NHS. While discussing their experience, they talked about what the meanings of care, and the expectations and beliefs attributed to the experience of being cared for by others. This pre-knowledge might have impacted the researcher's capacity to be open about what was heard at the subsequent individual interviews, therefore the researcher acknowledges that although she gave enough space and flexibility for original and unexpected issues to arise, what arose from the service users in the group discussion was influencing her understanding of the experience. However, it is acknowledged that in a interpretative phenomenological analytical approach to research it seems unlikely that researchers could embark upon a project without having at least some awareness of the issues surrounding the area (Brocki & Wearden, 2006).

Service users linked the care they had received to a dependent sense of self upon others. They also linked the care to a sense of helplessness to care for themselves, a sense of powerlessness and how it adversely affected service users' experience of self. In discussions about what is possibly lost and

what gained when one is looked after by others, they talked about positive and negative elements of the experience contextualised in their sense of the interactions and relationship with the mental health system and professionals. For example, service users reflected on the aspects of receiving care from others both in terms of the personal characteristics of those providing the care (controlling, lacking empathy) and the organisational expectations (i.e. when you do get better you won't be cared for).

Such use of the focus group in data generation regarding the interview schedule is consistent with the researcher's philosophical commitment to IPA and phenomenology, whereby the very nature of an experience is relational and interconnected (Todres & Wheeler, 2001). As Glendinning (2007) puts it, "Phenomenology is all about being alive to the possibility of launching and relaunching new ways of reflecting upon experience" (p. 1). In IPA, the researcher plays an important role not only in data analysis but equally in data generation (Brocki & Wearden, 2006). Therefore, the researcher believes that the role of the researcher in data generation, i.e. the design of the interview schedule, in how the questions were generated, as well as during the interviews, is of importance to qualitative work. The use of this focus group acted as a working arena in which the assumptions and pre-conceived ideas of the researcher could be juxtaposed, as the focus group acted as a means of opening up the experience and allowing external contextualised input from service users who had experience of the phenomenon under exploration. This is in tune with the dynamic role of the researcher in IPA in all phases of the research process. Furthermore, it takes the interpretative facet of IPA a step further, and utilises it not only during the process of analysis but also in the data generation process. This is further supported by Brocki and Wearden (2006), where in a critical evaluation of IPA studies, they acknowledge that the interpretative facet of IPA in data generation is not always made clear, with only a few papers describing the interview construction and the process of designing the interview schedule. This research therefore utilised this group process to elicit data that would be less accessible to the researcher prior to interviewing service users. However, a different group could have affected the orientation of the questions in a different manner. Thus, the researcher acknowledges that the people who accepted to join this focus group are not representative of the entire population of mental health patients.

3. NHS and City University London Ethical Approval

The ethics process involved meetings with the research manager of the trust, in order to discuss this study. The trust agreed to act as Research Sponsor for this study, subject to a favourable ethical opinion being given. Ethical approval for this study was sought in July 2009. A submission was made

to the (NRES) in July 2009. In September 2009 full approval for the study from the Research Ethics Committee was granted (appendix V). Management permission was then obtained from the host organisation prior to the start of research at the site concerned (appendix VII). An initial meeting took place with the clinical director of the host organisation, who approved and permitted the study to take place in this organisation. Ethical approval was also sought and gained from the City University London ethical committee (appendix VI) .

4. Participants

4.1 Sampling criteria

An NHS psychiatric clinic was used to recruit participants for this research. A meeting took place with the clinical director, where potential participants who satisfied the inclusion criteria were identified, suggested and discussed. The nursing staff allocated to those participants were also briefed on this process by the clinical director, and were asked to assist the researcher in the process of organising meetings with the participants, as well as in other practical issues.

The sample of the present study was criterion based so as to ensure homogeneity (Morrow, 2005), as the emphasis within IPA studies is for researchers to aim for a purposive homogenous sample (Smith & Osborn, 2003) so that the research question has significance and is relevant to the closely defined group.

Therefore, potential participants were required to meet the following inclusion criteria:

(1) To be aged 18 and above
(2) To have received a hospital admission to the acute wards of the mental health unit of an NHS hospital with a primary diagnosis of depression provided by a consultant psychiatrist, fulfilling DSMIV, or ICD 10 criteria (DSMIV, APA 1994, ICD 10, WHO, 1990).
(3) To be able to give informed consent to participate in the study, which is in line with ethical practice in the conducting of research.
(4) To be fluent in English. This is in keeping with the phenomenological-Heideggerian perspective, whereby language is emphasised as the vehicle through which the question of being can be unfolded (Scoyoc, 2010). The researcher believes that language is the vehicle but also the destination of our thoughts.

Language fluency was one of the criteria, given the nature of qualitative research where the analysis of results is based upon the interview material and language, and therefore it was essential that the researcher and participant be able to communicate with each other in a manner that enabled the shared understanding of their dialogue to be achieved. Patients with a secondary diagnosis of personality disorder were not excluded, while patients with a diagnosis of an organic disease and/or presence of psychosis were excluded, as this could have affected their capacity to consent.

4.2 Recruitment process

Patients who had received hospital admission for 4 or more weeks and who satisfied the inclusion criteria were given an information sheet by their allocated nurse. The participant's information sheet was written in a clear manner and clearly explained the reasons of the research and what the participant was expected to do during participation (appendix II).

Nursing staff on the wards assisted in giving the information sheet to the potential participant, giving them time to consider participation, encouraging the careful reading of the information sheet and ensuring that they had understood the content. The rationale of the researcher in including the nursing staff in this phase of recruitment was to allow the participants to take a positive step if they wished to participate, rather than having to decline an invitation, so there would be no perceived pressure to participate. Nursing staff were asked by the clinical director to assess the potential participant's capacity to make the decision to participate in the study by ensuring they understood the following: the purpose and nature of the research, the benefits and risks of the study, the alternatives to taking part. Nursing staff also helped ensure the participant was able to retain the information long enough to make an effective decision, and able to freely make a choice. Patients then let the nursing staff know of their willingness to participate in the study and their wish to discuss their involvement in the research.

Nine individuals showed an interest in participating in the study and eight out of the nine, who satisfied the above inclusion criteria, participated in this study. One patient was unsure of his availability for the interview due to frequent hospital leaves, and therefore did not take part. They thus were booked, with the assistance of their allocated nurses, with an appointment to meet with the principal researcher in a quiet consultation room within the unit, to facilitate further discussion about their possible participation. The consultation room was selected as it was a quiet and familiar place for the patients and somewhere they would feel at ease. The nurses also provided the researcher with a portable alarm devise to ensure safety of both the participants and the researcher during meetings.

5. Ethical issues

5.1 Informed consent

The initial meeting consisted of the researcher introducing herself formally, informing each participant about the study and its purpose in greater detail, and allowing for questions regarding the study. Participants met with the researcher twice. In the first meeting they were asked to sign a consent form (appendix III). This included confirmation that individual participation was voluntary and that they were free to withdraw from the study at any time, without giving specific reasons and without their subsequent medical care or legal rights being affected. It further stated that with the participant's agreement, the treating consultant psychiatrist would be informed of participation by the researcher. The form was countersigned by the researcher. All eight participants gave their written informed consent to participate in this study. A second meeting was arranged in order to proceed to the interview phase. With the participant's consent, the researcher informed the treating consultant psychiatrist, in writing, of their patient's participation (appendix IV).

5.2 Sample size and demographics

Data collection commenced on October 2009 and was completed on December 2009. In this study, eight patients were recruited and agreed to participate. In IPA, small sample sizes that provide rich data are the norm as this allows differences and similarities to come forth (Smith & Osborn, 2003). The age of the participants ranged from 33 to 60 and the mean age was 49.

Diagnosis of these eight participants was stated in their files and included: Chronic depressive illness, Major depressive episode, Depression, and Postnatal Depression. Participants' overall length of hospitalisation experience ranged from 3 to 48 months. Case notes were used to confirm the participants' diagnosis and information on their length of hospitalisation.

Whilst suicidality was not one of the inclusion criteria, this was a shared characteristic among the group of 8 participants and most had a history of attempted suicide. This is frequently encountered in a psychiatric in-patient unit as the clinical decision to admit a psychiatric patient to hospital is primarily based on judgement about the patient's acuity, severity, and danger to self or others. Given this threat to self or others, preventing suicide and violence is the most common reason for hospitalisation.

At the time of the interview all the participants had had at least a 4-week period of current hospitalisation. All participants had received psychiatric medication, and one participant had undergone ECT. All participants were involved in group psychotherapy while in hospital. All of the participants' employment status had been influenced by their mental health condition and none of them were employed; they all relied on welfare benefits at the time of the interview. Five participants were married, two were in a relationship, one was single, and most lived with their partners. As far as the ethnic background of the participants is concerned, all of the participants were Caucasian/British. Half of the participants held a diploma, and two held a postgraduate diploma. Four participants were male and four were females.

A full summary of demographic information can be found on appendix IX.

5.3 Confidentiality

All participants were informed that the interview material would be audio recorded and transcribed, and all participants consented in writing to this. Participants were informed that all information would be maintained as confidential. All personal information and records would be kept strictly confidential, complying with the requirements of the Data Protection Act (1994) and Caldicott Principles.

All participants were given an identification number which was used throughout the writing up of the research and in any subsequent publications. Also, by coding all the data's identifying information, the data was de-identified so that confidentiality could be ensured. All notes and correspondence were kept in a locked filing cabinet that only the researcher had access to. Notes were transcribed verbatim and stored on password-protected computer facilities and NHS-encrypted memory sticks. Participants' material will be presented to the research supervisor and examiners only for evaluation purposes and the third parties who will have access to participants' data will be required to treat the material as strictly confidential. Furthermore, the host organisation is kept anonymous and is described in generic terms in the final report, so that the anonymity of the participants is not compromised.

Regarding breach of confidentiality, the participants were informed and made aware of the fact that any harm/risk to the participant or others communicated during the interview and identified by the principal researcher would be communicated to their consultant psychiatrist and to the clinical supervisor.

5.4 Potential distress

Every measure to safeguard risk was followed in line with best clinical practice. Furthermore, the interviewer, being a counselling psychologist, had experience in dealing with people who were distressed, and so the interviews were conducted as sensitively as possible. Participants were informed that any risks communicated or identified by the researcher, to the participant or others, would be communicated to their consultant psychiatrist and to the clinical supervisor. Participants were informed that should they wish, the researcher could refer them to somebody else who could help them. Participants were made aware of their right to request the termination of the interview through the participant information sheet, at the point of consenting to become involved with the study, and were orally reminded of this prior to the interview.

6. Data collection

6.1 Interviews

For the purpose of this study, semi-structured interviews were designed and conducted. Semi-structured interviews are useful in helping the researcher gain a detailed picture of the participants' accounts of a particular topic, allowing greater flexibility than structured interview, and facilitating rapport and empathy between the participant and the researcher. Semi-structured interviews "give enough space and flexibility for original and unexpected issues to arise, which the researcher may investigate in more detail with further questions" (Pietkiewicz & Smith, 2014, p. 10). The researcher reasoned that this type of interview format was consistent both with the aim of the study as well as the particular recruited sample group, as it would allow the interview to be guided by the participant rather than the schedule, hence by the participant rather than the researcher.

The questions were open and expansive, and followed a 'logical order' in terms of temporal sequence. An IPA interview schedule generally adopts a 'funnelling' approach, starting at a more general level and moving gradually towards more specific topics (Smith et al., 2009, p. 61).

This interview schedule started with scene-setting issues, and the experience of current hospitalisation, and continued with questions that gradually pointed towards more sensitive issues, such as perception of self and relationships with others, how hospitalisation fits with the participant's life, and issues relating to dependency elements of care.

Semi-structured, in-depth interviews were used to explore the following topic areas:

- Context information – participants' views of current hospitalisation
- Aspects of hospitalisation – positive and negative sides
- Links between depression and the sense of self – issues of in/dependency
- How they perceive their own role in their lives, and how this has changed over time through the depressive experience
- The role hospitalisation has played with regard to their sense of self
- **Their perception of the development of their relationship with others**

The researcher believes that the qualitative research process is a non-linear one, and therefore the interview schedule was used as a guide. The researcher was open and alert to the material that each participant was narrating.

The schedule can be found in appendix I.

6.2 Interview procedure

It was decided that interview meetings would take place in the wards, in a separate, quiet consultation room that the clinical director kindly allocated for this purpose. Organising the time of the interviews was left to the participants and researcher to decide. Once the interview date and time were arranged, the researcher informed and consulted the participants' treating doctor, so as to ensure that the interviews would not be carried out at a stressful or unsuitable time for the patients. Nursing staff were notified by the researcher and aware of the location and approximate duration of each interview, for safety reasons. For the duration of the interviews, the researcher carried an alarm, and nursing staff were informed of these arrangements, so that safety could be ensured. The researcher used the first interview to help refine the questions and get a sense of how long the interviews would last.

The interviews lasted between 40 and 80 minutes. They were all recorded on a digital voice recorder. The participants were informed of this through the information sheet and their permission was sought in the consent form both for the recording as well as for the transcription of the material.
Most of the participants expressed enthusiasm about this study, and all verbally expressed their eagerness to the researcher about their participation. None of the participants stopped the interview process because of feelings of distress. None of the participants withdrew from the study.

6.3 Transcription

All interviews were transcribed by the researcher. All identifiable data was replaced in the transcripts with coded data. IPA generally requires a semantic record of an interview, with notable non-verbal instances included (Smith et al., 2009). The researcher followed this guideline at the transcription stage.

7. Analysis of data

Analysis requires the researcher to carry out a case-by-case idiographic investigation. Initially, the transcript was read through several times, and was treated as data. The aim was first to achieve an intimate appreciation of the accounts and secondly to interact with the text. In subsequent readings comments of interest, relevance or significance were made on the left-hand margin of the text. The next stage attempts to take analysis further, returning to the transcripts and in the right-hand margin documenting emerging themes that are at a slightly higher level of abstraction and which may invoke more psychological terminology, while at the same time staying grounded in the text (Smith & Osborn, 2003, p. 68) (appendix VIII). The annotations in the left-hand margin of the transcript are complemented by the emerging themes on the right-hand side of the document. These initial thematic codes attempted to describe participants' experiences. Some of these identified themes followed the interview schedule but others were new. These emerging themes are listed in order of presentation and the researcher tried to understand the connections between the themes and cluster them, "searching for patterns, connections, and tensions" (Smith & Osborn, 2003, p. 232). Within these clusters, super-ordinate themes were derived. This is an iterative and cyclical process of analysis as themes are revised on the basis of their ability to encompass meaning. During this process the analysis moved from the descriptive to the interpretative level, and emergent themes were checked back against the data to ensure that the researcher's interpretations were supported and grounded in the data (Smith & Osborn, 2003).

After all the data had been analysed transcript by transcript, it was re-analysed across all interviews. Themes that were strongly supported by the data of all or the majority of the interviews were extracted. Master tables of each theme, detailing sub-themes, with cited instances from the transcripts of each participant, were developed by the researcher (appendix X). In accordance with these, a table of super-ordinate themes was constructed (appendix XI) (Smith & Osborn, 2003). This phenomenological reading was informed by an empathic stance, which will be presented in the analysis chapter, and which will be followed by a more theory-driven interpretation that will, in turn, form a second level of interpretation.

7.1 Quality criteria in IPA

Qualitative research acknowledges the conducted nature of data, and therefore it has been recognised that "qualitative research should be assessed on its 'own terms' within premises that are central to its purpose, nature and conduct" (Spencer, Ritchie, Lewis & Dillon, 2003, p. 4). Different guidelines have been developed in order to assess the quality and rigour of qualitative research (Elliott, Fischer & Rennie, 1999; Yardley, 2000, 2008). In order to evaluate this present IPA research the researcher has used Yardley's (2008) framework in order to explicate validity (Smith, 2010). This framework highlights the emphasis on four broad principles:

Sensitivity to context
Yardley (2000) suggests that good qualitative research is sensitive to context, emphasising not only the socio-cultural context of the participants but also the theoretical and empirical literature relevant to the study. The author believes that this has been very salient to this research, a fact that is reflected in the literature review process.

Although it has been an exhausting task to move between and process the empirical and theoretical literature of three different themes from different disciplines, this process has helped the researcher to identify current gaps in the literature and to formulate a research question that will contribute to clinical practice. Furthermore, as this research was conducted within a contextual constructionist epistemology, both data gathering and data analysis have been grounded in the situational, personal, socio-cultural conditions within which they were produced. The use of a focus group in data gathering, and the consideration of socio-cultural implications for the current picture of mental health care, is a reflection of this.

Commitment and rigour
Yardley (2008) sets four key factors in this area: thorough data collection, depth/breadth of analysis, methodological competence/skill, and in-depth engagement with the topic. As discussed above, the choice of the research design, the proficient use of the method chosen and the benefits of it in relation to its relevance to the profession, as well as the process of collecting data, highlight the way in which this study demonstrates commitment and rigour. Discussions and brainstorming sessions with experienced IPA researchers, and a service user research expert group, as well as the consultation of

a multitude of relevant sources of literature, have facilitated a multi-layered understanding of participants' accounts and the topic at hand.

Finally, it has been suggested that IPA has become the 'default' option for many students at different levels, resulting in poor quality IPA which in turn could be due to an apparent lack of training in a variety of qualitative research methods (Hefferon & Rodriguez, 2011, p. 756). The selection of the method for this study was not based on IPA's appealing nature. Course doctoral level training on qualitative approaches has helped the researcher to develop skills and methodological competence, and previous experience in doing quantitative and qualitative research using a phenomenological hermeneutical method cultivated a research interest in the interpretative element of the researcher's role in research, which led to the use of IPA as the preferred method for this study.

Transparency

Transparency is concerned with attention to reflexivity and the particular ways in which the researcher may have influenced the outcomes of a study. In other words, it is about how well a reader can understand exactly what was done and why. In this study the researcher tried to achieve transparency in different ways and at different levels. A thorough and detailed explanation of how data was collected, and the use of verbatim extracts from the transcripts, enable readers to evaluate the fit between the data and its interpretation (Yardley, 2008; Elliott et al., 1999). Furthermore, the reasoning and transparency of data can be followed on a paper trail that the researcher kept of all data and steps involved during the development of themes and super-ordinate themes (appendix IX, VII). Smith encourages the use of an audit trail, not as a means to enable others to assess the interpretative decisions made, but to make transparent the procedure and to demonstrate the reasonableness of the analysis (Smith, 2003). Peer review was utilised with two peer IPA researchers. They agreed to audit one of the transcripts and agreed on the themes produced, thereby illustrating triangulation and the data's sound trustworthiness.

These peer discussions helped the researcher to be aware of assumptions, thoughts and pre-conceptions throughout the whole process of data generation and analysis, and generated considerations of how these may be influencing the data. This is reflected in the section on self-reflexivity. In addition, the researcher kept a reflexive diary which took the form of field notes, where observations and impressions about the interviews were entered into a notebook as soon as possible after the interview had taken place. This is in keeping with Smith's (2009) suggestion of using additional data such as note keeping, or drawing upon case notes, as a useful means of contextualising an interview.

Impact and importance

The final principle guiding this study, the value of this piece of work, is reflected on the emphasis the researcher put into explaining the relevance of this piece of work to the profession of counselling psychologists and into illustrating how it can contribute to clinical practice by facilitating a greater understanding of the dynamics of care. Some features of mental health settings – separation, social isolation, inflexible rules, lack of freedom, and controlling environments – have been reported to promote dependency (Bonavigo, 2016, p. 571). This piece of work opens up a dialogue about what it is that draws patients to rely on the services. Patients' dependency on an in-patient service is a multi-faceted concept, and whilst a static form of institutional dependency makes dependency a negative phenomenon, care-givers' focus should be on the integration of patients within their own community, and on newer services such as community care, which in turn should aim to foster the patients' self-determination and active participation in decisions about their care. As a result, in-patient services need to work towards promoting this transition.

In summary, this piece of work intends to throw light on the meanings patients attach to their experience of care, thereby promoting our understanding of how in-patient services work and inform our therapeutic practice whilst we are working as in-patient psychologists or as psychologists in the community.

Chapter 4: Analysis of Data

1. Chapter overview

In this chapter the three main super-ordinate themes derived from the interpretative phenomenological analysis are presented, together with their sub-themes.

Master table of themes

Theme 1: Containment

Sub-theme 1: Sheltered boundaries

Sub-theme 2: Seeing the self in others

Sub-theme 3: Gaining therapeutic insight

Sub-theme 4: Mediation

Theme 2: Attached

Sub-theme 1: Emotional alienation

Sub-theme 2: Regressive states

Sub-theme 3: Separation anxiety

Theme 3: Arrested temporality

Sub-theme 1: A past self

Sub-theme 2: Helplessness

Sub-theme 3: Remanence

These three main super-ordinate themes are *containment*, which captures the hospital becoming in positive terms a containing place of interpersonal exchanges away from the outside world, to the point that it creates *attachment* to the mental health unit. *Arrested temporality* captures an aimless idleness and an inability of the patients to project themselves into the future.

Somewhat like a 'catch 22' situation, these three themes capture the duality of the experience of hospitalisation, both across different participants and within an individual participant. At the same time, participants described their sense and realisation that at some point in time they were going to have to leave the hospital, yet at the same time felt the idea of leaving the hospital to be both scary and frightening. This gives the hospital the role of a switching point which allows for a psycho-physiological slowdown or what has been conceptualised as stasis. This duality is captured in all three themes where the experience of receiving care entailed both elements of being contained as well as attached and stagnant elements, providing a rich portrayal of the breadth and complexity of the experience of care of psychiatric in-patients. Each sub-theme will be presented and explained using verbatim quotations from the interviews. In the quotations, empty brackets indicate material that has been omitted. Participants are referred to by pseudonyms throughout. The source of the quotation is

indicated by page and line reference numbers. Following the description of each theme and its sub-themes, a second more theory-driven reading will follow, which will attempt to provide a more interpretative account in the context of the existing literature.

2. Empathic reading

2. Theme 1: Containment

2.1 Introduction

As explained earlier, most participants had a past history of suicidality, or experienced suicidal ideation at the time of their hospitalisation. The first theme of the lived experiences of being cared for in in-patient psychiatric care following a suicidal crisis or from having been a risk to others posits the meaning of this experience as being in a place of containing interpersonal exchanges away from the outside world, in both the physical and the interpersonal realm. This first theme captures the experience of hospitalisation as a positive one; the in-patient setting acts as a containing sphere that provides patients with a space in which there is positive detachment from the outside exigencies of daily life.

This superordinate theme is less about containment in buildings and institutions than about containment in relationships and social networks. The theme therefore pays attention to the physical, social and psychological aspects of the in-patient experience. It is comprised of four sub-themes of the various specific structures and aspects of hospitalisation; the *sheltered boundaries*, where participants feel safe and comforted in a stress-free atmosphere, *seeing the self in others*, and the experience of seeing the self in others extending beyond feeling connected with other patients to understanding the self through such connections, and *gaining therapeutic insight* – the understanding of the self through psychotherapeutic work and therapeutic encounters (the dynamics within this containing space; the relational elements consisting of relationships with patients and staff) and mediation , the way the hospital and families of participants interact for the benefit of participants

The inter-relationship between patients' inner worlds and the mental health service itself, with its structured and accessible matrix of containing relationships, captures the experience of hospitalisation as a positive one for patients.

2.2 Sub-theme 1: Sheltered boundaries

The first sub-theme embedded in the in-patient experience is that of being physically protected and shielded from and against outside worries and responsibility. Patients are physically contained in a place that offers comfort through a positive detachment from the outside world, accomplished by creating an interpersonal atmosphere (and relationships) where the suicidal person can experience warm, care-based, human-to-human contact. This occurs by means of the sense of security offered within the in-patient relationships with staff.

Tim: *'when I first came in I was probably non-communic... you know, I didn't want to speak to anyone. And that's gradually built up with the support from the staff. Maybe that's, ah, you know, this sort of... there's a comfort there when you talk to them because they are very user friendly so it's... it isn't the word to use, and then gradually it gets better .Having the care is a comfort. The mere fact that staff are there and accessible.... It's very comforting to know that you're within a professional group, you know.' (4/19)*

Participants describe their interactions with care providers and a structured regime as having a positive effect on their perception of the hospital as a safe and therapeutic environment. For example, Tim and Nicole are describing how the hospital setting offered them a shelter and a break from their lives, current problems and difficulties.

Tim: *'things are progressing with me in this hospital, before coming here I felt I was being fed, drugged and maintained. I didn't have any feeling of a structure whereas I've got more of a feeling of structure in here. I feel cared for by the mere fact that we have a kind of structured regime where we... we, I mean I smoke, which I shouldn't do, but I... I'm allowed to go out and smoke when I want to, the staff here are very comforting, in general. Also the lack of any outside intervention that you don't need is a comfort when you're in hospital.' (2/40)*

Nicole: *'Um, logically, I was fine. As far as I was concerned, and it was almost, well, I've had a baby, things are not right, so there's something wrong. It was like a punishment, but now, obviously I'm better, it's yes, I mean, it's it's fine, but it is very difficult to cope with at the beginning. I now feel quite sheltered almost from the real world. It's like the hospital has given me some sort of respite, from everything that was going on.' (3/67)*

In this research participants conveyed their sense of safety both from themselves and the outside world. Being sheltered and separated from the outside world is somehow mirrored by the concept of incarceration; the person is adrift from the outside world and imprisoned somewhere else, however, this imprisonment is not perceived negatively by participants, rather as a necessity. Angela describes

the experience of hospitalisation as running in parallel with a life outside, a life that runs even through her absence where she does not experience herself as part of this world.

Angela: *'The hospital looked after me, that's, um, and whether it's the hospital that's changed me or, or how I've changed myself, I'm not sure. Um, 'cause it's been so long on, in hospital that, um, it's like, it's just normal day living now. Being in hospital is like...normality, where being outside is almost abnormal.'* (7/4).

Angela: *'I've been trying, trying to get to the life where I can live with my family and not two, two different levels. Um, I mean if I was let out without the hospital then, as I say, I wouldn't be around, I know I wouldn't. So it's the hospital keeps me safe. (17/18)*

In the extract below, John describes how the ward becomes a shelter from the outside world, giving him a sense of protection from something worse that could happen while outside the hospital, and expressing fear for how things could evolve outside. Again, the hospital is viewed as a safe place which provides sanctuary, and a caring and nurturing place where participants feel protected from themselves and others.

John: *'I think of it as positive and necessary. I mean I think, yeah I think if I hadn't have had the professional attention, I don't know, I might have, I might have gone the wrong way or something bad might have happened.'* (8/47)

For Paulina, while the noise of being with people is experienced as overwhelming, confusing, and distant, the silence of being alone seems to amplify her painful thoughts. Her account consists of a combination of the vision and agency of the depressive experience: she can see out but she cannot get out. The glass door might imply the experience of inaccessibility she feels towards the world, encompassing not only the physical environment but also the social one; the reciprocity of one's relationship with other people.

Paulina: *'it seems scary when I'm actually out there but when I'm in here looking out the window, I feel a bit safer because I've got that glass door, you know, the glass doors are there so I've got something in… between me which is stopping me and that makes me feel a bit safer, knowing that there's something, something there. If I was to go out or they were to let me out on my own, ah, to be truthful with you, I wouldn't come back. I would do something serious so, um, which is why I'm on level three, so, because I know how I still, still feel. (11/32)*

'...being in here...It's, um, I don't know, it's weird. It's like it's like my home, if you know what I mean, it's, it's, it's like it's like my home and I just feel safe, safe here.' (13/90)

Paulina: *'Being in hospital is like you're being, you're actually being cared for and looked after and you've got a doctor that you see every week or whoever you're under. And you're able to talk about your feelings and everything else as well, how things have been going and how you're feeling. Because there's staff around and people who understand what I'm going through and know exactly what's going on and how I'm feeling from day to day. Um, and that makes me feel safer because every time they have handover they read through the, the notes. So you haven't got to go through everything with them about why you're in here because they've already read your note and know.' (14/2)*

Paulina reflects on the system that knows who the service user is, remembers their individual life story and kind of 'holds them in mind'.

Phil, however, appears to describe the hospital as a place he inhabits from which the possibility of interpersonal connection is absent; the staff to him look impersonal and distant.

Phil: *'Well, I'm still alive. So that's how it's affected me. Still alive. Um, because if I wasn't here, you know, I would have been dead weeks ago. (9/30) 'I'm being looked after so I can't hurt myself, but not care, no. You're being watched, but you're not being cared for. That's how I look at it. (3/12)*

For some participants there was a shift in their perception of the hospital from unsafe to safe. Laura also expresses fear regarding life outside the hospital, using the metaphor of a bolthole, and a sense of belonging within the environment of the hospital.

Laura: *'...as soon as I came in I hated it, but the next day I felt sheer relief. It's like having a bolthole, really, isn't it? When I first went off on night leave, I really, really missed hospital because of it, because of that support, because of that structure, because everybody's here. (4/46)*

Laura: *'I feel significantly, I feel significantly better depression-wise...I feel safe; um. It's a break from the responsibilities of home life; so it just, it just removed you from responsibility. I used to just go out for a few hours and come back, and I needed it, definitely, and you can't really come up, come to much mischief, well, danger-wise, isn't it?' (3/18)*

It was evident from participants' narratives that patients on this acute in-patient psychiatric unit experienced intense vulnerability and that most participants experienced the staff-patient relationship as a protective element.

The findings of this sub-theme suggest that hospitalisation was mainly seen as useful – an opportunity to slow down, take time out from their stressful lives and a safe place where they could rest and be taken care of. Most participants appreciated hospitals' structured containment and perceived it as helpful.

2.3 Sub-theme 2: Seeing the self in others

The experience of encountering, interacting with and living with a group of people with mental health issues was central to participants' accounts of in-patient settings. As participants described it, being in hospital alongside other patients was a positive experience, and the experience of seeing the self in others extended beyond the context of feeling connected – it was also part of feeling understood. Proximity to other patients with 'problems' came to be a valued part of the hospitalisation experience, as it helped participants to feel less alone, to feel understood and to put their own problems into perspective.

Tim: *'I do have great relief in that because I feel if you share someone's problem, you can relate to your own symptoms and realise that you're not unique because you do get this unique feeling, well, I do anyway, and then you… and when you find that someone else is very much in a similar situation, from any walk of life, from any background… it kind of gives you comfort.' (3/72)*

Tim: *'Talking to other patients can be more useful, in my opinion, than therapy itself. I believe in group therapy which we don't operate.' (3/67)*

John mentions how he is looked after and that this provides him with a sense of connectivity with others.

John: *'when I've been feeling very tired or when I'm feeling a bit dizzy they've been very, oh, you know, why don't you go to bed for a couple of hours or, why don't you sit down for a minute or… they've been very, yeah very proactive and, and doctor, the doctor has been very good, I felt.' (6/105)*

Similarly Angela, through her interaction with other patients, appears to make sense of her own self and others, by devoting time to better understand others and her own self, so that this offers itself as a way to connect to other people.

Angela: *'I find a great deal of help and encouragement with speaking to other patients about their problems. I find that that's very therapeutic for… not only for me, but for the other patients, um, and I… I'll speak to any of the patients, It's quite amusing really because we analyse everybody who comes in when we get a new boy, and we spend quite a bit of time deciding amongst ourselves what's wrong with them.'* (2/44)

Nicole, through talking to other patients, appears to normalise her recent difficulties as well as finding relief for her sense of alienation.

Nicole: *'when you don't feel quite right in yourself, it's very hard to be in, cause it's quite a social setting. But now, as I'm improving, it's much better, we've got a little group, that sit and chat, and it's quite nice, and in some ways, it's sort of, some kind of therapy, really, although we don't go looking into any depth. It's quite nice to realise you're not the only person, that things happen to, and it's not your fault.'* (2/52)

For Laura, the sense of connectivity that other patients provide seems to alleviate the fear of loneliness, which highlights the importance of connectivity within the hospital context.

Laura: *'I think there's a massive risk to being in hospital; I think you can become dependent on the nurses, I think you can become completely dependent on other people here, I think you can… I like company, so there's always somebody; even if I just sit and do a puzzle, there's always people around. That's what scares you when you get home.* (6/35)

Paulina describes how her illness isolates her from others. However, she recognised the importance of approaching others for help.

Paulina: *'on my bad days, I don't want to be near anybody or talk to anybody or… I just go quiet and just want to be left alone and my head's then starting to spin round and, ah, all different thoughts are coming into my head then. (10/39) ' …I don't interact much with patients. I would like to be able to talk to patients, especially staff more 'cause they can help me with this stuff. But it's very hard for me to approach them because of him giving me the orders. He tells me that I'm not to go and seek help or I'm not to go and tell the staff that I've got, that he's bothering me today. Um, which is really hard because, ah, I need to be able to tell them so that they can help me and tell me not to listen to him or give me something to calm me down. (45/5)*

Phil represented a negative stance in this respect, as he drew a clear dividing line between himself and all other patients, which he was not keen to cross. Perhaps this relates to his need to be perceived differently than others, making sense of his suicide as a conscious choice. Linguistically, the use of the words 'patients' as opposed to 'other people' conveys his negative stance towards care-giving and the hospital. This captures the difficulty of engaging patients with staff and how challenging this can be if patients do not feel they require nursing interventions.

Phil: *'Obviously in here people are more subdued, because they're not themselves, are they? Whether it's medication or whether… be it the real…they're more subdued. So you don't… you don't have the same sort of interaction with other patients as if you would be with people outside. So you're more subdued as well. You don't want to upset anybody, um, so you tend not to interact as much with them as you would with other people. (11/1)*

Accepting that they were suffering from mental illness was one layer of acceptance. Some participants spent years knowing that something was not right before being diagnosed. Acceptance might have been preceded by denial or by having to face one's own pre-conceived ideas of mental illness but was eventually associated with a sense of relief, as the diagnosis legitimised the person's experience. Worries about going crazy were replaced by an awareness that they suffered from a real, legitimate illness that had a name.

2.4 Sub-theme 3: Gaining therapeutic insight

Participants discussed a process of striving to make sense of their behaviour and situate their psychological states within the context of their life experiences. Participants described therapy as an important intervention that promoted recovery, providing them with a space for growth and insight. Most considered it important to gain understanding of their current psychosocial stressors and historic psychological vulnerabilities. Therefore, the therapeutic relationship was identified as a method of enhancing this understanding.

This sub-theme captures the value of in-patient psychotherapeutic input and how therapy is appreciated by patients when working through their difficulties with an understanding and protective care giver. Psychotherapeutic relationships appear to contain parts of careseeker's experiences, helping them to identify, verbalise, and make manageable their previously uncontained feelings. Such an experience of being externally cared for, and perhaps emotionally mirrored, may facilitate the

patients in developing a secure sense of self that can be resilient in the face of external stress and creative in relationships with others, rather than distrustful, defensive or destructive.

Tim: *'I find it excellent on here with the doctors and the CBT. It is a… it is a different kind of thing. I feel I'm getting something this time. Do you know what I mean? I feel as though… things are progressing with me. Before, in the other hospital …umm I felt I was being fed, drugged and maintained. Here with the therapy it's different. It's running towards an explanation of understanding where your particular anxieties depression has come from.'* (4/19)

Nicole describes below how CBT helps her to shift the focus away from external elements that she cannot control, and bring the focus to herself. Through this she manages to feel better by regaining control in her life.

Nicole: *'I do CBT, so there is quite a lot to take on board, um...but it also takes away some of the worry. So, instead of, you know, I'm more worried about me and getting better, rather than everything else that's going on on the outside.'* (6/10)

Laura describes how through CBT she manages to develop a new way of relating to herself and deal with her problems in a more constructive way.

Laura: *'The CBT helps you because it changes you, it does definitely change your way of thinking, definitely.'*

Researcher: *-In what ways do you feel it helped you?*

Laura: *'Well, I, I would… I was very much: I ought to do this, I should be feeling this, I should be… by 16 months, I should be enjoying them, I should be… and he said, you know, you need to take that out. Whereas today, I, I had the CBT and I just said to him, I don't know the twins like I want to know them, whereas before he said I would've said, I don't know the twins like I ought to know them; that's the big difference. The fact that I was forever guessing what people were thinking of me… Not… I wasn't paranoid, but I'd always think…and I'd always take every comment personal [sic]. And he just makes you write it down and decide between your thought and emotion, so that's really helped.'* (5/1)

Most participants described how they appreciated therapy sessions with a CBT therapist and the CBT-oriented psychiatrist.

John talks about the importance of a good therapeutic relationship as this helps him to be more cooperative with his doctor and work towards his recovery (importance of therapeutic relationship to build on).

John: *'Doctor L.; he's just very, I don't know he's very, when you, I feel very good when I'm with him having therapy because he, he talks about your problem in a very, in a very detailed way. But he also says it in a, there's a certain way he has of delivering what he's saying so you can sort of roll with it and listen with it and feel better as a result of listening proactively to what he has to say. And, yeah, I think he's a very, I bet [?] he's a very good doctor to deal with for people with psychiatric problems, you know, when you need someone who's going to deliver what, you know, he's saying very carefully and proactively so it will work. And it, it seems, seems to work that way, I feel. (6/111)*

John: *'They've allowed me to, to grapple and I won't say fight against them but, but, er, erm, my periods in hospitals have been very productive and I've been able to think practically. Even, even though my subjective experience is floating round I, being, having the excellent nurses and the doctors, their advice and various activities that you can do have been very helpful, I would say.'* *(2/39)*

Pauline and Angela describe how therapy helped them to gain some insight regarding the contributing elements that led to them feeling unwell.

Pauline: *' Dr L. helped therapy-wise. He's gone over what he think's caused it, right back to childhood, which I agree with, and he thinks the depression's been here for two years. He's made me more aware… and he helped me gain insight into why I've been depressed for so long.'* *(5/1)*

Angela: *'Therapy helped me to gain some insight. I used to always say that I'd like to be good at my job, um, and would always stay up extra to make sure that my job, my work was done. It's important to me what people think of me. (14/35) It is important but not as, not as much as it was. Though I realise now with therapy that even in here I am like a good patient, I like to be um, I like to be a good patient, that's part of the, the same thing as being good at work.'* *(14/35)*

Again Nick talks about the insight gained through therapy. He appears to use this insight in order to make sense of his interpersonal relationships outside the hospital and how dysfunctional ways of relating with others contributed to the development and maintenance of his mental illness.

Nick: *'I've always said to my wife in the past, you know, that I depend on you too much and she says, well, you've got to do more. But now after therapy I realise that I'm not like a young kid with a mum, being looked after by my mum. I didn't think like that before. I'm a fully grown man that's got to do*

my part in life and not regard my wife as my mum, which is, you know, it can happen…and it has done, I realise now both our faults and our aim is to put them right and get on with proper life' (14/39).

Nick: *'The hospital took me away from the problems I had at home and it made me realise that what I'd done and it was continuous on a day-to-day basis what I'd done, and made me realise it. It gave me a lot of time to think and a lot of time to regret.'* (3/5)

Overall, all participants acknowledged the importance of in-patient CBT in gaining insight regarding the elements in their lives that triggered and maintained their difficulties. Evidently, through this sub-theme, the participants highlighted that even though they were in a critical period of their illness, they could still benefit from in-patient therapy. This could further inform their care plan for their recovery in the community.

2.5 Sub-theme 4: Mediation

In-patient hospitalisation often brings family issues into the treatment arena. Participants talked about how significant relationship problems existed prior to hospitalisation, as a result of their mental illness. Most participants attributed to hospital staff a mediating role in facilitating these troubled relationships. It seems that prior to participants' diagnosis or hospitalisation, they lacked realisation of how their illness impacted their family. They lacked the understanding of how overwhelming it could be to their significant others who were indirectly affected by it. Often patients experienced guilt about what they put their family through. The hospital staff and the psychotherapeutic work patients did whilst admitted to hospital appeared to have a mediating role on patients' significant relationships. Thus, the sense of containment that the hospital offers to the participants appears to transcend into their family environment and help in the management of patients' personal relationships. The family, through the understanding of their relatives' problems, is able to offer shelter and containment to the participants within their relationship.

Nicole: *'We have been separated since 1999, and although we had an accident and had my daughter, um, I'm hoping, and it seems to me that that has changed in a positive way. I can see how I've pushed him away over the years and he can now see why I've done it, because he's come to all my meetings. He's been very supportive, and hopefully out of this has come something positive and maybe we can try at our marriage again, which you know, is quite a big thing really.'* (10/37).

Nicole: '*...because he's been to the meetings and understood what I've spoken about at the meetings a bit more, that maybe it's just with more understanding, you know? He's learned from this experience that you know, maybe before things were like, well, you're not my favourite person, go away, and rather than questioning that, he did exactly what I asked him to do. Whereas now, he's probably thought, well, actually maybe J wasn't very well, and pushing everybody away, because it was easier than dealing with it, which is, you know, something that I now know I do.*' (10/51)

Hospitalisation usually validates a person's diagnosis and establishes patient-hood. It appears that through their hospitalisation and diagnosis of mental illness, Pauline and Nick have received a more empathic stance from their partners, which consequently improves their relationship. Prior to hospitalisation there was a considerable lack of the partners' understanding of their behaviour, but once this behaviour was established as symptoms of mental illness, partners adopted a more considerate and containing attitude towards patients. Both sides acknowledge that being criticised was not helpful.

Pauline: '*My partner was very patronising and very, um, self-righteous and up on his soapbox sort of thing. Now that the doctors have talked to him and explained he sort of understands more and his attitude is a bit different, um, more understanding, but he still finds some of it very hard to understand. But he's trying to get to understand, um. Why I do do the things that I do and he's beginning to understand that it's because I'm being told by the voice in my head to do it.*' (15/56)

Nick: '*I think my wife understands basically what's gone on and why it's gone on and that she herself, has a part to play in it in helping me. The doctor and staff have talked to her and I think she realises now that she has a role to play. Instead of sort of, you know, constantly nag, nag, nag, she's got to understand that everything will get done. You know, I can't, ah, do sort of six jobs at once. Um, so she understands that and she's more considerate towards me in that, in that respect and basically all she says she wants to forget the past completely, forget I've been in hospital two or three times, don't keep reminding her and just damn well get on with it. Basically that's it, yes.*' (13/15)

Angela re-established her relationship with her children, as they appear to have gained a better understanding of each other. The relationship difficulties that she was experiencing with her children were a manifestation of her symptomatology rather than an inability to be a good enough mother. The insight that she has gained during her hospitalisation has helped her to be less self-critical and focus on building a better relationship with her children. Thus she focuses more on the relationship rather than criticising herself.

Angela: *'my children have now started coming to sessions in here. He is holding sessions for me and my children altogether 'cause I, I feel really guilty that my children have been pushed to one side for my work. I feel that my work stopped me from being a good mother, that I've, um, taken on too much or my job and so much responsibility that my children were I think are neglected. They, they say that they are not. I think it helps them coming here, 'cause they understand my difficulties and perhaps I will start feeling less guilty about them.'* (17/23)

Again, as Laura describes, the hospital not only has the role of containing her but this also extends into her relationships with her husband.

Laura: *'I couldn't talk to my husband before. Whenever I was ill, I'd relapse or I'd be at a point – I don't know what to call it – it was easier to tell to my GP rather than Gareth because I didn't want to upset him. Whereas now, Gareth's come to the majority of my therapy sessions in here, he's… so now it's much easier because he knows just as much of it, he's part of it. He knows why I've done it, to try and protect him, and he's also… can recognise when I'm going… hopefully, I won't, but when I go downhill he can now recognise it.'* (21/113)

However, according to Phil, instead of containing the interpersonal relationships, the hospital affects them negatively, due to the stigma attached to mental illness.

Phil: *'I am very, very disappointed. I've got quite a few friends, and I'm disappointed that none of them have come to see me. If you've got a broken leg, then everybody knows you've got a broken leg. But in a psychiatric unit, it's a lunatic asylum and it's… like people don't want to go anywhere near. Because I've been in here no one's come to see me, I've noticed that. I'm very disappointed… very disappointing.'* (10/23)

A shift in perception was evident in most participants of this study. Most patients implied that their initial experience was changed as their hospitalisation progressed. It thus seems important that staff need to appreciate the pre-existing thoughts that patients have about a psychiatric ward and allow for exploration of patients' assumptions and interpretations in their professional interactions with them.

3. Theme 2: Attached

3.1 Introduction

This theme consists of thoughts and feelings in a chronic continuum of participants' experiences regarding the pre-hospitalisation, hospitalisation, and post-hospitalisation phases. Three sub-themes are central to the experience of being in the hospital; *emotional alienation*, relating to elements leading to being admitted to hospital, *regressive states*, emphasising patients' being allowed to regress to a stress-free atmosphere that appears to foster dependency on the mental health system, and *separation anxiety*, fear of the prospect of discharge where participants communicate being unprepared to leave the containing space of the hospital.

3.2 Sub-theme 1: Emotional alienation

Prompted by the question of telling the story of their depression and their current hospitalisation, most of the participants began their narrative by painting the scene of the onset of their depression and the reason for their hospitalisation. All participants belonged to the substantive group of people who have received formal mental health care for a suicidal crisis after making a serious attempt on their life or for having become a threat towards a member of their family. The experience of suicidality is frequent in patients within psychiatric in-patient settings, as one of the aims of a psychiatric admission is to protect people from being a risk to themselves and thus harming themselves or others. Most suicide attempts were formulated as escapes, to the extent that they were driven by a wish to get out of a mental torment trap. Participants appeared to use the concept of escape, which came across as a way of escaping emotional states. Perhaps this implies that participants rely on the hospital to become just another way of avoiding the world.

The hospital does not only have to be a place of avoidance or a place where responsibility can be escaped. It can also be a place where the state, in the presence of the hospital, takes away the power of the individual to commit suicide.

This sub-theme captures the relational and social context that gives rise to physical solutions to affective distress – dangerous feelings, thoughts and acts showing how a lack of emotional connection can create a sense of emptiness, confusion, and foreignness.

Angela talked about how isolated she felt prior to hospitalisation, talking about her inner emptiness and a sense of meaninglessness when trying to maintain a distance from perhaps a threatening outside world. At the beginning the hospital appears to function like a mechanism that provides and secures her distance from the rest of the world. This loss of basic functioning confirmed her profound estrangement from life itself. The sense of alienation has thawed since she has been in hospital. She feels cared for and she accepts the staff as being there for her.

Angela: *'I felt isolated before I took the overdose. I felt really isolated; I was cut off from the world. Myself, I did it myself by, um, just couldn't go out anywhere. I couldn't sit in my car which used to... Now, I can remember one day I was sat there, just sitting in the car for five hours, I just sat in the car and didn't know what to do with myself. I just locked the doors and let myself, went in five hours, everybody's wondering where I'd been. But I just wanted to be isolated, away from everybody. But since I've been here I feel cared for, um, 'cause the staff are there for me, yeah.'* (4/9)

Nicole also described herself almost as if she had been "evacuated", being on autopilot, noting a failure to adequately attend to her embodied experiences and the hospital as appearing to have a rescuing role. Feeling depressed can generally disturb a person's relationship with the things and beings of her world, and in Nicole's case, her perception of her environment no longer stood in agreement with the form of life in which she once felt at home.

Nicole: *'I didn't know who I was, where I was, felt completely disassociated from my body. I just didn't know who I was'* (13/75).

For Nicole a kind of *mental homelessness*, so to speak, occurs where she loses meaning, communication dwindles and the familiar takes on an unrecognisable dimension since the affective connection to the familiar is lost.

Nicole *'I don't think I could have made it much further without hospitalisation. Um, I didn't realise that at the time. I was, sort of, on autopilot, not really, there was no feeling there, no emotion, no anything.'* (8/61)

'To be honest, before I came to the ward, I was in a very, very dark place. Um, almost existing but not actually doing anything...' (2/6)

Pauline again talks about an absent self, a need to escape all aspects of a dysfunctional family life. She appears to dissociate, leaving herself, like going to the corner of her life and watching from a distance. Given her depressive tendency towards withdrawal, suicidal ideation, and self-consuming feelings of grief and pain, she appears isolated and overwhelmingly alone.

Pauline: *'I tend to lock myself away and away from my family and everything and I go with, very withdrawn, in with myself and then I start contemplating suicide.'* (13/99)

'I just want to end, end my life and let it all be over with so I haven't got to carry on no more. My, my second daughter suffers from, um, PTSD, paranoia. She self-harms, she smokes weed, she gets

drunk, she's sexual promiscuity [sic] and she's only 14 years old. And then I've got my other daughter, who is 11 now. Um, PTSD, paranoia, ADHD and self-harm so I've got that as well going on with both of those. And then I've got my eldest son who's got his own mental health issues as well so I've got that as well going on. And I just can't, I can't cope with it all, it's all just…it's all just, all just getting too much.' (12/47)

Phil also talked about how what triggered the events that led to his despair was his lacking a sense of belonging and a sense of ownership of his life, leading to a diminutive self-perception where he tried to escape his life by killing himself. For him a psychological discontinuity occurs between how a person sees things when he is depressed and how he saw things before depression, including how he perceived himself.

Being unable to act, and likewise unable to enter into meaningful contexts of activities like holding a job, having a relationship, managing his finances, and the loss of an emotional bond, coupled with his perceived essential inability and incapacity to act meaningfully, seems to have led to his whole life appearing devoid of other possibilities and so suicide contemplation might have been the result of this initial implicit reflection upon his incapacitated state.

Phil: *'I split up with my partner, and I moved out, and I was… I took a room in the pub. And of course that didn't help by being instead of… not being going home and… and then work was getting…I was doing little jobs instead of where I was usually doing big jobs and the money wasn't coming in and I was living on my credit card, and things just finally got ahead, and I thought I can't take this anymore, I don't want… I said I've been down this road before and I don't want to go down this road again. I've just had enough of everything – everything – and the more I thought about it, the more determined I became that this is it, this is the end and it was just a case of carrying out… killing myself.' (2/30-42)*

Perhaps as a result of the process of reflection and self-interpretation, consequent upon the primary experience of inability, strong feelings of guilt and worthlessness arise.

Phil: *'I don't like to owe people anything. I sort of… feel guilty. And that probably obviously dropped me down even further, you know. And then the whole world just seemed to implode on me.' (3/62)*

Laura talks about her traumatic experience of giving birth and her subjective feelings of disconnecting from relating to and bonding with her babies, and her thoughts about attempting to escape these feelings by harming either her babies or herself. She appears to disconnect from the experience of motherhood, perhaps making up for the loss of her previous pregnancy and her sister's loss of a baby. She described her feelings of disconnection with the babies, and how profoundly disturbed she felt

by this, so much so that this impeded her seeking help and support either from her partner or from professionals.

Laura: *'To be honest, I kept… I keep so much to myself that it's not until I start to getting better, as Gareth said, did I… did he realise how ill I was [took a very deep breath] because I kept this front up, which, I think, is why I crashed.'* (13/38)

Laura: *'I had a difficult pregnancy; we had IVF to have the first pregnancy and it was twins, but we lost them. Then I had fertility treatment to have the, to have the twins and my sister miscarried as we fell pregnant… I didn't want to even look at any of the scans, I didn't want the… so, basically, when they were born, they were early, they were taken away into special care, so I didn't see them for 24 hours, and then I didn't want to see them at all. I was… I don't want to touch their skin; I don't want to even look at them. And that was the start of it. I got post-natal depression, which then just spiralled out of control. And then the final reason for admission was the risk to the twins, well, one of the twins, and self-harm and suicidal intention, basically."* (1/14)

One of the domains influenced in the depressive experience is the patient's interpersonal relatedness. The feeling of being emotionally disconnected from other people features in almost every account. All participants exhibited great difficulty managing their emotional distress and reported a sense of an impasse with the lives they had, pushing them to seek a physical solution to their affective distress, in the form of attacks on the body, such as with suicide attempts.

They all talk about how depression alienates them from their social and natural environment by disordering their capacity to affectively engage with life. Patients' flight into isolation from others results in a profound experience of aloneness, whereby they are left with themselves. Left alone with selves that they blame or loathe and who turn to self-destructive activities or other dysfunctional behaviours as a way of alleviating an intolerable internal experience. In this sense the hospital as a context can become a place where patients experience a sense of mental, rather than purely physical, security; it's the hospital that keeps them away from their troubled lives, aiming to prevent further damage to the participants.

3.3 Sub-theme 2: Regressive states

Participants described how they often felt cared for in hospital, in the sense of having one's daily needs met and being freed from or spared the vagaries of 'the outside world'. This sub-theme captures the experience of being cared for by others while admitted to hospital as almost being a vacuum

interval from reality, or replacing reality. Participants seem to have the need to break away from the responsibilities and anxieties of a troubled domestic adult life, and perhaps feel relieved of playing roles in those areas of life where they experienced difficulties. As feeling depressed can attack what it is to have a sense of agency, participants regression appears to address their need to experience a less adult-like state – one free of responsibility. Therefore, this sub-theme captures the impact of depression and hospitalisation on participants' sense of agency.

Angela talks about her sense of feeling incapacitated by her mental health condition, giving the hospital the role of taking care of her while regressing into not having to take responsibility, and feeling a detachment from her sense of agency.

Angela: *'Well if I wasn't in hospital and I was at home, obviously I'd have to look after myself, but what, I don't think I would be capable of putting up with a normal daily living, 'cause a lot of it just makes me anxious and I feel I just want to hide, run away and hide, go and stay in bed. If I'm left to my own devices and there's no nursing staff and no sister, then I will just stay in bed.' (15/15)*

Although Nicole describes a soothing element in allowing the hospital to take care of her, it's as if she experiences a necessity to remind herself that she needs to be an adult and that there is an adult life waiting for her to be resumed outside the hospital context.

Nicole: *'you don't have to make any decision in here. You don't have to do anything, um, that you don't want to do, unless you make conscious effort, to make your own decisions, and it can be something really silly as, I'm going to do my washing today. Unless you make a conscious effort to be part of the real world, even though you're not in the real world, um, I think you could really get lost in it.*

You know, I could quite easily have sat back and really not bothered, and stayed in here indefinitely, because that's how bad I felt.

I could stay here and quite happily plod along and let everybody else look after my children, and at the moment, the way I feel mentally, that wouldn't bother me.
You...um, I can stay in here and basically not do anything. But, I think you have to be conscious enough to know that you need to function outside of here.' (8/82)

Angela: *'I feel relieved that I haven't got to deal with, with anything really. I'm very much protected, um, and I hope that I come out of this illness and I will be back to being a responsible, independent woman, but at the moment I don't feel like I have the ability to do that.'* (10/41)

John seems to describe the identity of a patient as if it's something external that could absorb him. He appears to talk about the realisation that the identity of a patient can substitute previous perceptions of the self and that being a patient could be what one becomes forever, perhaps implying the possibility of denying an adult life accompanied by adult responsibilities. This is almost as if he confronts the identification of his experience as 'a hospitalised depressed' person and can come to see depression as an integral part of who he is.

John: *'I think hospital could make you much more wary of the fact that you are a potential mental health patient and you've got to understand that. Erm, and, you know, if you've been in once you could, you could be in hospital again; there's nothing to say that you wouldn't. So I think that changes things a bit. You could be in hospital forever…'* (9/74) *'… as a fulltime, er, as a live-in patient.'* (2/25)

Both Phil and Pauline talk about an infantilised and emasculated version of themselves whose former functionality is not performed, and in its place is a childlike lethargy, and a feeling of passivity and powerlessness.

Phil: *'In here it can become very, very boring. Um, it… very lethargic. You're not actually doing anything as such, so it… it is. If you… I'm a couch potato in some respects. Um, but like there are OT… there are OT classes, don't get me wrong, but you can have an half an hour or an hour doing something, but then the other [sighs] like 15 hours that you're up, you're not actually doing anything sort of either physically or mentally, so you do become very, very either sitting watching the television. The most strenuous thing you've got to do in here is have a shower. It's great that everything gets done. It's… if… if you're outside at home in the home environment, and you have someone doing that for you, you'd be absolutely over the moon, but you… it's something like being a child again, and somebody doing it for you.'* (7/16)

Pauline also talks about herself in a rather passive tone, almost as if the 'I' feels like a passive victim of the depressive experience, as if she has lost the agential vitality that could allow her to count on herself to be able to live her life as she wants. The regression here is implied in the experience of self-authorship of action which is threatened or even absent.

Pauline: *'even my partner says to me, you show no emotion whatsoever. He says, I could be sitting here watching a funny film or literally crying [?], and he said, and you're just sitting there with just a normal face on, you're not even laughing, not even doing nothing. And that is what I've, I've become and that's what my life is like living. That is what it's like.'* (11/6)

Nick seems to find himself in a cyclic situation of hospitalisations where he describes a passive self, and not being able to control or have a sense of mastery in his life, almost as if the hospital is a context that he needs to revolve around whenever things get difficult outside. This seems to provoke an internalised experience of shame as a sense of having failed, or being a failure.

Nick: *' People, um, people are conscious of me coming into hospital every sort of so many months but each time I come out of hospital they're hoping it won't happen again, and each time I say it won't and it does.'* (11/157)

Laura talks about the lack of being responsible about simple everyday tasks while in hospital and how antithetical this is in life outside the hospital. She appears to acknowledge that the structure of the hospital encourages a loss of adult life whilst one is in it.

Laura: *'Well, just on a practical, on a practical scale, I can be at home now, and I'd be like, oh, my goodness, I've got nothing out for dinner, because you just, you just look on the board: oh, what have you got for dinner? So you lose that. I can run out of nappies… and some of it, I know, is depression, but you don't have to think for yourself, and I go home and I sort of sit there and… or I fly around the house doing absolutely loads. I mean, I think there should be, I can't say, but I think there should be where you can make your own drinks or whether you…when you have to strip your bed. I think they could get you a lot more involved in everyday tasks, basically; start taking some responsibility.'* (8/20)

Some participants treat being in hospital as a welcome relief from being outside and having to stay in control, and thus see this as an opportunity to let down their defences. This often results in their letting go of personal responsibility and placing hospital staff in the position of taking care of them. However, most participants experience in this state a sense of loss, regressing to earlier developmental phases which appear to validate their dependency needs as they function in a less adult-like state, one which is free from responsibility.

3.4 Sub-theme 3: Separation anxiety

In their incapacitated state, marked by a profound inability to interactively connect to other people, depressed patients come to feel removed, detached, and alienated from others. For most of the

participants 'home' was not experienced as a place of safety, comfort, healing, and/or tranquillity. On the contrary, 'home' was experienced as a dangerous place – a place of uncertainty, the unknown, potential threat, and overwhelmingly scary. Therefore most participants expressed a psychologically intensive sense of fear and anxiety with the thought of leaving hospital. Some participants reported that they felt they did not have the 'tools' or skills for coping with post-discharge or even a short home leave. Some participants openly communicated that they were not prepared to deal with the outside world and shared intense suicidal thoughts while in hospital.

This sub-theme appears to emphasise the importance of considering the participants' attachment, which in turn may foster dependency to the in-patient setting. If a mother and her child walk together in the street, as soon as the mother's hand and the child's hand become separated from each other, the child will soon begin to panic. Similar to the lost child, most of the participants captured the experience of separating from the hospital almost as that of being stripped of the familiarity of a way of living, finding themselves out of synch, utterly aware of danger, fearful of the external environment, wildly sad and panicky.

Pauline communicates that she does not feel at home either outside hospital or in her own body. Not feeling at home with what once seemed familiar to her exhibits how the lack of affective connection to one's previously familiar surroundings can impact a person's perception, giving the impression that everything looks grey and removed, and the feeling that any involvement with the world outside hospital – any kind of external social interaction – is threatening.

Pauline: *'I can't bear to go out. If I go out I have to have someone with me because I will, my partner know that I will go and jump, try and jump again from the bridge, which I've tried before. I've done the sea before. I jumped in front of a car three weeks ago before being admitted into here.' (3/75)*

Exhibiting almost existential angst at the prospect of being out, she seems to talk about the safety of her self-confinement while in hospital and the threat and painfulness of social interaction, appearing exhausted, estranged, lonely, grieving, and scared of her own mind. Social situations appear to force the depressed person to do things that they no longer feel capable of doing and the mental exhaustion that goes along with the feeling of relentless demand can thus be felt as physical exhaustion, the depleted state becoming an embodied sense of effort that imbues life and the world. As such, escape becomes the only possibility for rest.

'I've been out with my sister today. She picked me up and I went out for, but I get really anxious. Um, and when I come back after being out, I feel deflated because it's like all my anxieties got worked up

and worked up and then when I come back I feel safer here; now I've become like deflated, so it's like phew, and, um... But I'm hoping to build up.' (5/9)

Nicole also appears scared of leaving the hospital as the outside world is experienced as a source of discomfort and pain that is difficult to inhabit and that she wants to escape from. She prefers to go back to the hospital where no demands are placed upon her depleted self. She talks as if she is acting in a world where her self-concept appears to be fixed and not fluid.

Nicole: *'The idea of being out is scary... In here, I can, I feel as if I can maybe be myself a bit. Outside, you have to put on a front for people, whereas if I have a down day in here, it doesn't matter to anybody. They know it's just a down day, and you know, and you get a chance to talk to people, or little things that need to be done, whereas at home, you don't have that support, you know, for somebody saying, oh, you don't seem yourself today. What's wrong? All the facilities to go back to bed, which I can find helps with me quite a lot, just to sleep it off for a while, if I'm getting really anxious.' (6/71*

Tim talks about his reliance on others, daughter and sister.

Tim: *'She's got two young children who are depending on her and they... they've just got an old-age pensioner almost who's dependent on her. So she has two sets of worries; she's got to worry about the kids and the school and then she's got to worry about dad and all the rest of it. So I would like not to become so dependent but because she's there and a girl, ... well, I, you know, I sometimes get a fear, if I didn't have her, and if I didn't have my sister, like some people do in here that must be very difficult to cope with and very difficult for somebody in that position to get well albeit that they may be a situation where they become, um, you know, hospitalised, or whatever the word for it is , I can't remember, you know, the... where they rely on... on the hospital and can't do without it.' (11/15)*

Angela talks about the hospital as being a base for her, her home, her current reality, and the world she knows and is familiar with. She acknowledges that it is the chronicity of her hospitalisation that makes her anxious when she leaves the hospital, and that her feelings of anxiety are not a result of her mental illness.

Angela: *'I've spent the last two and a half years being looked after and as well as being ill, um, trying... the ward, it's looked after all angles of my needs. So whether I'll be able to cope without it when I leave the hospital…it's quite frightening, so I'm sure I'll be ready for it I mean when it comes to it.' (7/4)*

Laura and Pauline talk about their need to retain proximity to the hospital as this is something that makes them feel safe. They appear to exhibit proximity-seeking behaviour, perhaps using the hospital as an unwanted yet safe attachment figure, reflecting their non-preparedness to deal with the transition to life outside.

Laura: *'I can see the purpose of home treatment teams who kept trying to keep me at home. I found the transition back home so hard, but then I think: was I just not well enough? Basically, I just rushed it; I just wanted discharge, so I did seven nights out, which was far too long, and then crashed, basically. So that's why I've been in here quite a long time. I think, for me, personally, it's just got to be a very, very gradual return back home. Really gradual and then come back in for a break, go back out and do it that way.'* (8/11)

Pauline: *'Um, really, going out is quite a worrying aspect, um. Even when I'm going out with my partner just for an hour into R. S. it's quite an effort. Um, being prepared ready to go out for a night and a day is going to be something that's going to be very, um, hard going and something that's going to push me to the limit to know whether I'm going to be able to make it right through to the next day, sort of thing, without having to come back on that same night or the early hours.'* (10/62)

It appears that separation anxiety highlights participants' difficulties with leaving the place that contains them, almost echoing proximity-seeking behaviour to an attachment figure, and seeing the mental health system as an attachment system, where leaving it might be distressing.

Nick displays patterns of repetitive admissions, perhaps implying a 'cannot do without' attitude: *'basically it's every sort of two and a half to three months. Um, you've got Christmas, then you've got June, then you've got September so it's every now and again that this is happening.'* (11/146) *'people, um, how can I put it; they're conscious of me coming into hospital every sort of so many months but each time I come out of hospital they're hoping it won't happen again, and each time I say it won't and it does'* (11/157)

As Nicole was experiencing a lack of secure attachments and healthy relationships outside hospital, it was understandable for her to worry about losing the sense of containment that the hospital relationships offered, hence her fear of letting this go.

Nicole: *'The hospital is scary in itself because you can become dependent on it. But I know that I can't afford to become dependent, um, because I've got people depending on me. And that in itself is quite worrying, you know, all the time when you're, sort of, thinking, I've got to get better, because*

I've got to get out, and I can't…I've never had, never had people look after me. Um, and deal with stuff that goes on, so I find it very difficult to let go of this care'. (3/74)

Most participants described a sense of existential angst and dread at the prospect of being discharged or leaving the hospital; being away from hospital could be an anxiety-provoking experience that seems threatening to most participants. Perhaps being in a place of safety, cocooned from life's stressors, means they are fearful about what happens when this experience gets removed along with the prospect of discharge, as most participants seem unable to deal with the transition to life outside.

4. Theme 3: Arrested temporality

4.1 Introduction

Temporality in terms of the past, present and future often appeared fragmented in participants' accounts. Time was not experienced as a relational order of processes which interact or resonate with each other.

This third theme relates to the participants' and the hospital's sense of time: capturing how these two worlds collide. There was a difference between the individuals' context – how participants perceived time – and the hospital's concept of time as being more static. Participants seemed to repeat the same activities over and over again every day, appearing to have a rigid daily structure. They woke up, had a wash, ate breakfast, took their medication and perhaps see their doctor. The hospital has its own version of its daily structure and so these two worlds inevitably collided. The participants and the hospital appear to look towards different directions. The hospital sees itself as a people mover, a process that attempts to do the same procedure all the time. Early versions of the Recovery movement spoke about lost parts of the self, with the aim of rediscovering or uncovering those aspects of the self that were lost during the process of mental illness. The participants talk about their past adult selves, wanting to recover that past self: "I want to go back to my old life". In this way, they appear to be looking to the past, like Janus, longing to go backwards in time. On the other hand, the hospital looks towards a future direction. Towards helping people move forward. These two separate worlds, that of the participants and that of the hospital, meet in the in-patient setting.

The theme of arrested temporality is composed of three sub-themes: *a past self, helplessness*, and *remanence*. The first two reflect participants' changed sense of self through the comparison of prior/post experience of mental illness, and *remanence* captures participants' difficulty in projecting

themselves in the future while stagnating in the present. These appear to be reinforced by the procedural way the in-patient setting operates.

4.2 Sub-theme 1: A past self

Here, participants talked about their past selves, meaning their experiences of their lives prior to being ill. The self was experienced as a passive object in most cases, where the sense of agency was lost. This illustrates the experience of lost consistency, of a loss of continuity between the past non-suicidal self and the present suicidal self. This appears to capture the experience of a psychological discontinuity and a loss of coherence in the sense of self in the context of the disruption of an integrated self. This is exemplified by the descriptions of a past self, where participants described a responsible active adult, not influenced by their mental health experiences, in contrast with their current life status. In other words, what was and what is.

Participants talk about a gone self, belonging to the past, almost as if they have lost their reference point. Angela talks as if she does not own her life presently, speaking of her past self and implying a discontinuity of herself before and after her depression. She describes a self that she no longer recognises, who seems unfamiliar to her, almost as if she is describing a separation from both herself as it appears to her now and herself as she has understood herself to be in the past, implying a psychological discontinuity. Her use of the phrase 'taken over', describing depression as descending from outside of herself, might stress the lost agential vitality discussed earlier, implying both an absence of the past self as well as the presence of a 'foreign invader'.

Angela: *'it's like, it's like another person's taken over; my personality has changed completely. I'm real… I used to even I used to have, do public speaking. Part of my job, I'd do presentations. I mean I can't, I couldn't even sit in front of a load of people anymore, so it, it has changed, um, and I don't know how.'* (16/3)

She continues to keep the past preserved in the present both in the form of self-accusation and by using comparison. *'I was a very busy person…I was an area manager, um, and I ran 25 units nationally, I was all over the country; I did a lot of driving. But I was very busy, used to work to about midnight, and then go to bed and I was up again at half five, started driving again. Um, and I think I burnt myself out really. The first signs of anything was I just couldn't get out of bed. I know it sounds really silly that you can't get out of bed, but I, I couldn't.'* (3/28)

Pauline also uses a passive construction "everything has been stripped away", which again presents depression as an outside force, echoing her grief over her lost self and her felt inability to recover those aspects of the past self. This might imply that it is not just particular attributes that she has identified as 'lost' but that she retains an image of herself that pre-existed her depressive experience. She additionally speaks of failing to make sense of her current present self. This current self appears absorbed by physical and mental pain and is thus rendered silent, inert, and withdrawn.

Pauline: *'A lot of that seems to be, though, as if it's been stripped away since I've had the voices and hallucinations. It [unclear] my self-esteem, my ability to concentrate, everything has just been stripped away from me. I used to do the cooking, the cleaning and everything but it's all just gone.' (4/19)*
'Um, I used to go out and used to take myself around the shops, I used to go and visit friends, used to go out at night time three times a week. Since I was last in here, I've become a recluse for the past two years in my own home.' (3/71)

This is an example of her losing even more of her identity, in that she identifies herself becoming a recluse.

Tim talks about the shift from what he was to what he has become. This is experienced as a loss of coherence in his sense of self, such that his experience of self-authorship of agency has shifted. In his words: having "gone full tilt".

Tim: *'I was a very independent person, completely independent when I had a business, in fact, I had a tendency not to see Nicola (daughter) and the boys… I've got two sons as well but yes, that's turned the other way round. Now I feel as though I depend on her, not…not…not the other way round. I got to a stage where really I wasn't able to make any decisions for myself. But I… I kind of lost my independence and then I've, I've replaced that with a dependency so that it's gone full tilt.' (72/11)*

Nick talks almost as if he has become a person who performs for others, which seems to facilitate action, since it gives both a reason to act and a guide towards action. However, his new role seems to lack meaning, as if not being guided by him. He says, "I needed to be a different person", and thus might be implying a failure to sustain action beyond the need to perform.

Nick: *'My role completely changed because I found myself at home 24 hours a day and things needed to be done. I'd needed to be a different person and I found that very hard at first, very hard indeed, um, trying to do everything at home. Instead of being out working in the factory I was, well, doing*

things at home and I found that role very difficult at first. Um, fortunately now I've got used to it and I just get up each day and get on with it, just become a normal person' (8/59). 'I think the conception of what I was and what I am has changed dramatically.' (8/69)

Phil uses polemic terminology. His experience of depression is seen as a constant battle, as if he is at war with life itself. Being battered, he expressed his experience of loss of control in comparison to his former independent experience of self. Out of his feeling of independence, he expresses his overall feeling of surrendering to an unwinnable battle. Additionally, he exhibits the sense of an overwhelming demand on his mental resources. In being suicidal, the mental exhaustion that accompanies the feeling of the relentless demands of his life was perceived as physical exhaustion too, where escape becomes the only possibility to rest.

Phil: *'Well, I have been independent and I've got to the point now where I... I can't keep fighting. You know I don't want to keep fighting. I've given up on fighting, and, and... it's sort of like a professional boxer who's gone too many rounds, I feel I've been battered so much that I don't want to be battered anymore.' (13/45)*

John echoes the idea of a self which is of no more use. It is almost as if he talks about a self that was a sequence of processes that have now ceased and with it appears to cease any future-oriented thinking, so that the idea of a potential change of the current state seems to be absent from his experience. Thus the emphasis is given to the 'no longer' past self that is experienced painfully with an inherent inability of the current self to produce change.

Phil: *'I know I just miss, I miss teaching, I miss teaching a lot and, yeah I miss study, too, mmm, so it's those things really...I used to live in Suffolk. I, I haven't lived in Suffolk since 1988 or '87. I've lived, I lived in, er, Bristol, then in Kent, then London, then Japan, then China and Mexico and then a lot of time in France. And now I'm in Essex. This says it all I guess.' (12/76-83)*

Angela again talks about an experience of stasis in terms of experiencing herself, with an inability to extend into the future. Whether she is in the hospital or outside, she remains tied to the current state of affairs, to the present moment, with no elements of future expectations or anything else to anticipate other than suicide – there is a gap where the future should be. The self appears absent from the need for self-preservation and has shifted into the hospital so as to preserve her life.

Angela: *'All your needs are catered for and [pause]. When I go, if I'm out or even here, I mean I still hurt myself here but it's, I know that it's up to a certain degree that there's ways, stuff here which I*

can do here which could never be that bad because all the, I mean the, all the ways of strangling yourself have all been taken, taken care of.' (7/17)

Similarly, Laura talks about what once was and what is getting lost.

Laura: *'I think you lose confidence in here; I think that's a massive thing, because you don't take responsibility for anything you do. I think you lose your confidence.' (7/2)*

4.3 Sub-theme 2: Helplessness

This sub-theme is about participants' sense of helplessness and their felt inability to maintain a sense of control of their lives. Most participants described suicidality as the reason that led to their hospitalisation. As if in a state of ego failure or self-break up, while admitted to hospital their self-perception was that one was *helpless* to extricate oneself from something intolerable. The participants' views and expressions of self suggest that their suicidality was far from resolved.

Pauline describes her diminished sense of agency, loss of ability to perform everyday acts, and inability to act. Her sense of helplessness perhaps signifies her inability to project herself in the future in a way that allows for an altered relationship with possible future events.

Pauline: *'A lot of that seems to be, though, as if it's been stripped away since I've had the voices and hallucinations. It [unclear] my self-esteem, my ability to concentrate, everything has just been stripped away from me. I used to do the cooking, the cleaning and everything but it's all just gone'. (4/19)*

She emphasises how she hands herself over to the hospital so that they may preserve her, thereby implying a fixation to the present, stemming from her perception of future-oriented movement as impossibly difficult and as a solid obstacle, and therefore stagnating in the present and resigning from the future.

Pauline: *'it's good to know that I've got that care there and that they're there for me, um, because I think, if I didn't have, if it happened and they didn't have hospitals and there was nowhere for me to go, I don't think I'd be able to manage getting up, let alone eating and…'(6/26)*

For John it is as if his significant others are separated from him by an abyss; no longer able to be reached. Patient identity is ingrained; his family perceives him as a patient, appearing helpless to cause any change.

John: '... haven't seen as much of my wife and it's been affected a bit, you know? It was, er, I've got to always take those tablets and I've always got to, you know, [creaking] take special liquids, things that make me feel tired and those things and I have to take them at certain times. I think those, some of those are things that affect the way your family because they're watching you as you take it, it affects the way they think about you and they're always very, like you've got to take your tablets, you know?' (11/20)

For Laura, others are as if "out to get her"

Laura: 'For example, we've had lots of discussions over the children's safety and everything, which, looking back, was reasonable, but at the time I felt like everyone was out to get me. Um, I think you think people are talking about you, I think you think people are judging you, and I think it takes away your coping strategies.' (7/6)

Very vividly, Phil talks about how depression has disordered his capacity to affectively engage with life, making multiple use of the word 'care' and signifying how depression has diminished his ability to find meaning, which leaves him helpless to think of anything else in the future but suicide.

Phil: 'I don't care about anything anymore. I really don't care about anything. And I know I don't because I don't care about tomorrow; whereas I would… if I was… if I was well, then I would be thinking about tomorrow, or I'd be thinking about next week… but I… I can't even care less about tomorrow, so I'm thinking I've got…I've gone past the stage of worrying about other things.' (4/7)

Both Phil and Angela further down express their helplessness whilst in the hospital as they convey that death is both ever-present and yet beyond their reach.

Phil: 'I'm not motivated. I'm not… because I don't care. I don't care if I have a cup of tea or I don't have a cup of tea. Um, I haven't eaten since I've been in here. I think that is… I've got no appetite, but that's just another way… in my own mind I think, and I've been thinking about this to myself, I think it's because I want to die that I'm not eating is another sort of subconsciously act, because it would never happen anyway, but subconsciously I'm trying to starve myself to death.' (7/7)

Angela: 'I still feel like I'm safe on the ward; I feel that I am safe on the ward, um, and I'm not safe off or can't be on my own off the ward because I would do, do something, I'll commit suicide, like taking tablets or strangling myself. Um, 'cause I know that they're, you know, a team, I'm, it's just like they just get on with it.' (5/2)

Pauline talks about the feeling that one should 'by rights be dead', signalling perhaps a loss of embodied self-worth where the experience of suicide is perceived by her as a part of the natural order in the sense of natural rightness, stemming from her description of herself being somehow already dead, empty, hollow, non-responsive, numb, not there. This rightness in death might reflect feelings of guilt about failing to make sense of or meeting future expectations of her life, which appear to motivate the desire to escape self-awareness by means of committing suicide.

Pauline: *'I can't make sense of any of my life at the moment, just that I'm just existing at the moment, whereas I shouldn't be. I should be where I'm meant to be, which is six feet down [crying], not above the ground, underground is where I'm meant to be.' (20/160) 'when things get too tough outside I, I prefer to just lock myself away indoors but then things tend to build up and build up and build up and then I end up doing something silly and then I end up in hospital.' (13/94)*

4. 4 Sub-theme 3: Remanence

As discussed, patients talk positively about the hospital staff taking care of them, almost as if conveying that they want to be taken care of for ever and ever. This seems to awaken and validate their dependency needs. As outlined above, most participants described the element of being cared for by others as having their daily needs met. However, although most participants appreciated the importance of being in a stress-free atmosphere, they were all critical of the fact that they had no responsibilities whilst been admitted to hospital. Some participants experienced this as a stagnating, boring experience, as a lack of trust from staff – that the self cannot be trusted – while others experienced it as a comfortable situation where one can go backwards developmentally by becoming a child again. Though patients acknowledge that the hospital environment buffers them from the demands of the outside environment, they do realise that they need to exercise some control of themselves whilst in hospital so as to respond to the routine demands of their surroundings, and that they should be expected to conform to the usual adult standards of behaviour in the hospital unit, something that does not happen.

Tim appears less concerned with not being trusted or related to as an adult and more with feeling as if they are an incompetent child pressed into enforced inactivity. Perhaps the fact that there are no expectations from a patient, almost as if any kind of anticipation is absent, points to a direction that nothing is practically significant anymore, that nothing pushes for action and so nothing offers the possibility of meaningful change.

Tim: *'I feel, there's a lack of trust …to be able to allow to do things, for example, at meal times, we all sit at a table and it's delivered by one of the help, you know, the…whatever they're called, the support workers. Whereas a simple…most of these people are capable of going to a counter and asking for something and carrying it. I think that would be good for them.' (5/43) 'Everything is done for you. You don't have to even make your bed. It's…which is a simple task of throwing a quilt over, but, ah, you're not expected to… to really do anything.' (5/48)*

Again, Angela, while acknowledging the convenience of being taken care of in a practical sense, provides a comment which captures how this is the antithesis to outside adult life, a situation whereby patients lose their independence and responsibility to the point that once they return to life outside of the institution, they may be unable to manage everyday demands.

Angela: *'I think it makes, can make me lazy, um, because not going to do things like cooking, somebody's prepared a meal for you and you haven't got to do the cleaning 'cause somebody's doing that for you. So it makes you a bit lazy, that's what going home, it's getting back into doing normal, everyday things, like hoovering and cleaning.' (6/25)*

Angela also seems to experience a lack of any kind of anticipation other than keeping herself going, which again does not offer any possibility of meaningful change.

Angela: *'well everything's done, so in a way that's I mean it's, it's not inconvenient, but if everything's done for me. I mean I make the bed but I don't have to make it, you know; the people will do it. But I mean I like to do what I can, um, but, you know, you don't ever worry about food or where it's coming from. You know that there's going to be a meal ready for you, um, and there's somebody there to help you cut it up if you needed to, so you don't have to do very much really, what you have to do to keep yourself going.' (6/17)*

Furthermore, thinking of the hospital as a second family for her indicates the familiarity of the patient to the context. Such familiarity captures the participant's confinement to the present and not being directed towards the future.

Angela: *'When I first got in here I just wanted to put the duvet over me and let the whole world go away.' (3/28) 'Now, I mean, um, if at night time when I've been on level three the nurses have been there and up with me, been up all the night, and I think that's just the way they are. It feels like they're, so really like it's a second family.' (4/1)*

Sadness, experienced in depression, can be a harsh disruptor of activity, often a quite paralysing experience in which active pursuit is suspended almost entirely. If the hospital allows this inactivity,

perhaps this makes it even harder for the depressed individual to regain or cultivate the agential element that is lost during depression.

Pauline: *'Um, it's just about sitting around , waiting for your breakfast and then your tea break and then unless you've got OT to go to, which I went today to OT, um, unless you've got that to go to, it can be very, very long, long, long day. And then you decide that, because you're getting so tired because it's such a long day because you're just sitting around…' (7/52)*

Loss of autonomy is captured in Phil's comments about not being expected to do anything whilst in hospital.

Phil: *'in some cases I think it takes away too much from people, because then they become lazy. It's great not having to worry about doing these things, but in other respects it's taking too much for granted as well. I don't have to do it doesn't mean that you can't do it.' (9/6)*

'If you're getting everything done for you, then you become so used to it that you take it for granted. And people do take things for granted. It's like anything. If they can get away with an inch, they'll take a mile and even if they're not realising they're doing it, it's… you become set in your ways'. (9/15).

Phil seems suspended in time, manifested in his inactivity and resignation whilst in hospital. Feeling as if he is a burden to others might be the result of an initial implicit reflection upon his felt inactive state. This might give rise to strong feelings of guilt and worthlessness, which might be projected onto hospital staff in the form of negative feelings about their inability to help him and produce change, hence his rejecting their care.

Phil: *'I feel I'm a failure. I'm angry because I'm still alive, and I feel that the nurses and the doctors would be… it'd be better, but if it was somebody else who could sort of take my place it would… that would benefit more than me. That's how I… that's how I… I've gone that low that I don't… I don't really want any help off anybody; because I don't think they can give me any help.' (4/15)*

Nick talks about himself in a way that echoes earlier developmental phases, where the meaning attached to being in hospital is like a kid who is punished for wrong doing, and in which care givers are treated as objects on which projections of authority figures are made, locking him in a child-like position.

Nick: *'Well, there was a need because of what I had done, but once I'd been in hospital a while I felt that I didn't need to be there anymore. I'd done my penitence so to speak and now I should be back with my family.' (5/31)*

For Laura the hospital becomes a refuge away from the responsibilities of motherhood and adulthood, where the hospital perhaps becomes an escape from the meaningful awareness of current life problems. However, she recognises that although one can receive such comfort from a life free from responsibility, it can also be possible to become dependent on it.

For her, it is almost as if she no longer feels totally integrated into her home, or into her life with the roles she has, and that she seems to symbolically perceive the hospital as yet another 'home'. The familiarity and feeling of being at home in the hospital does not mean that she experiences the positive feelings one might associate with the feeling of being at home. Something can feel both familiar and also wrong.

Laura: *'I've really, really had to… I've got really supportive family [yawns], really, really supportive husband, and he's kept me going, but I think… I can see how people slip into just becoming very comfortable in here and very much, well, this is my home, where I can permanently have to… I'm scared, I'm in here, but I'm going to enjoy it, I guess, in a way. I don't enjoy being in here; I enjoy not having the responsibility for the boys.' (8/40)*

Furthermore, her withdrawal from others while being admitted to hospital seems to be expressed not only in terms of an actual physical isolation from other people but also an emotional and experiential distancing from others.

Laura: *'…I can say to people, oh, I don't want, don't come up here till whatever time, because there's no point, and it means that I can go off and have that time, just for me, which I've never had before. I've got the five children, so I'm always, there's no space, so in a way, it's quite nice to be able to use that as an excuse, almost, just to keep everybody where I need to keep them at the moment, you know? '(6/16).*

Overall, these three themes, containment, attachment and arrested temporality, shape the experience of being cared for by others for the individuals that participated in this study.

5. Interpretation of suspicion – a more theory-driven interpretation

As stated earlier, this research attempts to offer a short, second level of interpretation, following Eatough's and Smith's (2008) suggestion that an IPA that draws on hermeneutic approaches can

provide opportunities for interpretative analysis, contextualising participants' accounts in reflections and relevant theoretical material, thus making it possible to link findings to the psychological literature.

5.1 Theme 1: Containment

The first theme of containment captures how the reciprocal action between self and world is disrupted, with the hospital becoming the boundary of these two worlds, and is often described with the help of metaphors such as : being inside a 'bubble', 'glass wall', 'glass box', or 'cocoon'. These accounts from participants remind one of Plath's (1966) 'bell jar' metaphor, signifying that the world is variously described as inaccessible to the self, or with changed meaning, in the sense of its having been lost or altered in its significance for the self. A somewhat similar view was reported by patients in the USA, interviewed by Thomas, Shattell and Martin (2002), who saw the hospital as a refuge. Rather than feeling as if the hospital was constricting them, the patients felt as if the hospital had freed them from their self-destructive impulses (p. 102). Similarly, Walsh and Boyle (2009), in their user-led research on acute psychiatric hospital services, also found that the psychiatric hospital environment does have positive aspects to it, as was evidenced by participants experiencing safety and sanctuary, and managing to develop friendships and fellowship. All of this served to combat isolation, and led to the enjoyment of some activities, and the patients referring to staff as having good qualities.

Most participants described the care they received in expressions of the staff's presence and in terms of caring interactions. This echoes themes from other research, whereby an understanding of the staff's presence in terms of spatial and temporal aspects (Iseminger, Levitt, & Kirk, 2009) is experienced by the participants, who also view the staff to be a sustaining force in which the nursing presence has created the possibility for a "caring interaction" (Iseminger et al., 2009, p. 448).
 In the nursing literature, the concepts of presence and caring are often linked. Presence has been defined as "an intersubjective encounter between a nurse and a patient in which the nurse encounters the patient as a unique human being in a unique situation and chooses to spend herself on his behalf" (Doona, Haggerty, & Chase, 1997, p. 3). Similarly, in other research, patients perceived the hospital as "a haven from the pressures of the outside world" (Walsh & Boyle, 2009, p. 35), as a place that provided time and space for reflection, personal safety, and that helped to reduce feelings of isolation by providing fellowship with other patients. The sub-theme of sheltered boundaries points towards the experience of vulnerability. Feeling safe, however, was not only about physical safety, as it incorporated an experience of both physical security and of emotional safety; in other words, a space

where the present is trusted. Patients used a mothering metaphor to articulate their experience of feeling safe. Some patients articulated experiences similar to those reported by Barker and colleagues (1999), in which "some people were more than happy to hand themselves over to the nurse" (p. 107). This seems to be related to the fear experienced when participants are outside hospital, and perhaps is due to the sense of inability they experience because they believe that they could not establish a sense of structure on their own, and thus reflects their feeling that they lack the ability to control their own lives. However, while a lack of control elicited a feeling of fear, if that situation was contained and controlled by someone else, for example the staff or the ward, the fear appeared to be more manageable while the participants were in hospital.

The element of containment was also highlighted by the significance of relationships whilst being an in-patient. The importance of relationships among in-patients has been reported in many studies (Johansson et al., 2009; Gilbert et al., 2008). Patients' relationships to each other in psychiatric in-patient care have been reported either positively or negatively, in that other patients are perceived as a safety risk that one has to manage (Quirk, Lelliot, & Seale, 2004, Wood & Pistrang, 2004), as the source of feelings of anger and aggressive outbursts (Johnson et al., 1997), and as being supportive and understanding (Johansson et al., 2007, Wood & Pistrang, 2004). McCann and Clark (2005 found that mental illness sometimes damages relationships, while at the same time eliciting support from others, and concluded that the illness acts as a mediator of social relationships. The analysis of the study' s results indicate that it could be the contextual relational elements, and interactions, as well as the person's ability to understand and have some control over those interactions, which determine how relationships will shape participants' hospitalisation experience.

What was further illustrated is that the therapeutic input received in the wards was valued by most participants. Most participants described how they appreciated therapy sessions with a CBT therapist and the CBT-oriented psychiatrist. They appeared to engage well with therapy, as it suggested ways to think about themselves and their future that might lead to a validated way of understanding their life story. Lysaker, Roe and Buck (2010) depict this process as a way for individuals to arrive at enriched narratives and increased awareness of their loss and grief, and as the next steps in restoring hope and motivation.

It has been shown that CBT's short-term, problem-focused nature makes it a natural candidate for psychosocial interventions designed for use within in-patient settings, especially when one considers the current constraints placed on in-patient care (Wright et al., 1993). Prior studies suggest that CBT offers a promising approach for the in-patient treatment of Major Depressive Disorder (MDD), both alone and in tandem with pharmacotherapy (Stuart & Bowers, 1995; Stuart & Thase, 1994; Veltro et

al., 2006, 2008). Furthermore, Page and Hooke (2012) examined the effectiveness of a CBT program for patients with depression that was adapted to an in-patient psychiatric clinic, and found that the intensive program brought about reductions in depression ratings when compared to other programs found in the literature. More generally, but importantly, it was able to achieve these gains within a two-week period, rather than the more usual 16 to 20 weeks of treatment. The authors concluded that CBT for depression can be adapted to an intensive program suitable for delivery within the model of care found in in-patient settings. Several other studies have highlighted that CBT applied specifically to patients with suicidal behaviour can decrease the frequency of such behaviour in the future as compared to other treatments (Brown et al., 2005; Tarrier, Taylor, & Gooding, 2008). Another beneficial therapeutic element of the wards seemed to be the involvement of participants' families as this facilitated a better understanding of what the participants were going through. Many randomised clinical trials have demonstrated that family-based interventions reduce relapse rates, improve recovery, and improve family well-being among participants. In addition, patients with major depression show greater improvement and significant reductions in depression and suicidal ideation when treatment includes a family therapy component than when it does not (Heru & Drury, 2007).

Finally, as most participants viewed hospital in a positive light, this seemed to imply that their initial experience was changed as their hospitalisation progressed. It thus seems important that staff appreciate the pre-existing thoughts that patients have about a psychiatric ward and allow for exploration of patients' assumptions and interpretations in their professional interactions with them. An important element that needs to be considered is what stage the patient is in in their hospitalisation and whether this is their first hospitalisation or not. For example, Lally's (1989) research showed that being admitted to hospital for the first time meant that the individual might be faced with a conflict between their prejudices toward psychiatric patients and the realisation that they are one of those patients.

5.2 Theme 2: Attached

Most participants talked about feeling emotionally alienated whilst admitted to hospital. Emotional alienation is a theme well supported in the research of depression and loneliness. Isolation, depression, and feelings of hopelessness are commonly described as emotional precursors to the suicide events for patients (Montross et al., 2014). As Graham puts it, "Depression ... is not just a mood disorder or specific to feeling or affect. It also is a disorder of care and emotional commitment as well as, oftentimes, of self-comprehension" (Graham, 2010, p. 47). This might relate to how depression limits one's ability to function and act, understand and perceive, relate and respond to,

and therefore connect with oneself and one's environment. Perhaps it captures the depressed person's feeling of estrangement from the felt meaning of practices, where one no longer finds oneself within an everyday context of activity and amidst routinely encountered possibilities for action. Hence, while the sense of ability is not entirely eroded while depressed, it is modified dramatically up to the point where the daily routine of life begins to require enormous effort, whereby the body lived in seems to 'rigidify' and turn into something resistant to action.

Another important finding was participants' sense of feeling incapacitated by their mental health conditions, and thereby giving the hospital the role of taking care of them while regressing into not having to take responsibility for themselves. Acceptance of mental illness has been repeatedly identified as important for the way people adapt to their experience and ultimately recover (e.g. Davidson et al., 2004; Jensen & Wadkins, 2007; Jönsson et al., 2008; Ridgway, 2001; Smith, 2000). However, research also indicates that acceptance can contribute to a passive stance of being a chronic patient unable to function (Kartalova-O'Doherty & Doherty, 2010), with lower levels of functioning (Warner, Taylor, Powers, & Hyman, 1989) and engulfment (Lally, 1989). Yanos, Roe and Lysaker (2010) proposed that acceptance of having mental illness can affect one's hope and self-esteem, which can then influence a range of factors, including risk of suicide, social interactions or coping. Warner and colleagues (1989) suggested that to prevent the negative impact of acceptance, the individual needs to develop an internal locus of control, while Lally (1989) found that the person should maintain a self-image of being competent while acknowledging the reality of having a mental health difficulty.

A striking aspect of depression is a marked diminishment in, or lack of, action and motivation. Amongst many other things, depression is a vivid case of mental illness undermining agency or action and characteristically involves a discord between a person's judgements, beliefs and utterances and what they do or fail to do (Smith, B., 2012). Chow & Priebe (2013) talk about clinical paternalism and how this can reinforce patients' dependency on services, but suggests that in modern psychiatric hospitals less emphasis is put on institutionalising; institutionalisation is rather displayed in terms of policy and legal framework, clinical responsibility and paternalism, or is understood as the patient's response to institutional care. Although institutional organisation and clinical responsibility aim to provide a structured and safe environment, which will facilitate the treatment process and help monitor patients, it can also unintentionally institutionalise them.

Furthermore, depression is accompanied by a loss of affective connection (Everett, 2013), suggesting that along with the presence of unwanted, unwieldy, and unattached emotions, the depressive's "affective disconnection manifests itself in the depressive's estrangement from objects, projects,

practices, ideals, other people, language, and oneself. These two horns of depression exist in a feedback loop and neither one appears to have temporal or causal priority" (p. 54). Given the depressive tendency towards withdrawal, suicidal ideation, and self-consuming feelings of grief and pain, the depressive position is isolating and the person ends up feeling overwhelmingly alone.

Most participants expressed a psychologically intensive sense of fear and anxiety at the thought of leaving hospital and openly communicated that they were not prepared to deal with the outside world, by having intense suicidal thoughts while in hospital. This could emphasise the importance of considering the patients' attachment, which in turn may foster dependency to the in-patient setting. Attachment theory holds that humans are social animals that need relationships for survival (Bowlby, 1988). Attachment behaviour is any form of behaviour that results in maintaining proximity to an 'attachment figure', usually a care giver. Such behaviour is most obvious when people are frightened, fatigued or sick, and is assuaged by comforting and care-giving (Bowlby, 1979). This behaviour can be seen throughout the life cycle, especially in emergencies, as a function of protecting a developing and vulnerable organism. For some patients the hospital, as an institution, may act as an attachment figure while a patient is experiencing a crisis or is feeling severely unwell, and might be the only place where they feel accepted or not out of place. This attachment, however, is not without cost as it is painful to acknowledge that the only place one might feel 'at home', or feel as if one belongs, is in an acute mental health in-patient ward. Moving on from the hospital appears to be potentially fraught with difficulty; the patient wants to move on from the shame and stigma of the mental health institution, but can only do this by leaving their 'secure base'. Since a psychiatric ward is an artificial and controlled social setting, participants stress the fact that it is essential to provide them with adequate social re-adaptation skills for the environment to which they will return. It seems that the hospital's atypical social interactions and routines must have substituted the normal social codes learned from society, thereby further increasing the difficulty in re-adaptation. Therefore, the in-patient to outpatient transition must be conducted in a very careful manner. Participants place emphasis on the elements of proximity to and contact with the hospital, implying that they attribute to the hospital the role of an attachment figure, with its primary importance being that of a regulator of stress and arousal.

It has been suggested that the meaning of the experience of hospitalisation can become assimilated into the patients' defence repertoire in such a way as to motivate them to maintain the hospital as a direct defence anxiety against intolerable intrapsychic conflict (Downing, 1958). Symbolically, being discharged may be perceived as being sent away from an attachment figure, which offered a protective blanket at the time of crisis. This appears to result in patients feeling unsure of themselves,

feeling as if they are losing their ability to be in control of themselves, and feeling the need to be cared for – forever and ever.

Bowlby (1980), in his description of attachment theory, highlighted the importance of safe and secure environments; however, the application of attachment theory to adult mental health services is relatively recent. Attachment theory was originally developed as a way of explaining the close bonds observed between an infant and care giver (Bowlby, 1969). Bowlby proposed an attachment system that became activated on behalf of the infant under distress (i.e. separation from care giver, threat, etc.) and caused the infant to engage in behaviours aimed at maintaining proximity to the care giver (crying, clinging, etc.). These behaviours then elicit comforting behaviour on behalf of the care giver, which calms the infant, restoring a sense of emotional well-being or "felt security" (Sroufe & Waters, 1997). How the care giver responds to the infant is of particular importance in attachment theory, as it forms the basis of the working models created early in life.

5.3 Theme 3: Arrested temporality

Finally, temporality was an interesting theme drawn from participants' narratives, in that it gave a holistic account of past, present and future echoed in participants' experiences. The theme of arrested temporality conveyed either a sense of a passive self, whereby narratives suggested that participants thought that they could not cope with their lives, or a changed sense of self as the result of depression, a feeling that their lives had undergone a qualitative shift, where the past self, or the no-longer self, was painfully experienced.

The hospital, as if conspiring with depression, seemed to play a mediating role in this shift by keeping time still. What most of the participants' accounts reveal is that their present experiences are somehow caused by an external force, thereby implying that there exists an external locus of control, and that the way in which they make sense of their experience of depression is uncontrollable and thus threatening.

Being unable to act, and likewise unable to enter into meaningful contexts in external hospital activities (such as joining a team, feeling like being a part of a group – such as a family that struggles for a common cause, having something at stake collectively, etc.), leaves one tied to the current state of affairs and thus trapped in the present moment (Slaby, Paskaleva & Stephan, 2014). This sub-

theme echoes Tellenbach's (1976) term 'remanence', referring to time, that is, to "temporal entrapment in the melancholic position, describing the familiar phenomenon of the course of existence seeming to slow down and verge on stagnation". (p. 148).

The arrested temporality was further manifested in the sense of helplessness that was depicted in participants' narratives regarding their current state and an inability to project themselves into the future. Helplessness has its roots in Seligman's (1975) concept of *learned helplessness*, which states that expectancies about the lack of control over events lead to feelings of depression. This model, refined by Abramson and colleagues (1978) proposed that *hopelessness,* the expectation that highly desired outcomes will not occur, or that highly aversive outcomes are certain, is a proximal sufficient cause of depressive manifestations. Ehrenberg has named depression a: "pathology of time", because the depressed person sees no future (Ehrenberg, 2010, p. 233). People with depression often report a feeling of time moving slower than usual, combined with a feeling of hopelessness towards the future (Ratcliffe, 2012). There is an alteration in temporality in depression where the spontaneous reaching out for the future is interrupted and the person is fixed or frozen in the present (Fuchs, 2002, p. 225).

The feelings mentioned above also link to the elements of boredom discussed earlier, whereby patients were critical of the lack of responsibility they experienced within the unit.

The literature of the experience of staff and patients in psychiatric wards highlights a major difference between the two groups of professionals and patients with respect to their concept of time. For nurses, the work shift generally moves too fast, while patients see time as standing still and with little to do other than to talk with other patients. Patients report that having so much downtime was actually hurtful, and not helpful, to their overall progress towards health while admitted to hospital. Shattell & Andes (2008), acknowledging different perceptions of staff and patients, report that one of the consequences of phenomenological research is a greater appreciation of what it is like for patients to experience something. Although nurses may feel gratified that psychiatric patients experience the hospital as a refuge from their turbulent existence in the outside world, not enough is being done to prepare patients for their return to that world. The same authors further describe how patients report feeling bored in in-patient environments, attributing the lack of structured activities as a detriment to their physical and emotional well-being. Patients frequently found that nurses on the wards often appeared too busy to spend time with them, thereby increasing patients' experiences of boredom and frustration. As a result of this, people who use mental health services often find that the greatest therapy on an in-patient unit is the companionship of other patients.

Depression in this theme is captured as a situation where the depressed individual in the deepest despair of depression finds it impossible to orient themselves towards other possibilities. Their future appears to be characterised by the absence of any future possibilities and the fundamental movement which characterises human life is interrupted, and thus the feeling of stagnation is dominant. None of the participants have reached a place where they envision a new future self. And the question is whether they will ever reach a place where they escape a static self. This is because following the diagnosis, the suffering, the process of hospitalisation, and the attempt to get to understand oneself as someone who lives under the diagnosis of depression, awaits the deep fear that depression will return and will result in losing the connection to themselves, time and the future, once again.

Chapter 5: Discussion

5.1 Interpretation of findings

The following section aims to interpret the results of the current research in the context of the research question, pre-existing literature, and relevant psychological theory. Whilst the experience of psychiatric hospitalisation has been acknowledged as stressful, very little research has explored the experience of being cared for by others from a service-user perspective. The current research thus provides an initial understanding of the experience of being looked after by mental health professionals within a psychiatric in-patient unit.

5.2 Containment

This theme conveys the appreciation of both contextual and social interactions within the in-patient setting. Relationships focused on were those formed between staff and patients and patients amongst themselves. Between staff and patients, effective communication and protection from risk at critical periods were identified as a key factor in building relationships. Staff's characteristics identified as being important were qualities such as being nice, caring, friendly, and understanding. These characteristics were valued by over half of the participants interviewed.

Participants also identified the importance of being able to relate to other patients in both a social and therapeutic way. Moreover, participants reported feeling safe as in-patients. Both the staff and the environment contributed to participants' perceptions of safety. The experience of being cared for by others was captured in the importance of the staff being around and providing a sense of control through maintaining rules and boundaries, while participants who identified themselves as high risk in terms of suicide or harm to others expressed a sense of feeling safe. Generally, participants placed particular value on the containing elements of the environment, such as locked doors and having people around who were able to handle high levels of distress. Therefore it could be argued that participants' overall positive views of hospitalisation seemed to relate to their belief that they had been a risk to themselves or others before admission, and thus saw their admission to hospital as a necessary measure in preventing further harm. Therefore, this theme's findings highlight the importance of social (relations with staff and other patients) and psychotherapeutic aspects in addition to the physically safe environment.

The study's findings add to a body of evidence which indicates that the patients appreciate receiving support for their mental health problems and having access to a safe place during a crisis (Katsakou, Marougka, Garabette, Rost, & Yeeles, 2011; Jones et al., 2009; Quirk et al., 2004; Katsakou & Priebe,

2007). Interviews with participants showed that for most of them, the ward was a place to come to when they were in need of care. It was captured as a place of refuge that gave them a sense of security, almost homeliness, and containment away from their roles outside hospital, and which appeared as a great support to these patients. The role of in-patient psychiatric care is usually depicted in the literature as being the last resort when other open forms of care have failed. But as is shown in this research, it can also become a place of refuge when mental health difficulties and suffering are hard to manage at home.

Recent research highlights the elements of coercion and lack of freedom patients experience while admitted to hospital; however, this was not something that these participants described as an element of their in-patient experience. Research shows that in-patient care can leave patients with negative experiences of feeling unsafe, helpless and disrespected by staff (Wood & Pistrang, 2004), and is associated with shame and stigma (Borge & Fagermoen, 2008; Jones & Crossley, 2008), feeling frightened and perceiving the environment as volatile and threatening (Andes & Shattell, 2006, Frueh et al., 2005, Reddy & Spaulding, 2010, Stenhouse, 2013).

Feeling frightened whilst admitted to hospital is a phenomenon widely reported by previous studies of service users' experiences of acute psychiatric settings (Jones et al., 2010, Quirk et al., 2004, 2006; National Patient Safety Agency, 2006). Though an admission to a psychiatric clinic can be a stressful experience and a source of threat to the patient as it implies a separation and a dislocation from one's familiar surroundings, the findings of this study show that most participants in this research did not talk about the hospital as a frightening place but rather highlighted its protective role from a threatening *outside*. For these participants the therapeutic elements of the ward were mostly positively perceived. The hospital was seen as a safe holding place that could temporarily take care of the person's needs, as a place that helped them to slow down, take time out from their stressful lives, as a place where they could rest and be taken care of, or as a place they could turn to when they felt they could no longer cope on their own. Generally, the hospital was seen positively, and not always in the light of a therapeutic environment, or a place of healing, but rather as a holding, safe place. Contrary to previous research, this theme illuminates that what is central to the participants is the emotional rather than purely physical aspects of the in-patient context, being felt as a containing place.

Furthermore, the theme of mediation addresses the important issue of providing family interventions within in-patient settings. This finding therefore suggests that as well as being safe and secure, it is important that the hospital environment be experienced as 'permeable'. Psychiatric hospitals have been described as 'spaces of transition', intended to prepare the service user to return to life in the

community by encouraging a degree of connection between the community and the clinical environment (e.g. Quirk, Lelliot, & Seale, 2006). The idea of transition has recently been brought forward in terms of the hospital being experienced as 'permeable'. Quirk et al. (2004, 2006), who conducted an ethnographic study of life on the ward in three acute psychiatric units in London, described the permeability of modern psychiatric units, as contrasting with the impermeability of the old asylums. In recent work, Wood et al. (2014 highlighted the idea that the design and environment of mental health care hospitals need to create a therapeutic environment which facilitates the well-being of the patients and staff, but which also needs to be equally conducive to the well-being of those who provide informal care, by providing a 'permeable' (Curtis et al., 2008) and accessible environment for the family and friends who care for patients from within the wider community. In their study, care givers prioritised a ward's permeability to relatives and community networks and argued that private visitor spaces and separate faith rooms make an important contribution to continuity of care and hence to patient well-being.

As recent UK strategies supporting care givers acknowledge the important role that care givers play as "essential partners in the treatment and recovery process" (Worthington & Rooney, 2010, p. 2), it is important to consider whether current models of in-patient care allow for such permeability. In the UK, family work continues to be seen as an intervention that is offered mostly by community services. On a more complex and specialised level, services can offer families psychoeducation, consultation, family interventions (FIs) and therapies (Eassom et al., 2014). Although family involvement is recognised by international government policies and psychiatric guidelines by stipulating that families should be supported and actively involved in psychiatric treatment, research suggests that family involvement is often not implemented in routine mental health care. Both quantitative and qualitative research report themes where families feel isolated and marginalised from the care planning process (Walsh & Boyle, 2009; Cleary, Freeman & Hunt, 2005; Rose, Mallinson & Walton-Moss, 2004). Family intervention as a treatment approach seems under-implemented; for many, contact between professionals and families remains limited to telephone calls during crisis periods (Kim & Salyers, 2008). Some suggest that this relates to general problems of implementing new evidence-based practices in clinical services (Lucksted, MacFarlane & Downing, 2012), while other research proposes barriers that are more specific to family interventions, such as the danger of an increasing burden related to care-giving, role strain, lack of experience and interest (Simpson & House, 2003).

Maybery and Reupert (2009) identified some basic barriers to the adult mental health workforce becoming family focused including: organisations often not having adequate family- and child-

friendly policies and procedures; the adult mental health workforce lacking skills and knowledge about families, children and parenting; and the workforce needing to increase their encouragement of patients by including family members and dependent children in treatment of the ill parent and by including the provision of psycho-education. The sub-theme of mediation illustrates that understanding the 'culture' of the family may greatly influence the family's willingness to work with the treatment team. Such an understanding of the "culture" of the family and the family's point of view could be the first requisites to successfully working with families, as providing psycho-education to the families of patients has been shown to contribute to strengthening family relationships, as the participants feel better understood and supported by their family. This could therefore lead to a more sustained clinical improvement for patients at discharge.

The findings highlighted that the social encounters with other patients also contributed to the experience of feeling contained. Such relationships contained qualities that only the patients between themselves could provide and had elements of the experience of being in the same situation, as in the cases of feeling unwell and needing care, having company, and sharing the experience when feeling discontented or isolated. This sub-theme of patients' socialisation with each other perhaps offers an expression of ordinariness whilst receiving an admission to hospital where the participants' need of retaining their social identity alongside the patient-identity is made possible through their interactions with each other. The psychotherapeutic culture of the unit was a significant element of the unit, contributing to a sense of feeling understood. The interactions with both participants and staff were generally seen as positive, where one did not fear judgment, perhaps due to the fact that there was no pressure to justify one's behaviour. Participants felt supported and accepted the way they were as they knew what the other person was going through, thus leading to a sense of shared understanding.

The National Mental Health and Well-Being Advisory Group (Seager et al., 2007) came up with a list of universal psychological need which Seager and Manning (2009) simplified as: the need to be loved, listened to, to belong, to achieve, and to have meaning and hope. Seager (2011) wrote that it is relationships that meet these needs, nurture people and create mentally healthy human beings, and it is ultimately only relationships that can repair emotional damage, combat a profound sense of inner alienation and lead to something that can truly be called 'inclusion' in the human world. Indeed, 'inclusion' is by definition a relationship-based concept. It follows, then, that care services for mentally tormented, vulnerable people need to incorporate the universal human developmental need to be part of a nurturing and structured environment (Seager, 2011). What this sub-theme revealed is that the health care environment on the ward turned out to include a complex web of relationships between people on the ward, and which appeared to be a major asset in patients' care. Since this was

a beneficial aspect of patients' hospitalisation, it then becomes important that staff create a relational environment of satisfying connections within the milieu; not just typical professional relationships, as it seems that the value of relating has to do with the scaffolding, or the architecture, of the therapeutic relationship. Overall, the psychotherapeutic ethos of these wards and the relationships created within the in-patient context appear to contribute to the overall experience of feeling contained whilst admitted to hospital.

The findings mentioned highlight the importance of the individual's depressive experience, their social relations with staff and other patients, and therapeutic interventions, extending to patients and patients' relationships. Thus the hospital provides the setting for particular social relationships, between staff and patients, between the patients themselves, and with their families. It is through these interconnections that the acute psychiatric unit can provide a therapeutic space for healing and the potential for the recovery of its patients. Finally, it appears that the psychiatric ward, functioning also as an artificial and controlled social setting, is essential to provide patients with adequate social re-adaptation skills for the environment to which they will return. Specifically for patients with long hospital stays, at some level it seems that the hospital's atypical social interactions and routines substitute for the normal social codes learned from society. As such, the in-patient to outpatient transition must be conducted in a very careful manner. This theme highlights how critical the period following hospitalisation is for individuals with mental disorders.

5.3 Attached

The analysis of the data revealed that the participants experienced a changed relationship between the self and the world, exhibited attachment behaviour towards the hospital as an institution, and saw the hospital as a care-giving system, mediating these two worlds. The way they talked about this suggests that they experienced a loss of affective relations to others, a loss of agency and adulthood, a loss of action and motivation and a disruptive relationship between the self and the world, where dependency and attachment upon the hospital system appeared to be the predominant form of relating to the world. This was an unexpected finding, as it was attachment and not dependency that characterised the experience of being cared for by others.

Notwithstanding the difference in origin, the literature treats dependency and attachment as being closely related, with Gewirtz (1969) using similar concepts to account for both whereby attachment is seen as a form of dependence of the behaviour systems of one person upon the unique physical and behavioural stimuli provided by a particular person, and dependency is related to a larger number of

unspecified individuals. Furthermore, dependency is treated as a manifestation of attachment that includes a wide-ranging set of conscious and unconscious behavioural strategies that reflect and affect cognitions (Bornstein & Bowen, 1995; Bornstein, 1996. The purpose of dependency, as opposed to attachment, is specifically to procure care-taking. Attachment is regarded as a broader concept, in that attachment behaviours may not necessarily specifically involve procurement of direct care-taking, but can simply involve proximity to an individual or merely an internal sense of felt security derived from the attachment (Steele, Van der Hart & Nijenhuis, 2001).

People with severe mental health problems may generally come from unhealthy, unhappy and unfortunate care-giving environments. Too often the mental health care system in the UK can be experienced as one more unhealthy care-giving environment that repeats or reinforces the problems of the past (Seager, 2006). Bowlby (1988) and Guntrip (1953) both note that care-seeking behaviour is reactivated in adults in times of illness and distress, and only abates when met with care-giving. Many in-patients upon admission adapt to their environment intrinsically, particularly those who live for prolonged periods in restricted environments. They become dependent on receiving care from services, lose their confidence when making decisions and consequently become institutionalised (Chow & Priebe, 2013). This in turn is linked to "social breakdown syndrome" (Gruenberg, 1967), which is characterised as the loss of normal role functioning with a varying degree of exclusion from typical family or community roles, which can be the by-product of any treatment that removes the patient from his or her regular social environment (i.e. long-term hospitalisation or excessive 'overprotection' on the part of clinical staff and/or family members).

Attachment theory appears to hold significance when considering the experience of care within in-patient psychiatric settings. As a theory of affect regulation and interpersonal relationships (Wei, 2008), it can provide us with a lens through which individuals view, interpret, and internalise social interactions. With staff playing a key role in the in-patient environment, and dealing with in-patients during times of distress when their attachment needs are activated (Ma, 2006), it seems important to consider the care relationship as constituting a key factor in service attachment.

The findings of this research build on previous papers highlighting the role of attachment theory in mental health care. Just as a therapist is able to create some of the parameters of a secure base when working with patients so may a service. However, although attachment theory began as a clinical enterprise, and has been usefully applied in the field of child mental health, its wider application to the everyday clinical understanding of adult mental health and mental health problems has lagged behind the available research (Ma, 2006). Along the same lines, Seager et al. (2007) also state that attachment theory provides a universal evidence base that has not yet been fully recognised or utilised

in general mental health policy and service design. He poses the vital question "If early attachments are this powerful and formative in human personality development, why is our society so blind to attachments when designing its mental health care systems?" (p. 215), concluding that this ongoing 'mind-blindness' in our adult mental health services is, therefore, potentially quite harmful, especially when it is considered that these services are dealing with the very people for whom early attachments have already gone badly wrong (p. 218).

Most participants described a rather idle life in terms of practical issues whilst admitted to hospital, experiencing themselves almost as regressing to earlier developmental stages. Regression is supported in research in which most researchers report an atmosphere of 'institutional aimlessness' in the in-patient setting (Walton, 2000, Barnes, Davis, & Rogers, 2006). Furthermore, it has been shown that there is a close connection between depression and regression. Psycho-dynamically, regression manifests itself in egocentric behaviour, referred to by Freud (1917) in *Mourning and melancholia* as when mature mental functions are given up, and the person has great difficulty making decisions often about the simplest of things and cannot take any responsibility even for themselves, becoming totally preoccupied with themselves. Thus, such an individual needs a person who can guarantee his narcissistic stability and who will relieve him of particular ego functions. According to Matakas and Rohrbach (2009) it is through admission to a hospital ward that the patient has the opportunity for regression of the anguished symptoms, the depressive mood, lack of drive, and vegetative symptoms, to improve. However, they postulate that the depressive process is not stopped through regression, but that it is less visible. The authors suggest that regression can be separated from depressive experiences by appropriate treatment procedures and thus an effective strategy for the prevention of suicide is to allow the patient to regress for as long as they are depressed and to the extent that is needed. It is this regression that protects the patient from suicide, because the negative symptoms of depression will be diminished by the possibility for regression (p. 170). However, this current research emphasises that such need, and hence allowance of the need to regress, is not without cost and might reactivate patients' attachment needs, resulting in leaving them feel unequipped to leave the hospital.

The analysis further revealed participants' feelings of lost agency while admitted to hospital. As a severe depressive experience can have a dramatic effect on how and whether a person is motivated to act, these first-person descriptions seem to support the idea that a pattern of passive behaviour occurs among psychiatric in-patients, characterised by hospital attachment and resistance or reluctance to discharge.

Depression usually sees a reduced sense of self-agency associated with negative affect, experiencing a diminished sense of self (Roe, 2005). This feature of the depressive experience, coupled with participants' experiencing an absence of responsibilities and normal activities that reflect everyday life – those ordinary tasks whilst in the ward – shows that the balance between self-reliance and external help is one that has to be handled very carefully. Personal responsibility has been identified in previous literature as important for recovery (e.g. Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; Smith, 2000; Resnick, Fontana, Lehman & Rosenheck, 2005; Tooth, Kalyanasundaram, Glover and Momenzadah, 2003). It has been linked with power and control (Bonney & Stickley, 2008), autonomy, empowerment and self-determination (Andresen et al., 2003), agency and efficacy (Davidson et al., 2003 and active coping (Onken et al., 2007, Ridgway, 2001).

A necessary requirement for self-management is a sense of agency (Slade, 2009), a self-belief that the person can have an impact on their own life. As described by most of the participants in this research, this can be a difficult process precisely because mental illness often takes away agency and thus it can be a painful and lengthy process to get to the point of actually doing that work. The "resulting avoidance often expresses itself as a wish to be rescued, fixed, made better – for someone else to take responsibility" (p. 166). Slade (2009) further claims that this avoidance behaviour pattern can create "a toxic cocktail with clinical responses" and that "when viewed through a clinical lens, it is easy to pathologise the avoidant behaviour as a personality trait or illness symptom. Responses which potentially decrease agency include focusing on compliance; imposing rather than offering treatments; responding to disagreement with compulsion rather than validation; communicating that the clinician knows the solution to the person's difficulties; and trying to fix the person. These responses get in the way of recovery." (p.167) The lack of responsibility that participants in this research experienced, combined with the structured regime of the hospital, seemed to create a climate of compliance, passive or active, towards self-care and recovery, linking the hospital and the professionals as the primary agents of care. Though obviously a depressive experience places limitations on what a patient can do or achieve, the pre-illness selves were able to manage a large number of commitments or high levels of stress, which was not true for their present selves. Although their subjective thresholds for stress had changed following the onset of illness, generally there was acceptance and allowance of the current state both from the hospital as well as from the participants. Nevertheless, the participants were critical of this aspect of hospitalisation. They almost acknowledged what Klapman stated in 1957 on his reflections on hospitalisation: "if we seek to make hospitalisation truly therapeutic we shall not overlook to what extent hospitalisation itself conspires with the patient to produce a state which robs him of all incentive..." (Klapman, 1957)

The idea of ownership regarding recovery is highlighted in recent research. Gilburt (2013) emphasised how recovery is largely framed as something that staff do, with staff being the primary agents of change. The staff take ownership of recovery, its meaning and implementation, with care provision mediated by their perceptions of recovery. Although it has been acknowledged regarding the transformation of the delivery of health and social care that care still relies too heavily on individual expertise and expensive professional input, despite patients and users wanting to play a much more active role in their care and treatment (Ham et al., 2012), this challenge does not appear to have been met. What the sub-theme of regression highlights is that the participant's response to their illness and their coping is linked to the experience of being cared for by agents of care and reflected in how and whether the in-patient milieu allows room for action and personal responsibility, or for reliance on others and pathological attachment upon the mental health system.

Furthermore, the sub-theme of separation anxiety brings out that most participants, regardless of perceiving the caring relationships in a positive or negative light, exhibited intense distress at the prospect of leaving the hospital. The thought of not being a patient somehow meant not receiving support, and as a result, one was again responsible for oneself: One was back alone with the corresponding 'freedom' (existentially) and corresponding uncertainty of the future to deal with. Attachment theory postulates that the attachment system in adulthood will be activated whenever felt security is threatened and when adults are faced with events that they perceive as stressful or threatening. Weiss (1991) suggested that relationships that can have this function of attachment occur if they display specific characteristics including proximity seeking, elicitation of threat and the use of attachment as a secure base. Thus, support-seeking behaviour (e.g. expressing distress or seeking comfort or assistance) in adulthood can be considered a manifestation of the attachment behavioural system. Furthermore, attachment theory postulates that emotional well-being in adulthood, as in childhood, will depend in part on having an accessible attachment figure who can serve as a reliable safe haven in times of need. Adshead (1998) suggested that it is reasonable to anticipate that patients with a history of failed or insecure attachments are likely to be individuals whose internal cognitive models make it difficult for them to manage very stressful situations, and who might have developed maladaptive behavioural strategies in response to either internal or external stressors. Psychiatric illness can be a particularly potent stimulator of such behaviour because of the threat to internal and external safety, and therefore such individuals exhibit attachment behaviour towards health care professionals and institutions.

There is strong evidence that a time of significantly heightened risk for suicide is the period immediately following discharge from a psychiatric hospital (e.g. King et al., 2001). Given that the participants' accounts reveal a profound isolation and alienation from the external world, the anxiety

reported about the prospect of discharge might represent the patients' attachment upon the system. Seager (2006) claims that vulnerable in-patients at a time of distress can feel more secure as they start to build certain attachments to individual staff, to fellow patients and even to the system as a kind of 'professional family' (p. 218). Thus he urges us to conceptualise the hospital not just as a place where an illness gets treated, but as a place where new attachments are sought out and also resisted, where the hope of being listened to, understood, contained and 'reached' is both re-stimulated and defended against. It should be seen as a place where new experience can repeat, reinforce or challenge old experience and, therefore, in this context any observed or apparent improvement in symptoms are perhaps the result of nascent, hopeful attachments and containment afforded by the hospital setting (Seager, 2006).

Although several studies have indicated that the period of time immediately after discharge for patients whose mental health problems lead them to require hospitalisation appears to be a particularly high-risk one (King et al., 2001), there is still no consensus concerning the existence of this increased period of risk, and our understanding of the particular reasons contributing to this risk are far from complete (Cutcliffe et al., 2012).

Loch (2014) in her current review on the negative outcomes of psychiatric hospitalisation after a psychiatric ward discharge, found that there is a great level of distress in this critical period and that most of the outcomes seem to be more or less connected to a problematic transition from the hospital, where patients are fully assisted in all of their daily life aspects, to the community, where they must re-adapt to social roles and face the obstacle of an inhospitable society.

Recent phenomenological research supports the theme of attachment as a contributing / explanatory factor for the patients' non-readiness to leave the hospital. In Cutcliffe et al.'s (2012) phenomenological study on the lived experiences of being discharged following in-patient care for a suicidal crisis, the authors found that the experience is embodied by feeling scared, fearful, anxious, and stressed, and that it brought forth concerns about being un/ill/prepared, ready and fully informed. The experience was also described in terms of how discharge from the "place of safety" would result in the termination of the social, interpersonal connections that the participants had made while in the hospital. The authors offered a psychoanalytic conceptualisation of the hospital, described as or given meaning as an 'authority' (parental) figure, that had everything in control and organised; an 'authority' that kept them safe. Hence, to be discharged from the hospital was experienced as being sent away from the symbolic parental figure. The participants were going to have to cope without the "over-shadowing protective blanket" of the hospital and the safety net this represented. As a result,

some participants described themselves as not being sure of their ability to be in control of themselves (p. 26).

This theme on attachment upon the system therefore captures the special nature of proximity to and contact with the attachment figure, the hospital, where the proximity and contact are not enjoyed as such, but are of primary importance to the attached person as regulators of stress and arousal. As discussed in the first theme, the containing environment of the wards was seen by participants as conducive to promoting safety and interpersonal relationships, and now this current theme captures how participants attach upon this system, and thus the system fails to assist them to resume their lives post-discharge. If acute care is to become more than a mechanism for addressing and containing risk, better targeted interventions are required to help individuals find strategies that are transferable to the context of their 'real' lives. Since a psychiatric ward is an artificial and controlled social setting, which might further influence the patients' social codes of conduct, it appears essential that patients are provided with adequate social re-adaptation skills for the environment to which they will return. The profoundly depressed person is in a state in which all relationships have failed. An awareness of ongoing attachment processes in depressed adult patients, family members and treatment providers may strengthen the therapeutic relationships within wards whilst receiving treatment, sustaining clients' willingness to remain engaged, and thus the illness itself might not "become the only secure base to which the patient can cling" (Holmes, 2001, p. 48), and which even when things improve will be returned to whenever new threats and stresses arise.

5.4 Arrested temporality

This theme highlights that severely depressed patients' potential for significant change in the future is lost and is substituted by mourning of a loss. The results showed that what most participants talked about were memories of their past self, returning, and going back to past functioning. Holding past functioning as some ideal outcome, however, appears in itself problematic, as dwelling on what once was and therefore should be again could turn into an unrealistic expectation that sets the person up for failure. Furthermore, focusing on past normality can prevent a patient from shifting their baseline or creating a new one. Returning to a baseline for participants therefore was about going back to better times which they described as either normality, balance or who the person once was. From the participants' narratives it is indicated that their depression placed enormous limitations on what they could do or achieve. Whereas their pre-illness selves appeared to have been able to manage a large number of commitments or high levels of stress, this was not true for their present selves. Most participants' accounts convey the same thing; that there is no appreciation that things will be significantly different, no hope, and thus minor possibility of recovery.

In phenomenological thinking on depression, touching on work currently held on the phenomenology of depression, depression is described in two main and interconnected alterations by Fuchs (2014): that of 'corporealisation' and 'de-synchronisation'. By corporealisation Fuchs means the loss of goal-oriented capacities of the body, of drive, appetite and desire, seen as equivalent to a slowing-down and finally a standstill of lived time, in which the past, the guilt, losses and failures gain dominance over the future and its possibilities. It appears from the findings that mental illness generally, and depression specifically, not only interrupts the continuity of normal life but can also be accompanied by a radical change in subjective temporality. Fuchs (2010) points out that when the body is, "isolated from the surroundings by constriction, space appears inaccessible, unreachable and detached from the potentiality of the body, where the temporal movement of life will also cease and come to a standstill' *(p. 409)*. The inhibition of lived time in depression has also been highlighted by other authors (Blewett, 1992) and disciplines.

The finding of this research relating to temporality is supported by earlier literature about disturbed time perception in mental illness, and research that has focused on time perception and its relationship in the depressive experiences (Mezey & Cohen, 1961; Lehmann, 1967; Bech, 1975; Wyrick & Wyrick, 1977; Kitamura & Kumar, 1982). Blewett (1992), in research on subjective time experience in depressed patients, suggested that as depression changes the experience of 'being' with respect to both self and the environment, it is this time experience that is the medium in which this change occurs, and also the medium in which some memory functions and anticipations occur (p. 199). Furthermore, changes to temporal experience are often reported in depression, as Andrew Solomon writes: "When you are depressed, the past and the future are absorbed entirely by the present moment, as in the world of a three-year-old ... Being upset, even profoundly upset, is a temporal experience, while depression is a - temporal" (Solomon, 2001, p. 55).

Most participants were previously functional individuals, living demanding lives. However, they all described a passive resignation and a pessimistic outlook towards the present and their future. This is an important manifestation of the depressive experience, characterised by the danger of remaining behind (Ambrosini, Stanghellini, & Langer, 2011, p. 307). This remanence has been described by Tellenbach (1976) as characteristic of the pre-morbid and inter-morbid personality vulnerable to endogenous depression. It refers to time, that is, to temporal entrapment: it describes the "familiar phenomenon of the course of existence seeming to slow down and verge on stagnation (p. 148)".

Rumination has been defined as "behaviour and thoughts that focus one's attention on one's depressive symptoms and on the implications of these symptoms" (Nolen-Hoeksema, 1991, p. 569) and has been identified as a core process in both onset and maintenance of depression. It is often characterised by evaluative thinking, with patients making negative comparisons between themselves and others, between their current state and desired state, and between the current self and past self. Rumination is considered to be a functional response, conceptualised as an attempt to make sense of an upsetting event or to solve a problem.

Although the past is important because reflecting on past experiences, achievements and setbacks can help the person make sense of what is happening now, future planning seems more significant because it can give the person something to strive for. So whilst admitted to hospital it seems significant that work with patients is directed towards and is most closely linked with being grounded in the present. As shown by the sub-themes of helplessness and remanence, participants themselves are acutely aware of being different, no longer acting in a 'normal' manner whilst admitted to hospital, and experiencing a diminished sense of self. By becoming fixated on what they have lost, whether in the past or in terms of future plans, patients have prevented themselves from seeing other opportunities for potential gains. As Torgalsbøen (2001) suggested, individuals need to be given an opportunity to grieve and let go of earlier dreams so that they can pursue other potential sources of gratification. It seems critical, then, that whilst admitted to hospital, an element of returning to normalcy is present, as this can be viewed as a sign that the illness is under control and the person is doing well. Regaining normal life, or maintaining normal lifestyle, may involve doing ordinary activities within the in-patient context as well as spending time in ordinary environments (Davidson et al., 2005). Otherwise, the experienced present may extend indefinitely and turn into what Heidegger has called a "standing now", a breakdown of existential temporality (Heidegger, 1929–30/1995, p. 123–6). Slaby et al. (2013) state that this 'standing now' has nothing to do with a blissful absorption in the present moment, but rather amounts to a total loss of what normally is the lived presence of undisrupted agency. Heidegger's 'standing now', as the phenomenal signature of profound boredom, is a wasteland of lost meaning, a desert of senseless existence that has totally transformed all of the temporal dimensions – past, present, and future (Slaby et al., 2013, p. 17).

People who have been admitted to acute care psychiatric settings often complain of boredom (Shattell, 2008), and this has been continuously reported as a common experience for service users of acute psychiatric wards. Eastwood, Frischen, Fenske and Smilek (2012) offer an existential definition of boredom in accordance with writers such as Frankl (1984) and Maddi (1970) in which boredom includes a sense of emptiness, meaninglessness and a paralysis of agency, where the bored

individual is unable to find impetus for action, is withdrawn from the world, and experiences life as meaningless (Eastwood et al., 2012, p. 484). Literature suggests there is a bi-directional relationship that exists between boredom and both physical and mental illness (Binnema, 2004; Bracke, Bruynooghe & Verhaeghe, 2006; Davidson, 2003, Martin, Sadlo & Stew, 2006; Newell, Harries & Ayers, 2011). This not only enhances the potential for one's perceived lack of purpose, but also provides an opportunity for individuals with mental illness to perseverate over the negative symptoms associated with mental illness such as chronic sadness, mania, thoughts of harming self or others, and emotion dysregulation (Binnema, 2004; Bracke et al., 2006; Davidson, 2003; Martin et al., 2006; Newell et al., 2011). Boredom and the propensity to experience boredom are associated with a range of psychological, social, and physical health difficulties, correlated with mental health symptoms such as depression and anxiety (Goldberg, Eastwood, LaGuardia & Danckert, 2011; LePera, 2011; Sommers & Vodanovich, 2000) and negatively correlated with a sense of purpose in life (Fahlman, Mercer, Gaskovski, Eastwood & Eastwood, 2009; Melton & Schulenberg, 2007). Boredom is an emotional state, in which individuals experience a lack of external stimulation and engagement with the world around them; it is often associated with anhedonia and/or inertia and has explicit links to anxiety and depression (Csikszentmihalyi, 1990; Csikszentmihalyi & Csikszentmihalyi, 2006)

Boredom is proposed to involve the desire for mental engagement and the simultaneous inhibition of such engagement. The participants of this research describe exactly this state. Though they do not explicitly talk about boredom, they nevertheless wish to (but are unable to) become engrossed in a satisfying activity. It is at this point that the role of the hospital should not conspire with the emotional state that the depressed individual already finds himself in, therefore crystallising this situation. Patients simultaneously find themselves in a paralysis of agency while acknowledging that one of the elements of being cared for should be to engage them whilst admitted to hospital. Although the theme of boredom is a repetitive one when it comes to patients' experiences of psychiatric wards, it has been mainly conceptualised in terms of the stimulation qualities of the environment. Occupational therapy, relaxation groups, music groups, cookery groups, the hospital's design, access to natural light, and nature scenes are current mainstream psychiatric in-patient activities and examples of attempts to provide stimulating environments that will alleviate boredom and promote well-being. However, Steele, Henderson, Lennon and Swinden (2013) stress that although meaningful therapeutic activities are vital, mental health professionals should focus on the internal as well as the external dimensions of boredom, arguing that boredom may relate to the internal experience of meaning, which itself encompasses meaningful relationships and roles and a sense of control.

Chapter 6: Overview and Conclusions

1.   Chapter overview

This chapter offers an overview of the main findings by describing the meaning participants conveyed of their experience as emerging from the super-ordinate themes and sub-themes of the interpretative analysis of data. The chapter then considers the relevance and implications of the findings for counselling psychology. The overview concludes with an evaluation of the current study and makes suggestions for further research.

2. The meaning participants conveyed

The feeling of estrangement in relationship to the world, the alienation of oneself, and finally the loss of intentionality and agency are all common experiences of depression (Ratcliffe, 2015). This study explored what it is like for a depressed person to be cared for by others in an in-patient setting. This qualitative study shows that to the patients, care can mean many things. It is not just concerned with reducing the element of risk. It has been acknowledged that risk management, rather than dealing with patient problems, has become the focus of ward management tasks (Richards et al., 2005; Bee et al., 2006, Ratcliffe, 2006). This study shows that elements of care extend beyond the alleviation of risk that care can provide. The findings show the importance placed by participants on the containing elements of the ward, manifested in their feelings of safety, in the psychotherapeutic input they receive and in their relationships with other patients in the acute care context. Findings further illustrate that participants describe elements of attachment towards the mental health hospital, perhaps reflecting the perception of a lack of secure attachment outside hospital. These elements of attachment were conveyed in the participants' regressive behaviour, exhibition of fear to leave the hospital, and feelings of containment whilst receiving care. These elements of the care context appear to crystallise participants in their current position, as suggested by the third theme, not allowing them to move forward, whereby time perception seems to be changed, temporality dissolved and the experience of time focused on the present. The present is experienced as idleness, and excludes a future.

The results illuminate the meaning of the care-receiving experience, and bring forth the need for in-patient service processes to help individuals feel able to live their lives and not see them as having a disease that needs to be cured (which can be what the medical model reduces individuals to). Illich (1975) argued that the term 'diagnosis' gives the person a certain role that they associate with incapacity, uncertainty, and non-recovery, and separates them from the normal and healthy. Goffman (1961) escribed this role as a deprivation process, degrading the person's self-perception by peeling

off much of what the person has perceived as self, a sort of objectification process. Recent research describes recovery as a fundamental personal process involving an inner new sense of self and hope, which requires outer conditions that facilitate a positive environment of healing (Kogstad, Ekeland & Hummelvoll, 2011). As previously mentioned above, the emphasis in in-patient psychiatry is very much on the clinical practice and the worlds of psychiatric professionals. Thus, there is a need for qualitative studies involving patients, so as to throw light on the meaning participants give to the experience of care-receiving (Shattell, 2008; Quirk & Lelliot, 2001, 2006).

Subjective experience, by its very nature, does not lend itself to statistical analysis. Phenomenology does not approach symptoms of mental illness as isolated diagnostic criteria as medical science does, but in relation to the person and to the whole of the conscious experience in which these mental health experiences emerge. Thus this paper has contributed to the exploration of the personal meanings of this particular experience of being looked after as exhibited in this specific context, the in-patient one. Fuchs (2012) emphasised that every psychopathological experience is characterised by a personal meaning that patients attribute to it and a stance that they take towards it; suffering passively, giving in, acting out, fighting against it, or detaching themselves from it are some of these stances. This study has highlighted those critical periods of hospitalisation that can be very informative, and which can both contribute to our understanding of the form of the participants' experience in general, and aid in interpreting their depressive experiences specifically. The results have contributed to our understanding of the in-patient world from a psychological standpoint, showing that for the participants, receiving care had antithetical qualities; alleviating suffering while at times activating patients' attachment needs, which might in turn lead to the crystallisation of their mental health conditions. The alleviation of suffering was accommodated by the experience of feeling contained, from being supported, forming attachments with the mental health system, and having a therapeutic place of refuge on the ward. In addition to this, the experience of being attached and temporarily stagnant whilst admitted to hospital was also highlighted, underlining the somewhat antithetical qualities found within the experiences of receiving care and being looked after.

Ratcliffe (2013) proposes that "depression involves a radical departure from everyday experience" (p. 3). He conceptualises depression beyond intensification of certain familiar aspects of the depressive experience, such as feeling sadder, or more tired and less energetic. According to him, first-person accounts of the depressive experience indicate that it involves something quite alien to what – for most people – is mundane, everyday experience, whereby the depressed person finds themselves in a 'different world', an isolated, alien realm, adrift from social reality. This study therefore builds upon such an understanding of the experience of feeling unwell and being looked after by others, emphasising the significance of seeking an understanding of in-patient experiences.

Such an ability to appreciate and communicate what the in-patient experience is like will inform psychologists working within the NHS, and thereby enable them to address and implement attachment theory in adult in-patient psychiatry. By implication, throwing light on the understanding of the in-patient experience of care can have considerable therapeutic potential, by enhancing our understanding of how people who have been admitted in hospital feel and think about this experience.

3. Critical evaluation of the research

3.1 Strengths

This study has drawn attention to an area where qualitative research has been sparse, and mainly undertaken by researchers from other disciplines such as psychiatry and nursing. Research that focuses specifically on the depressive in-patient's experience has been even more limited as the majority of the studies conducted in this area have mainly focused either on different diagnoses or on a professional's experiences. This study gives a voice to patients to express their personal experience, and provides an opportunity to gain a deeper understanding of the unique challenges they face because of their identity as patients and mental health sufferers. The qualitative methodology has enabled patients to reveal, in their own words, a rich portrayal of their experiences. Therefore, the study has shed some light on how patients see themselves, what they think and how they feel in their internal states and in their interactions with others, and what it is like to be cared for by others.

In addition, this study contributes to our knowledge of how attachment theory is relevant to the adult in-patient context. This study has highlighted that as counselling psychologists we must be concerned with how the in-patient experience affects our therapeutic relationship with clients, as the need for understanding the psychological impact of the in-patient experience will be pertinent for many. Therefore this study has highlighted the complexity of the adult in-patient experience, from a psychological stance, and contributes to counselling psychologists' knowledge of the meaning that in-patient individuals attach to this experience and the psychological impact of one of the most important forms of care for vulnerable patients.

Regarding the generalisability of results, the researcher believes that the role of the researcher on data generation, i.e. the design of the interview schedule on which the questions were generated, as well as the role of the researcher during the interviews, are of importance to qualitative work. The use of the focus group acted as a working arena in which the assumptions as well as pre-conceived ideas of the researcher could be juxtaposed, as the focus group acted as a means to open up the experience and allow external contextualised input from service users who have had experience of the phenomenon under exploration.

As far as the credibility of the interpretation is concerned, it was facilitated by having two colleagues not involved in the study to check the plausibility of the analysis of data, but also to ensure that the explanation fitted the description. Moreover, attention was paid to discrepant data as the analysis maintained a balance between what was distinct to individuals and what was common to the group as a whole. The thematic analysis has highlighted elements of the experience of being an in-patient in psychiatric wards, and these themes have been explained and conceptualised through the framework of psychological theories in order to inform the work of counselling psychologist professionals working with the in-patient population.

3.2 Limitations

In considering the generalisability of these findings, it is important to take into consideration the intrinsic limitations of qualitative methods, including IPA. While qualitative methods offer depth, the generalisability of the findings is limited. The analysis is context-specific, and as such, other interpretations of the same material are possible. The researcher acknowledges that her experience as a researcher and her current professional and personal experiences could have also affected the analysis of the data. Although the findings may not be able to be generalised in the traditional sense, "each specific reader who derives insight from the study may be thought to extend its generalisability" (Thomas & Pollio, 2002, p. 42). According to Pollio, Henley and Thompson (1997), "Existential–phenomenological philosophy provides grounds for believing that reflections emerging in one dialogic context will not be incommensurate with, even if different from, those emerging in another context" (p.34).

The sample itself also prohibits the generalisability of findings as a different sample of patients and a different in-patient setting might have revealed different experiences. The use of a single National Health Service trust site also limits generalisability. Although contributions were predominantly based on the experience of care in one psychiatric unit, some participants had experience from other admission units too. However, the focus group employed by the researcher to generate the research interview guide allowed for the development of ideas, hypotheses and inferences as they are reported by other service users, thus making them relevant to any psychiatric in-patient.

Furthermore, the participants of this study all had higher-level educational backgrounds. While this might have been an idiosyncrasy of this particular sample, this high number might reflect the greater degree of comfort that more educated individuals feel when participating in research interviews, being more familiar with the research process per se and thus less intimidated. It should also be noted that

the responses of the participants were dependent on the psychological state they were in and how much their illness interfered with their responses at the time of the interviews.

3.3 Reflections on the research process

I received my in-depth education in qualitative research methods as a master's student, where I had the opportunity to delve into philosophical works of existential phenomenology, and the existential approach in counselling psychology practice. During my masters, I conducted qualitative research on the exploration of the experience of being old, which gave me a first-hand experience of a qualitative approach in research.

By reflecting on the initial stages of my research for the present study, I realise that in the beginning I held several stereotypes and assumptions about the experience of receiving care. What I realised during the process of this research was that when conducting research on a familiar area, one that relates to one's work, there is a need for an extra degree of carefulness. A useful thing that I had in mind was to regard myself as re-entering the field with fresh curiosity throughout the whole research process, and allowing the participants to walk me through their way of making sense of their experience of hospitalisation. This is in parallel with the role of the researcher in IPA, where a reflexive attitude needs to be maintained. Reflexivity refers to reflecting, thinking critically, sensitively, sincerely and candidly about the research experience and process (Willig, 2001).

In relation to the current study, further additions and new insights were happening as the study was progressing. At times, this constant reflection seemed chaotic and exhausting. Discussions with my research supervisor helped me to stay grounded in the data and become aware of earlier conceptualisations. Peer discussions with IPA researchers were very helpful indeed, as they provided an arena for thinking and rethinking about how my own beliefs and assumptions may have influenced the way in which I engaged with and made sense of the data, thus it raised my awareness of such issues and kept me constantly mindful of them.

The recruitment phase was rather smooth. The researcher was warmly welcomed by participants in the ward. Most participants agreed to take part in the research instantly, which perhaps reflects how patients value being listened to by others. With all the participants I could sense a contributory and participatory element in them that made them willing to talk to me. Of course, maybe this could also be a reflection of the sense of boredom participants can feel in the wards, but their willingness to take part seemed more to reflect their need to contribute to something that related to them. My contact and

time spent with the participants was a very intense experience for me. First of all, I was relating to patients from a different angle and with a different role – as a researcher and not as an in-patient psychologist. That was a prototypical experience for me. It is my experience that patients view an in-patient psychologist as a part of the overall therapeutic team and thus each contact relates to their mental health experiences. In this encounter I felt I was viewed as a separate human being and not as part of an overall therapeutic team. I felt that they sensed that I was purely interested in them and what they had to say on a personal level, instead of from a therapeutic intervention angle.

I found the bureaucratic elements of the NHS ethical approval process to be very time-consuming. Although in the end I had a very positive feedback, positive results and minimal corrections to make to my initial application before a favourable opinion was given, producing an application of the quality required to satisfy the committee was a time-consuming and labour intensive task. Of note is the fact that the form was not initially designed to be completed by someone planning to undertake qualitative research, but in the researcher's opinion, they have revised the form to satisfy the needs of qualitative researchers. For example, there is a need to submit research materials in advance, which doesn't fit with the more flexible research design of a qualitative study. The emphasis in qualitative research on its potential to produce unexpected outcomes rather than rely on predicted hypotheses puts the researcher in a place of having to negotiate and justify a degree of flexibility in the research design. Therefore, apart from the time element to actually prepare this very long form, another theme was feeling acutely that I needed to justify my research, not only in ethical but also in methodological terms, meaning that I needed to educate a panel about qualitative research. Although an absolutely necessary process for all research, and despite the NHS having a responsibility in assuring the quality of the work being done, it is my belief that the approval process is historically informed by and tailored to quantitative research, a fact that is reflected by the nature of the questions regarding the research design. I believe that the novelty and newness of qualitative work within the NHS is reflected in the overall ethics process, and could discourage qualitative research conducted with in-patients. I do not suggest the idea of a different pathway to qualitative research, as this would continue the historical debate over the quantification and qualification of data. Rather the opposite. I feel that the process developed to date reflects the ongoing dominance of a traditional medical model, in the form of quantifiable data and results. A less sceptical attitude towards qualitative work in a medical setting and an acknowledgement of the use and importance of qualitative research within the NHS should be evident within the whole ethical process. I do acknowledge, however, that obviously my experience is shaped from a single case situation. There may be other researcher committees that are equipped with more methodological and theoretical expertise relating to qualitative research.

4. Implications for Counselling Psychology

The findings of this study contribute to in-patient professionals' understanding of the patient experience, thereby facilitating the development of in-patient counselling psychology practice. It also extends into the importance of the service user in being cared for by a care-giver who is also contained. Containment thus goes beyond the mindful support available to the patient or service user. Counselling psychologists working in in-patient units need to become more actively involved in the containing elements of an in-patient setting, transferring what happens in the microcosm of a one-to-one therapeutic relationship to the macrocosm of the in-patient context.

Participants in this research experienced the hospital as a containing place that clearly kept them separated from external reality, up to the point where the outside world appeared threatening. As mental health illness brings forward feelings of threat, anxiety and isolation, it is important that the hospital, whilst becoming that containing environment, also provides a permeable environment where the inside/outside distinction is not too bold. As the results revealed, family involvement within the in-patient unit is significant. As Papoulias, Csipke, Rose, McKellar, & Wykes (2014) point out, the therapeutic potential of modern mental health care units is constrained not only because of the need to accommodate the needs of different groups, but also because such units crystallise an inherent tension between two contradictory policy requirements: first, that they function as spaces of seclusion; and second, conversely, that they facilitate a transition to and integration within the community (p. 174).

As the results illustrated, the need to attach whilst in hospital can be quite powerful, be it either to others, staff and patients, or to the care system itself. When a patient enters a ward, they are alone – cut off from their attachments. This structured containment provided by the network of attachments (including the other patients) within an in-patient unit that provides the very sense of security, may ironically trigger 'symptom relief', leading to premature discharge and a fundamental rupture of containment that may lead to suicide (Seager, 2006). Therefore, an important element for counselling psychologists working in in-patient settings is to explore the effects of such attachments with the patients and hospital staff, as well as build this into the discharge planning process by exploring with patients other available attachments once discharged, such as community teams.

Furthermore, finding a pattern that runs through the patients' relationships – past, present in the outside world and current within the ward – could be a powerful therapeutic tool that can enhance patients' understanding of their interpersonal difficulties, and which could be based on attachment

theory implemented in the culture of the ward. A healthy balance between a nurturing intuitive 'feminine' aspect and a boundary-setting, protective 'masculine' function of the hospital could facilitate recovery. Holmes (2015) suggests that this applies just as much to looking after patients as it does to bringing up children, in that the damaging separation between a 'feminine' intuitive psychotherapy and a 'masculine' scientific psychiatry needs to be overcome (p. 68).

The results highlighted the significance of psychotherapy within the unit, emphasising the importance of psychological interventions that will help in-patients benefit the most whilst admitted to hospital. As stated earlier, all patients talked about how helpful psychotherapeutic interventions and CBT were for them. Parallel to this, they talked about feelings of helplessness and idleness whilst in hospital, as they experienced a lack of normal everyday activities and responsibilities. Thus hospitals need to stimulate opportunities for patients, not just in terms of activities, but mainly in terms of allowing the experience of meaningful relationships and roles so as to gain a sense of control that will reduce the sense of boredom.

Counselling psychology needs to develop within an interdisciplinary approach and be informed as well as continue the tradition of philosophical and clinically oriented phenomenological reflections on psychopathology. Fuchs (2000) and Ratcliffe (2012), for example, have worked extensively on the phenomenology of temporality in depression and its relation to psychopathology in general. This is the type of research which needs to inform counselling psychologists' practice within the in-patient context. As stated earlier, human beings actively constitute time through their thoughts and actions. We do not live in an objective time. Whereas objective mathematical time simply passes, lived human time develops. It is well known that time experience is relative and dependent upon many, more or less objective, factors, such as age or the type of activity in which one is engaged (Draaisma, 2004). This theme creates suggestions and points to pathways regarding therapeutic intervention at those stages that could help patients to move along. The vision of a future where the person is not dominated by illness seems to be an important part of recovery.

Another important implication is the vital role of the hospital in injecting normalcy into the in-patient context, so as to prepare patients to reconnect with humanity and others. Counselling psychologists can then have an explicit and important role in in-patient psychiatry, not only helping psychiatric nurses in implementing this element in their everyday practice, but in also continuously establishing a psychotherapeutic culture in the in-patient wards. Cutcliffe et al. (2007), regarding the psychiatric nurses' role while working with suicidal people, stress the significance of reconnecting patients with humanity, whereby nurses need to represent humanity. Through the nurse-patient interaction, the patient then reconnects with another human being, thus taking the first steps to reconnect with

humanity. When the nurses are impersonal, the hospital takes the form of or imitates external reality, where patients feel isolated, unnoticed and disconnected from others.

Recent research supports the hypothesis that CBT can reduce suicide behaviour in the short term. Tarrier et al. (2008), in a meta-analysis of Cognitive Behavioural Interventions and suicide behaviour, reported that there appears to be a reduction across the spectrum of suicide behaviour with CBT treatment, thus concluding that treatment is effective when directly focused on reducing some aspect of suicide behaviour but not when focused on other symptoms, such as depression or distress, with a view to reducing suicide behaviour as a secondary effect.

The findings mentioned highlight the importance of the individual's illness experience, their social relations with staff and other patients, and therapeutic interventions extending to patients and patients' relationships. The interconnection between the social, physical and interpersonal aspects of the hospital setting provide pathways for improving patients' perceptions of the hospital as a safe place in which to recover. The author therefore recommends that attention be paid to these aspects in order to ensure that the psychiatric hospital functions as a therapeutic landscape. Feeling safe in the therapeutic interaction with staff in the psychiatric in-patient context is one significant element of patients' person–hospital encounters; another is the importance of feeling safe in relation to interactions with other patients. The existence of these elements appears both possible and able to be reinforced through the existence of the psychotherapeutic input and psychotherapeutic culture that the unit cultivates. Finally, this study showed that attachment theory holds significance when considering the experience of care within in-patient psychiatric settings, and this will be significant for counselling psychologists in their work with in-patients.

5. Suggestions for further research

The study showed that the support of fellow patients has a value as a complement to the care given by staff members and next of kin, and this is something that needs to be further investigated. In addition, the exploratory nature of the current study means that it provides a starting point for a wide range of future research. For example, it would be interesting to conduct similar studies with other participant groups or in more psychiatric settings to see if similar issues emerge.

In terms of qualitative research, the experience of hospitalisation within the NHS warrants further investigation from the field of counselling psychology. Further psychological research is needed to explore the affective responses of patients and the effects of hospitalisation on patients.

It is vital that the psychological needs of people who have been admitted to hospital are adequately addressed within counselling psychology, particularly in terms of their attachment needs as well as in terms of maximising the supportive aspects of their relationships with other in-patients and staff in the context of the ward environment.

The lack of qualitative psychological research conducted with NHS in-patients to date highlights the need for further qualitative research conducted from the service-user perspective.

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Appendices

Appendix I: Interview topic guide

Background Questions

- What has been your length of stay here in the hospital?

- Is this your first stay at an in-patient unit? What has been your previous contact with services?

Context information – participants' views of current hospitalisation

- Can you start off by telling me a little bit about what brought you here?

- What is it like or feel like to have all these professionals caring or looking after you?

- What is it like to be cared for?

- What are your feelings about being here?

Aspects of hospitalisation / Links of depression to the sense of self – issues of in/dependency

- How has being in hospital now affected you, in terms of emotions, worries, fears successes in terms of e.g. leaving here?

- What about positive aspects and less positive ones about being here?

How they perceive their own role in their lives, and how this has changed over time through the depressive experience

- How has depression affected you?

- What is it like being ill?

The role hospitalisation has played in their sense of self

- How has your sense of yourself changed over the time that you've been in hospital?

Their perception of the development of their relationship with others

- What about your relationships? Have they been affected (with staff/other residents/family/friends)?

Concluding the interview:

- Thank you for taking part. Express how their views are very appreciated.
- Ask "Do you have any questions you would like to ask about the interview?"
- When the research is finished would you like to see a summary of the results?

Appendix II: Information Sheet

1st September 2009
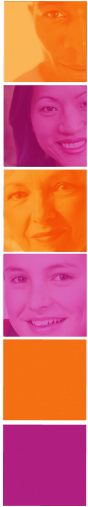
x Partnership **NHS**
NHS Foundation Trust

Participants' Information Sheet

We would like to invite you to take part in our research study. Before you decide if you want to join in, it's important to understand why the research is being done and what it will involve for you. So please consider this leaflet carefully. Talk to your family, friends, doctor or nurse if you want to.

Part 1
About the researcher:

I am Aria Christopoulou, Psychologist and also a doctoral student undertaking this research at City University as part of an academic qualification.

This study has been reviewed and approved by the ……. 2 Research Ethics Committee.

The following information will help you to get an understanding of the study, and also decide whether you would be interested in taking part in this research.

Study title: Dependency, Depression and Hospitalisation; Investigating the lived experience of being-cared for by others (mental health care professionals) in in-patient Psychiatric wards.

Why are we doing this research?

I am studying the experiences of care of individuals who are in hospital suffering with depression. I am collecting data from people who suffer from depression and who are in-patients of this mental health unit to enable me to investigate what it is like for you to be cared for. The research question is "what is it like to be cared for by others" in the sense of being supported by others. Knowing more about this will help me better understand the needs of people suffering from depression.

Why have I been invited to take part?

You have been invited to join our study because you have Depression and you are in hospital, so you are in the best position to throw light on the experience.

Do I have to take part?

No. It is up to you. If you agree to take part, we will ask you for your consent and then ask if you would sign a form. We will give you a copy of this information sheet and your signed form to keep. With your agreement, the researcher will then inform your consultant psychiatrist of your participation. You are free to stop taking part at <u>any time during the research</u> without giving a reason. If you decide to stop, this will not affect the care you receive. If you decide to stop, or you are unable to continue after your interview has taken place, then the data of the interview will be used by the researcher, but you will not be required to do anything else.

What will happen to me if I take part?

Your participation will involve a conversation with the researcher that will last for about an hours and will be audiotaped. In this interview I am going to be asking some questions about your experiences of care. This will help me to gain a better understanding of what is it like for you to be cared for by others. Then, I will try and make sense of all that you shared with me and compare it to the views of other participants. In order to make sure that I have rightly understood what you have told me I will send you a copy of my results and you can let me know yourself if you agree with my understanding.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get might help the way we treat people with depression in the future.

What are the possible risks of taking part?

You might become distressed during the interviews. As I am a fully trained psychologist, we will work with your distress together. Alternatively, I can refer you to someone else who could help you.

Who can I contact?

Please contact Aria through any member of the nursing staff, if you are interested or you would like to ask questions.

Thank you for reading so far – if you are still interested, please read Part 2:

Part 2

Confidentiality

All the material will be treated with confidentiality and your names will be disguised so anonymity can be assured. The material of the audiotaped interviews will be stored in special memory sticks that only the researcher will have access to. All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you which leaves the hospital will have your name and address removed so that you cannot be recognised. Some direct quotes from your interview may be used in the final report for this study, but will be used in a way that will not identify individuals who have participated in the study.

Only in the event that the researcher feels that you or somebody else is at risk will your consultant psychiatrist and supervisor be informed.

What will happen to the results?

All material from our interviews will be analysed and will then form the results of this research. Research will be published in relevant scientific journals.

Will anyone else know I'm doing this?

Only members of the internal clinical team who are involved in your care will know about your participation. With your agreement, the researcher will inform your Consultant Psychiatrist about your participation in the study.

What next?

If you wish to take part in this research just let me or your named nurse know. If you decide to take part, and for any reasons during the study you decide that you would like to withdraw, you can do so without further obligations. All you need to do is to let me or nursing staff know. You will not have to discuss the reasons for your decision.

Where can I get more information?

If you have further queries, questions, or you would like for us to meet and discuss in more detail, you can contact Aria Christopoulou through the nursing staff.

Thank you.

Appendix III: Consent form

<div align="right">

Partnership University **NHS**

NHS Foundation Trust

</div>

1st September 2009

CONSENT FORM

Title of Project: Dependency, Depression and Hospitalisation; Investigating the lived experience of being cared for by others (mental health care professionals) in in-patient Psychiatric wards.

Name of Researcher: Aria Christopoulou

	Please Tick
1. I confirm that I have read and understand the information sheet dated 1st September 2009 (version IV) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	
3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from the clinical team of NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
4. I understand that the interview that I will take part in will be digitally recorded and stored on password-protected encrypted memory sticks and will be deleted after transcription. I agree to this as well as the transcription of the material. I understand that the material will be anonymous and I will not be identified at any point of the study.	

5. I agree to the researcher informing my treating Consultant Psychiatrist of my participation in the study.	
6. I agree to take part in the above study.	

Name of Patient   Date   Signature

Name of Person   Date   Signature

taking consent

When completed: 1 copy for participant; 1 copy for researcher site file; 1 (original) to be kept in medical note.

Appendix IV: Consultant information sheet

Partnership University **NHS**
NHS Foundation Trust

Dear Dr ….,

Re: Research Participation

I would like to let you know that I am conducting research within the service and that one of your patients, Mr ………. has expressed his willingness to participate in this research.

The research title is: "Dependency, Depression and Hospitalisation: Investigating the lived experience of being cared for by others (mental health care professionals) in in-patient Psychiatric wards". The objective of this research is to understand the experience of service users being cared for by others (mental health care professionals) within in-patient psychiatric settings and the links between this experience and the depressive state.

Participants will be in-patients of the Mental Health Unit with a primary diagnosis of depression provided by their consultant psychiatrist fulfilling DSMIV, or ICD 10 criteria. Their participation will involve an hour's interview that will take place in the wards, whereby I will be asking them questions around their experience of being cared for by others.

Firstly, patients are informed of all aspects that are relevant to their decision to participate. When a patient voluntarily confirms his or her willingness to participate in the research, I will seek their informed consent, documented by means of a written, signed and dated informed consent form.

Should you require further information on this study, please do not hesitate to contact me.

Thank you very much for your anticipated cooperation.

Aria Christopoulou.

In-patient Psychologist

In-patient & Recovery Unit

Appendix V: NHS Ethical approval

……. Research Ethics Committee

Terminus House

9th Floor

The High

Harlow

Essex

CM20 1XA

 Telephone: 01279 419312

Facsimile: 01279 419246

28 September 2009

Miss Aria Christopoulou

Dear Miss Christopoulou

Study Title:	Dependency, Depression and Hospitalisation; Investigating the lived experience of being-cared for by others (mental health care professionals) in in-patient Psychiatric wards.
REC reference number:	09/H0302/94
Protocol number:	Version III

Thank you for your letter of 01 September 2009, 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 in consultation with the lead readers for your study.

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, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. *Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.*

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

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

Document	Version	Date
Supervisor CV Dr Seema Quraishi		
Sponsor Letter		14 July 2009
GP/Consultant Information Sheets	Version III	19 July 2009
Interview Schedules/Topic Guides	Version III	19 July 2009
Protocol	Version III	19 July 2009
Investigator CV		20 July 2009
REC application	Version 2.2	20 July 2009
Covering Letter		01 September 2009
Participant Information Sheet	Version IV	01 September 2009
Participant Consent Form	Version IV	01 September 2009
Letter from Aria Christopoulou		01 September 2009
Response to Request for Further Information		01 September 2009

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 Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

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@nres.npsa.nhs.uk.

09/H0302/94	Please quote this number on all correspondence

Yours sincerely

Mr …..
Chair

Email: ………….@eoe.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Mrs ………
R&D office for NHS care organisation at lead site

Appendix VI: City University London Ethical approval

Ethics Release Form for Psychology Research Projects

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

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

An understanding of ethical considerations is central to planning and conducting research.

Approval to carry out research by the Department of Psychology does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.

The published ethical guidelines of the British Psychological Society (2004) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.

Students are not permitted to begin their research work until approval has been received and this form has been signed by 2 members of Department of Psychology staff.

Section A: To be completed by the student

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

BSc ☐ MPhil ☐ MSc ☐ PhD ☐ DPsych ✓ n/a ☐

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

1. Title of project

Investigating the lived experience of individuals diagnosed with depression of being-cared for by others (mental health care professionals) in in-patient Psychiatric wards.

------

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

Aria Christopoulou

████████████████

████████████████

████

Tel: ████████

Email: ██████████████

----

3. Name of research supervisor

Dr. Jacqui Farrants

----

4. Is a research proposal appended to this ethics release form?   Yes   No

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

If yes, a. Approximately how many are planned to be involved? ---

- 8-12 participants

  b. How will you recruit them?

Participants will be recruited from those individuals who have been admitted to the Mental Health Unit , ……Hospital for treatment. Patients with a 4-week or more of hospital stay who satisfy the inclusion criteria will be given an information sheet by a member of the nursing team

c. What are your recruitment criteria? --

(*Please append your recruitment material/advertisement/flyer*)

Inclusion criteria

People aged 18 onwards, who have been admitted in the acute wards of the Mental health Unit/ ….. Hospital with a primary diagnosis of Depression provided by a consultant psychiatrist ,fulfilling DSMIV, or ICD 10 criteria (DSMIV,APA 1994, ICD 10, WHO,1990).

Able to give informed consent to participate in the study (this is in line with ethical practice in the conducting of research)

Fluent in English. (Given the nature of the methodology employed, the analysis of results be based upon the interviews therefore it is essential that researcher and participant are able to communicate with each other in a manner that enables the shared understanding of dialogue to be achieved).

d. Will the research involve the participation of minors (under 16 years of age) or those unable to give informed consent?   Yes   No

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

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

Interviews: The duration of these interviews will be approximately 1 hour and will be digitally audio-taped.

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes   No

If yes, a. Please detail the possible harm?

Measures to safeguard risk will be followed in line with best clinical practice. Furthermore, as a counselling psychologist I have the necessary skills should the participant become distressed during the interview. Alternatively, I can refer them to someone else who could help them. Any risks to the participant or others that will be communicated or identified from the principal researcher will be communicated to their Consultant Psychiatrist and to the clinical supervisor.

 b. How can this be justified? ---

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

Yes   No

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

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

Yes   No

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

Yes   No

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

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

computer records, tape/video recordings

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

All notes and correspondence will be kept in a locked filling cabinet and/or stored on password protected NHS computer facilities/ NHS encrypted memory sticks. Furthermore, the host organisation will be anonymous, so that the anonymity of the participants is not compromised. The host organisation will be described in generic terms in the final report.

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

All notes both electronically as well as paper notes will be deleted/ shredded.

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

Individuals identified to be suitable participants after screening will be given an identification number which will be used throughout the writing up of the research and any subsequent publications.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

(*Please append any de-brief information sheets or resource lists detailing possible support options*)

The outcome of the study will be made available to participants through a brief summary report as requested.

At a service level, the results will be discussed with the Lead Psychologist of the In-patients and Recovery units , as well as the Head of the Psychology service in … in terms of their implications for service planning and delivery. The study comprises my doctoral research in Counselling Psychology, City University. It is anticipated that the findings of the study will be written up and submitted for publication in relevant scientific journals.

If you have circled an item in bold print, please provide further explanation here:

Signature of student researcher Aria Christopoulou   Date : 22.07.2009

Section B: To be completed by the research supervisor

Please mark the appropriate box below:

Ethical approval granted   ☐

Refer to the Department of Psychology Research Committee   ☐

Refer to the University Senate Research Committee   ☐

Signature --   Date-----------------------
-

Section C: To be completed by the 2nd Department of Psychology staff member *(Please read this ethics release form fully and pay particular attention to any answers on the form where bold items have been circled and any relevant appendices.)*

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

Signature --   Date --------------------

Appendix VII: Research & Development approval

.........PARTNERSHIP NHS FOUNDATION TRUST

HONORARY LETTER OF ATTACHMENT

This agreement is between the named individual and ….. Partnership NHS Foundation Trust in respect to carrying out an approved Research and Development project.

FULL NAME: Aria Christopoulou

ADDRESS:

DATE OF BIRTH: 27/11/1978

TELEPHONE NO:

EMERGENCY CONTACT NUMBER:

COMMENCEMENT DATE: 1 February 2010

COMPLETION DATE: 1 February 2011

PLACEMENT ADDRESS: Mental Health Unit, ….. Hospital

SUPERVISOR: Sarah Lundqvist

TITLE OF RESEARCH PROJECT: Dependency, Depression and Hospitalisation; Investigating the lived experience of being-cared for by others (mental health professionals) in in-patient Psychiatric wards.

The individual must comply with the following conditions:

AGREEMENT

1. Whilst undertaking an honorary placement the individual will be allocated a named employee of South Essex Partnership NHS Foundation Trust who will be responsible for implementing the Trust's requirements in respect of the work required.

2. Individuals must not perform any tasks for which they have not been prepared unless under supervision.

3. During the placement any matters of a confidential nature, especially information relating to the diagnosis and treatment of service users, must under no circumstances be divulged or passed on to any unauthorised person or persons. Breach of confidentiality is a serious matter and may result in the termination of the placement.

4. Any event of misconduct or poor performance may result in the termination of the placement or in the event of any act of gross misconduct a requirement to leave the premises.

5. The senior member of the relevant department/s must be notified of any absence.

6. Whilst on placement with ……Partnership NHS Foundation Trust, individuals are required to comply with Trust policies and procedures and such rules for the conduct and administration of work as are prescribed by the Trust. The following are the main areas:

    a)   The Trust has an obligation under Health & Safety at Work Act 1974 to provide safe and healthy working conditions and methods. These responsibilities are outlined in the Trust's Health & Safety Policy, which will

be available on request. It is the individual's responsibility to acquaint himself/herself with the contents of the policy.

b) It is the individual's legal obligation to take reasonable care of his/her own health & safety and that of others who may be affected by his/her acts or omissions at work and co-operate by complying with safe working practices within the workplace. It is also the individual's responsibility not to intentionally or recklessly interfere with or misuse anything provided by the Trust in the interests of health, safety and welfare of its employees and other persons on their premises.

c) Individuals must notify their Supervisor of any untoward incident or accident, which occurs whilst on Trust premises. An accident/incident form must be completed in accordance with Trust policy.

d) In order that they may practise and promote fire prevention, to know the fire hazards of their working environment and to know the right action to take if a fire breaks out, the Trust requires individual's to be aware of Trust Fire Precautions policy.

e) All individuals are required to be competent to lift and handle in accordance with the Manual Handling Operations Regulations 1992.

f) The Trust manages all research in accordance with the requirements of the Research Governance Framework for Health and Social Care. Whilst on placement with the Trust you must comply with all reporting requirements, systems and duties of action put in place by the Trust to deliver research governance.

7. The Trust does not accept liability for the loss or damage to personal property. The individuals are expected to provide his/her own insurance cover against such risks. The Trust will provide cover for public, employer and product liability claims for its buildings and equipment.

8. …….Partnership NHS Foundation Trust is committed to a policy which discourages smoking and prohibits smoking on Trust property and on Trust business outside it.

9. …….Partnership NHS Foundation Trust has an Equal Opportunities Policy. All individuals are expected to observe this policy in their behaviour to the public, colleagues and service users.

10. Failure to comply with the requirements of this agreement may lead to the termination of the placement.

I have read and understood the conditions of my Honorary Letter of Attachment with the Trust and confirm my acceptance of them.

Signature……………………………………………………………..

Date:………………………………

Signature:……………….……………………………………………………………

On behalf of the Trust

Date:………………………………

Appendix VIII: Example of development of emerging theme

Original transcript	Emerging Themes
Interviewee: if you do not make a conscious effort to pull yourself and help yourself, in the situation that you're in, which is very difficult to do, then..i don't know, it's all very difficult… **Interviewer**: Can you tell me a bit more about what's making that difficult? **Interviewee:** you don't have to make any decision in here. You don't have to do anything, um, that you don't want to do, unless you make conscious effort, to make your own decisions, and it can be something really silly as, I'm going to do my washing today. Unless you make a conscious effort to be part of the real world, even though you're not in the real world, um, I think you could really get lost in it. You know, I could quite easily have sat back and really not bothered, and stayed in here indefinitely, because that's how bad I felt. I could stay here and quite happily plod along and let everybody else look after my children, and at the moment, the way I feel mentally, that wouldn't bother me. You...um, I can stay in here and basically not do anything. But, I think you have to be conscious enough to know that you need to function outside of here.	lack of decision making loss of autonomy/functions of an adult state excluded from real world hospital as a distinct entity/separated from real life Break away from responsibilities and anxiety/family roles Allowed to regress

Appendix IX: Demographic information

Age

35-45: 3 participants

46-55: 2 participants

56-60: 3 participants

Ethnic background

All participants were white British

Educational background

No diploma: 4

Postgraduate degree/diploma: 4

Employment status

No current employment

Family status

widowed 1

single 1

separated 3

married 3

Appendix X: Master table of each theme

Theme 1: Containment

Participants	Sheltered boundaries	Seeing the self in others	Gaining insight	Mediation
Tim	4/19a 2/40	3/72 3/67	4/19	
Angela	7/4 17/18	2/44	14/35	17/23
Nicole	3/67 6/71	2/52	6/10	10/37 10/51
John	8/47	6/105	6/111 2/39	
Paulina	11/32 13/90 14/2	10/39 45/5	5/1	15/56
Phil	9/30 3/12	11/1		10/23
Nick			14/39 3/5	13/15
Laura	3/18 4/46 3/18	6/35	5/1	21/113

Theme 2: Attached

Participants	Emotional alienation	Regressive states	Separation anxiety
Tim			11/15
Angela	4/9	15/15 10/41	7/4
Nicole	8/61 13/75 2/6	8/82	3/73
John		9/74 2/25	
Paulina	13/99 12/47	11/6	3/75 5/9 10/62
Phil	2/30-42 3/62	7/16	
Nick		11/157	11/14 6, 157
Laura	13/38 1/14	8/20	8/11

Theme 3: Arrested temporality

Participants	A Past Self	Helplessness	Remanence
Tim	72/11		5/48
Angela	16/3 3/28 7/17	5/2	6/25 6/17 3/28
Nicole		5/59	
John	12/76-83	11/20	
Paulina	3/71 4/19	4/19 6/26 13/94	7/52
Phil	13/45	4/7 7/7	4/15 9/15
Nick	8/59 8/69		5/31
Laura	7/2	7/6	8/40 6/16

Appendix XI: Master table of themes

Theme 1 Containment	Tim	Angela	Nicole	John	Paulina	Phil	Nick	Laura
Sheltered boundaries	4/19a 2/40	7/4 17/18	3/67 6/71	8/47	11/32 13/90 14/2	9/30 3/12		3/18 4/46 ,3/18
Seeing the self in others	3/72 3/67	2/44	2/52	6/105	10/39 45/5	11/1		6/35
Gaining insight	4/19	14/35	6/10	6/111 2/39	5/1		14/39 3/5	5/1
Mediation		17/23	10/37 10/51		15/56	10/23	13/15	21/113
Theme 2 Attached								
Emotional alienation		4/9	8/61 13/75 2/6		13/99 12/47	2/30-42 3/62		13/38 1/14
Regressive states		15/15 10/41	8/82	9/74 2/25	11/6	7/16	11/157	8/20
Separation anxiety	11/15	7/4	3/73		3/75 5/9 10/62		11/14 6 157	8/11
Theme 3 Arrested Temporality								
A past self	72/11	16/3 3/28 7/17		12/76 -83	3/71 4/19	13/45	8/59 8/69	7/2
Helplessness		5/2	5/59	11/20	4/19 6/26 13/94	4/7 7/7		7/6
Remanence	5/48	6/25 6/17 3/28			7/52	4/15 9/15	5/31	8/40 6/16

The Professional Practice Component of this thesis has been

removed for confidentiality purposes.

It can be consulted by Psychology researchers on application at

the Library of City, University of London.

Section D: Literature review

A counselling psychology perspective on therapeutic alliance: Considering the relevance of therapeutic alliance in in-patient psychology

1. Overview

The therapeutic alliance is seen as an essential ingredient of any approach to psychotherapy and counselling (Gaston, 1990). Despite a significant literature examining the effect of therapeutic alliance on client outcomes in a multitude of settings, in-patient settings have received less empirical attention. Although the concept of therapeutic alliance originated in psychotherapy, and despite research in psychotherapeutic settings evidencing alliance as a consistent predictor of outcome (Horvath & Bedi, 2002; Martin, Garske & Davis, 2000), the literature offers less assistance when trying to understand the specific nature of alliance in adult in-patient psychology. However, interest has started shifting in the in-patient context as well, suggesting its potential clinical relevance.

The amount of research in this subject area is reflected in its emphasised inclusion in recent psychological treatment guidelines, whereby it has been acknowledged that "for all treatments the strength of the therapeutic alliance is important in ensuring a good outcome" (NICE 2004, p. 16), and that successfully engaging the client and building a positive therapeutic alliance is associated with better outcomes across all therapies (DoH, 2007, p. 11). Moreover, therapeutic alliance is particularly central to the practice of counselling psychologists. The Health and Caring Professional Council (HCPC), in its 2009 Standards of Proficiency for Practitioner Psychologists, recognised the concept as being specifically relevant to counselling psychology, stating that counselling psychologists "must understand the therapeutic relationship and alliance as conceptualised by each model" (HPC, 2009, p. 28).

However, establishing a therapeutic alliance with psychiatric patients in in-patient psychological treatment poses specific challenges compared to other traditional psychotherapeutic settings and therefore needs to be treated as a distinct phenomenon in itself. Some of these challenges are: the diversity of relationships in such a multimodal interactional context, the multidisciplinary staff relations and sometimes professional tensions within staff teams, the diverse therapies that take place – ranging from psychological and pharmacological to physiotherapy, occupational therapy and nursing input – the number of professionals involved with patients as well as the significant relationships formed between staff, patients and other patients, the time limitations such as short length of hospitalisation, and the severity of the psychopathology. All these factors can affect the

formation of therapeutic alliance and the establishment of the goals set by each therapy. These challenges could also be factors explaining the lesser amount of in-patient alliance research. The greater severity of symptoms and the complexity of patient psychopathology, the difficulty in determining when it is appropriate to approach admitted patients for research, issues of informed consent and problems in the measurement of behavioural, relational psychological issues can all be factors that hinder psychological in-patient research and which show just how complex the in-patient dynamic is. There is a need therefore to explore the phenomenon of alliance in a different light from that occurring in traditional psychotherapeutic settings in order to find out how transferable the research findings of alliance are into in-patient practice.

This paper provides a context for and highlights the clinical and recent developments of the therapeutic relationship, with the primary focus on alliance in the area of adult in-patient psychology literature. It draws on established literature and has been initiated by the author's own experience of conducting counselling psychology and psychotherapy within a NHS psychiatric clinic. The aim of the present literature review is to answer the following questions: How is the concept of therapeutic alliance relevant in in-patient psychology? And what are the clinical implications, if any, of this line of research for counselling psychologists employed in in-patient psychiatric settings? It will open with a discussion of the concept of therapeutic alliance and will give a brief overview of the research areas that have examined this. This review is selective and makes no claims to be exhaustive. Systematic searches of the following databases were completed: PsyciNFO, PubMed, ProQuest, CINAHL, Embase and The Cochrane Library. The following key search terms were used: therapeutic alliance, psycho/therapeutic relationship, adult in-patient psychiatry. Titles and abstracts were reviewed to determine whether the studies were likely to meet the inclusion and exclusion criteria. Final determinations were made based on full-text review. References of accepted studies were then searched for any additional appropriate articles. Systematic reviews, qualitative and quantitative studies were included if they: 1) were peer-reviewed; 2) were published no earlier than 1997; 3) were available in English; and 4) specified therapeutic alliance as a topic of interest in the recovery process and / or investigated the therapeutic alliance or therapeutic alliance-based therapies as a predictor of treatment outcome, drop out, change in psychological symptom severity, or treatment satisfaction; 5) were only for adults. Studies that have investigated alliance's association to outcome, attachment, and drop out will be discussed in relation to assessment, measurement and methodological issues, followed by a review of older and more recent studies that have examined therapeutic alliance in adult in-patient settings.

2. Conceptualisation of alliance

The genealogy of alliance has been extensively investigated in many papers and is beyond the scope of this review. However, a historical (contextual or theory based) account of the concept might be helpful in providing an explanatory basis for the subsequent significant confusion in its conceptualisation.

Born in psychoanalysis by Freud (1912), the concept of alliance was later seen in humanistic psychotherapy by Rogers (1965), operationalised in therapy by Howard and Orlinsky (1975), reworked in psychotherapy by Bordin (1979) and became a "common active factor" of therapy by Frank and Frank (1991) across different forms of psychological treatment. This evolution of the concept juxtaposed a plethora of terms, as well as measures in current use that may reflect an overall uncertainty regarding its conceptualisation (Elvins & Green, 2008). For example, the earlier psychoanalytical arena conceptualised alliance on an "unconscious-transferential" base and treated it as a facilitative element for change, while the humanistic perspective conceptualised it as a "conscious and rational" encounter, considering it to be an active ingredient of therapeutic change (Horvath, 2006). Generally, most definitions agree that the therapeutic alliance represents "interactive, collaborative elements of the relationship in the context of an affective bond" (Constantino, Castonguay & Schut, 2002, p. 86) and has been proposed as a common, pan-theoretical factor that could account for positive therapy outcome regardless of treatment approach (Horvath & Luborsky, 1993).

As the concept of 'therapeutic relationship' or 'alliance' has many definitions depending on the theoretical orientation subscribed to, for the purposes of this paper these terms will be used interchangeably to denote the collaborative and affective bond between the therapist and patient, as well as the patient's and therapist's ability to agree on treatment goals and tasks. This reflects the three main themes of most theoretical definitions of the therapeutic alliance (Martin et al., 2000) captured in Bordin's work (1979, 1980), who in his attempt to bridge earlier theoretical divergences, conceptualised alliance as a unifying theoretical framework for all types of interpersonal change processes, designed to account for how clinical theory, independent of treatment modality, gets translated into a clinical change process. What he suggested in his theory is that therapeutic alliance consists of three parts: (i) a positive affective bond between client and therapist; (ii) an agreement of therapeutic goals; and (iii) an agreement of therapeutic tasks. Along a similar line, Hougaard (1994) offers a simpler, dual description of the concept of personal alliance and task-related alliance, and distinguishes the interpersonal elements of the relationship between a client and therapist from the

contractual ones, such as planning and goal orientation. This alliance theory is considered to be the most comprehensive (Muran & Barber, 2010), having provided the base on which Horvath and Greenberg (1994) constructed a widely used tool to assess the therapeutic alliance – the Working Alliance Inventory.

Most reviews comment on the deficiencies in both conceptualisation and assessment of alliance. In a recent review of the conceptualisation of the therapeutic alliance, Elvins and Green (2008) suggested that the alliance concept remained at a descriptive level with little rigorous fundamental research into the underlying processes behind its formation (p. 1184). Similarly, Horvath's (2006) review of research on the alliance in a historical context emphasises the need to develop a conceptual model that could bring the different elements of the therapeutic relationship into a cohesive framework. He concludes that without a consensual definition of the construct, such an "ecumenical status of the alliance makes it difficult to distil clinically useful guidance and training for the therapist" (p. 261). It is only natural to hypothesise just how difficult it becomes to translate research findings of alliance to clinical care and practice, since there might be aspects of the alliance that are not universal in nature, therefore it may be hypothesised that alliance has a different role in different types of treatments or in different settings, such as in-patient or rehabilitation units. Nonetheless, the importance of building a strong relationship in any treatment modality and of developing a firm patient-therapist alliance has been an overarching goal for practitioners, regardless of their theoretical orientation or context. Therapeutic alliance is considered as a vital, organic ingredient of any psychotherapy format, as across different psychotherapeutic approaches a good alliance generally points to the fact that the therapist and patient work well together towards reaching their common goals of therapy.

3. Therapeutic alliance relationship to treatment outcome

In this section a synopsis of key research areas in alliance within psychotherapy and outpatient psychiatry will be given, before a review of research on alliance and therapeutic relationship in in-patient psychiatric wards.

Several reviews on the therapeutic alliance in generic psychotherapy or counselling settings have been conducted on a variety of issues, including the historical and conceptual dimensions of the alliance (Horvath & Luborsky, 1993), definition of the concept, measurement issues and the relationship between the alliance and psychotherapy outcomes (Horvath & Symonds, 1991; Martin et al., 2000), therapy characteristics and techniques (Ackerman & Hilsenroth, 2003), the impact of

the alliance on outcomes in short-term dynamic therapy (Crits-Christoph & Connolly, 1999), and in behavioural (Sweet, 1984) and cognitive therapy (Waddington, 2002). The positive relationship between therapeutic alliance and treatment outcome has been verified for different diagnoses including depression (Krupnick et al., 1996), eating disorders (Gallop, Kennedy, & Stern, 1994), and schizophrenia (Svensson & Hansson, 1999).

Research has shown that working alliance is an important component of the therapeutic process as it appears to be an intermediate criterion of positive therapeutic outcomes (Horvath & Bedi, 2002), central to outcomes in psychotherapy, supported in meta-analysis of both adult (Martin et al., 2000) as well as child mental health research (Shirk & Karver, 2003). Furthermore, it has been shown to be a mediator of the relationship between attachment dimensions and psychotherapy outcome (Byrd, Patterson, & Turchik, 2010) and generally empirical studies of mental health interventions suggest that therapeutic alliance constitutes an important factor in explaining the outcome of treatment (Priebe & McCabe, 2006), regardless of the treatment employed (Horvath, 2001). Further, the strength of the alliance seems to be relatively independent of the type of therapy and of whether the therapist, the patient, or an observer assesses the outcome. However, it seems that the patient's report of early and good alliance is clinically the most useful indicator and the most consistent predictor of improvement as compared with other evaluative perspectives (Horvath, 2001). This consistent finding adds to the significance of investigating clients' perspectives in the research of in-patient alliance.

Meta-analyses examining the impact of several aspects of treatment and research design on the strength of the relationship between alliance and outcome have found a moderate but robust relationship across a broad spectrum of treatments. Although the correlational link is not very significant, it is constant, and greater than the relation reported between other treatment variables, such as therapist adherence to the treatment manual or competence and outcome (Fluckiger et. al.,, 2012).

Several studies have reported quite strong associations, with the working alliance counting for up to 30–45% of the variance in therapeutic outcomes (Mallinckrodt & Nelson, 1991), while others report that 5–9% of the variance in therapeutic outcomes can be related to the therapeutic alliance (Cooper, 2008; Castonguay, Constantino, & Holtforth, 2006). However, one can only question how measurable a relational aspect of the therapeutic process, such as the alliance, can be from a statistical point of view. In other words, is the numerical value of therapeutic alliance of any practical clinical value? The fact that these two variables, alliance and outcome, are correlated does not exclude other third variables, direct or indirect, that can account for or contribute to the alliance-outcome correlation.

Indeed, such variables have also received a lot of research attention, where the most popular lines of research are: clinical improvement and symptom change prior to the formation of alliance accounting for treatment outcome (Horvath & Luborsky, 1993); patients' interpersonal styles related to alliance (Gibbons, 2003; Johansson & Eklund, 2004; patients' interpersonal functioning related to alliance quality (Constantino et al., 2005; Gibson, 2003); different points of alliance assessment (Dinger et al., 2008; alliance development over time and outcome (De Roten et al., 2004); and impact of attachment on alliance (Diener, Hilsenroth, & Weinberger, 2009). Such correlational findings from psychotherapy research have limits and, as Samstag (2006) notes, the clinical importance lies in the knowledge of how alliance contributes to clinical change. Kazdin (2006) warns that such quantification of the alliance may result in "arbitrary metrics" (p. 148), and Priebe & McCabe (2008) critiques the capacity of reductionistic methods to reflect complexities of a relationship between two people.

4. Methodological issues

Overall, it seems that this critique of lack of clarity in both conceptualisation and measurement of alliance is present in most reviews and that it is mostly methodological flaws that are held accountable for this. alliance has become the most often cited 'common factor' concerning the quality of the relationship between the patient and the therapist; and frequently used terms are the 'therapeutic relationship', the 'working alliance', or the 'helping alliance' (Horvath, 2001).

The previously discussed theoretical conceptual superfluity extends into research and as a natural consequence researchers have created a plethora of measures and scales for the assessment of alliance, with different groups, diagnoses and settings. However, psychotherapy is different to psychiatric settings, and therefore models and findings of psychotherapy research may not be wholly transferable to psychiatric settings. For example, some of the therapeutic relationship measurements that were developed in psychotherapy are based on the Bordin's pan-theoretical concept of alliance (IPAS, WAI), some others on the psychoanalytical conceptualisation of alliance (Allen's TAS, AES, VTAS), and there are also some that measure the relationship from a Rogerian perspective. Furthermore, there are scales developed in psychiatry, but some lack a clear base on any theoretical model.

The issue of validity also complicates matters. Because research into the patient-professional relationship is relatively new in routine mental health services and has employed a range of measures of the relationship, such measures not always validated for this context. In a review of measures of alliance, Catty, Winfield and Clement (2007) identified 15 measures, 7 of which were developed in psychotherapy with good conceptual validation. Of the other 8, which had been developed for mental

health services, only a few had been validated for routine mental health services. The authors thereby concluded that there was limited evidence for their validity in general mental health services. This was consistent with earlier findings from Priebe and McCabe's (2004) and McCabe and Priebe's (2006) reviews of the therapeutic relationship in the treatment of severe mental illness. These authors also address the need for more conceptual work on the assessment of the underlying theory in which the measures are based and make explicit the necessity for this conceptual work to be specific in psychiatric settings. Furthermore, it has been suggested that most of the work in alliance may be methodologically flawed as it hasn't taken into account significant confounds in both measurement and causal analysis (Elvins & Green, 2008).

Alliance is an important contributor to therapeutic change and has received extensive empirical attention, being a critical component of effective psychotherapy. It is also a dominant concept in outcome studies. Castonguay et al. (2006) note, "alliance occupies such an important place in our conceptualisation of what good therapy entails that not paying attention to its quality during practice or supervision could be viewed as unethical" (p. 271), and state that alliance has provided an optimal venue for convergence between researchers and clinicians. On the other side, Kazdin (2008), in his paper on ways of bridging clinical and research practice, posits that psychological research in general fails to explain or identify mediators or mechanisms of change in order to reduce the gulf between research and practice. He states that the study of mechanisms of change has received the least attention in psychological research, even though understanding mechanisms may well be the best long-term investment for improving clinical practice and patient care. In short, understanding mechanisms of change can enhance the effects of treatment in clinical application. Establishing a causal relation does not explain the mechanism of therapeutic change.

Clinical decision making is criticised for not relying heavily on research. Yet how variables are studied and the ways in which the data are evaluated and reported often make the translation of findings difficult (Kazdin, 2008, p. 153). As mentioned earlier, the numeric value of alliance, though significant on its own in identifying causal relations to treatment outcome, also points to the way forward for qualitative psychological research to look into and explore the quality of therapeutic relationships and the intricate interactional factors that account for change. This thereby aids in generating a hypothesis regarding mechanisms of change, which can then point researchers in the right direction during the empirical process and outcome studies. This kind of multiple methodologies dialogue can not only deepen our understanding but also offer a meaningful relational depth between practitioners and researchers. For example, Safran and Muran (2000) and Safran, Muran, Samstag and Stevens (2001), drawing on qualitative studies, have taken the understanding of the centrality of

the alliance a step further, placing therapeutic work on problematic aspects of the alliance at the very heart of the therapeutic change process, developing processes of alliance rupture, repair and resolution. A wide range of qualitative methods such as phenomenological analysis and grounded theory, which aim to develop an explanatory theory of social processes, and which also allow for the captivity of inner experiences in a rich way, are ideal for this type of exploration of therapeutic processes and interactions. Therefore the role and impact of the alliance, as well as the ways in which alliance as a relationship can be enhanced, could become the foci of attention of more psychological qualitative research. Such a methodological dialogue will also be very relevant in populations with severe, acute and enduring mental health illness, and, in accordance with a modern NHS, place emphasis on giving choices to clients and including clients' opinions in service development.

5. Therapeutic relationship in in-patient psychology and psychiatry

Patients suffering from enduring and severe psychopathology have in most cases been in touch with several treatments and might possibly have lost hope in the treatment system. They may enter such treatment systems with great feelings of hopelessness and helplessness. At times admissions are non-voluntary, and many patients experience a bad initial mental health contact which often leads to problems such as fear or distrust in the system and /or staff, issues which may lead to interference with opportunities of positive therapeutic alliance. Furthermore, the acute in-patient level of care is more restrictive, therefore there is a propensity for coercive experiences to decrease opportunities for therapeutic relationship formation. The in-patient psychologist is in danger of being seen by the patient as part of the system, and not as an ally that has the patients' recovery at heart, which might influence the patients' motivation to engage in psychological work while admitted to hospital. Richards (2011), in her very clinically relevant paper on aetiology and resolution of alliance ruptures, identifies mandated therapy as one of the causes of alliance rupture. This is very salient for the in-patient context. Due to involuntary admissions, therapy can be perceived as having a mandate-type character, where the therapist becomes a representative of the 'oppressive system', therefore task-related alliance may not be obtained as the client might feel that there is no task to ally towards (Richards, 2011). The exploration of alliance during treatment in hospital units is therefore of clinical importance to psychologists working in in-patient settings, as therapeutic alliance and formation of therapeutic relationships may become a necessary precursor to technical interventions that can lead to positive treatment outcome.

In the context of in-patient psychiatric research, the therapeutic relationship is regarded as the foundation by which the professional takes an interest in the patient and hopes to induce recovery

(McGuire et al., 2001). Although older, there are studies that have investigated the therapeutic relationship and the alliance component in the in-patient context and linked the relationship to outcome, yielding important findings. The results of these studies will be included and discussed epigrammatically as they laid the basis for more recent exploration of the relevance of the alliance and of the therapeutic relationship in in-patient treatment.

Allen, Tarnoff and Coyne (1985) rated alliance in 37 mixed in-patients and found that alliance was strongly and positively correlated with better functioning at discharge and that longer hospitalisation was associated with more positive alliance ratings. However, the emphasis of the scale used by these authors was based on patients' contributions and patients' collaborative work, whereby greater collaboration was considered to be an indication of better alliance, and not the patients' views of the therapists (McCabe & Priebe, 2004). Therefore, the patients' views need to be heard in order to address this gap. Specifically, how patients make sense of alliance in therapy should be carefully taken into account, and this could be addressed through a qualitative investigation and not a quantitative one such as was carried out in the research mentioned above. Clarkin, Hurt and Crilly (1987) rated alliance for 96 in-patient patients with a scale equating patients' involvement in treatment with alliance and found that alliance in admission was positively associated with global functioning scores at discharge, and that alliance was also a predictor of the outcome of hospital treatment. The rating that these authors used focused on the patients' insight, and their need for and involvement in treatment. As mentioned above, the need for treatment and patients' involvement in treatment could be elements contributing to and signifying the formation of therapeutic alliance. Therefore, as these are not the sole factors involved, rating scales assessing quantitatively a concept that so heavily relies on interpersonal contact and sense of trust cannot throw light onto the experience of alliance within the therapeutic context.

Frank and Gunderson (1990) investigated the role of the therapeutic alliance in the treatment of schizophrenia in an in-patient setting, and found that schizophrenic patients who had developed a better alliance over the first 6 months of treatment were more likely to continue with psychotherapeutic work during the following 18 months and that a better therapeutic relationship was associated with less denial of illness. The authors of this study used a scale that had a general emphasis on the patient's ability to work purposefully in therapy, while the therapist's own involvement played a minor role. Alliance is a process facilitated by bi-directional intent of patient and therapist, therefore, methodologically placing the emphasis on only one of the two parties involved would produce a one-sided view of the role of alliance in therapy.

Gallop et al. (1994) explored the impact of alliance on the in-patient treatment of patients with eating disorders, rating both staff and patients' views in two periods (3rd and 7th week of treatment) and found that patients who left treatment early had lower alliance ratings and poorer relationships with the care team. Although these authors used one of the most widely used measures in psychiatric research (McCabe & Priebe, 2004), which is based on Bordin's conceptualisation of alliance and assesses the bond (attachment between client and therapist), the tasks (collaboration on therapeutic activities) and the goals (agreement of therapist and client on the goals and objectives of therapy), their results are hard to generalise due to the homogeneity of the sample, yet are of value to this specific population and the treatment clinics dealing with it. Hansson and Berglund (1992), using a patient rating scale with 106 mixed in-patients, found that better alliance during admission related to a better outcome at discharge from hospital. Their measurement also placed emphasis on patients' confidence in the staff, in general, and the quality of the relationship to the primary therapist. Yet this is still approaching alliance at a descriptive level, with little exploration into the underlying processes behind its formation.

Similarly, Lieberman, Von Rehn, Dickie, Elliott, and Egerter (1992) explored the role of the therapeutic alliance in brief hospitalisation by examining the agreement on the goals of treatment between staff and patient at admission, and found that lower initial agreement about the goals of treatment were linked to precipitous discharge while greater agreement was related to a decrease in symptoms, regardless of the use of medication. Finally, Beauford, McNiel and Binder (1997) assessed the quality of the therapeutic alliance between therapist and patients as a predictor of the risk of violent behaviour during hospitalisation and their findings suggested that the quality of the initial therapeutic alliance was a strong predictor of violence, even when other clinical and demographic correlates of violence were considered concurrently. Their results suggest that the better the initial therapeutic relationship predicts the transition to violent acts during the early phases of hospitalisation in closed units, the more likely the relationship will have less violent acts. Again, these authors used an alliance rating designed for in-patient treatment which placed emphasis on patient insight, and the patient's need for and involvement in treatment. Similarly, Secker et al. (2004) interviewed staff after 11 violent and aggressive incidents on an acute admission unit and found that the major theme was the lack of staff engagement with patients before and after the incidents. This study appears to imply that there is a unidirectional causal understanding of the interactions of staff and ward conditions to the outcome variables. The study's findings suggest that, unsurprisingly, staff engagement and fostering positive ward environments are beneficial to patients. However, how this can be achieved remains a constant challenge.

Evident in most of these earlier studies is that the emphasis of their assessment of alliance does not lie with interactional factors of the relationship or on the quality of the relationship between the patient and the therapist. Priebe and Gruyters (1993), in an earlier review of alliance in the in-patient context note that these studies mainly measured general motivation and therapeutic compliance rather than the quality of the interpersonal relationship with the therapist.

In a more recent review of methods and findings of the therapeutic relationship in the treatment of severe mental illness, McCabe and Priebe (2004) conclude that there may be no such thing as an ideal assessment of the therapeutic relationship and that the most appropriate method of the assessment depends on the purpose of the assessment. They thus suggest that "studies investigating how therapeutic relationships are influenced by service structure or training interventions may warrant different assessments than studies identifying which relationships are helpful and effective with which patients and in which situations" (2004, p. 125). In the same vein, Catty (2007), in a conceptual review of the therapeutic relationship measures in secondary mental health care, recommends that the selection of a measure for use in a study of the relationship in a secondary mental health service context "should be based on the relationship model most applicable to the service studied and / or the study's objectives" (p. 249). Overall, although these studies from the past two decades have limitations, either because of assessment issues (i.e. often using measures without information on their validity in this context), or because they lack a central focus on the interactional aspects of the therapeutic encounter, still provide substantial evidence that the therapeutic relationship and alliance should be regarded as important phenomena of in-patient treatment in general, and psychological in-patient work in particular.

Munder, Wilmers, Leonhart, Linster, and Barth (2010) recently worked towards earlier methodological criticism regarding the validity of one of the most detailed measures assessing the three aspects of the therapeutic alliance based on Bordin's conceptualisation: establishment of an affective bond, and agreement on tasks and goals between the therapist and the patient. In their investigation of the measurements of psychometric properties in in-patient psychotherapy, they found that in-patients rated the therapeutic alliance less positively than outpatients, suggesting poorer therapeutic alliances in the in-patient group (p. 237). The authors attribute this finding to contextual differences that might influence the alliance of in-patients to the individual psychotherapist and state that due to the limited empirical evidence on alliance formation in in-patient settings, any interpretation of their finding is difficult. Among these contextual differences they identify that the status of the therapeutic alliance with the individual therapist might be less clear than in outpatient psychotherapy, as positive changes in mental health can be attributed to each of the many components

that play a role in in-patient treatment. Equally, due to the multiplicity of relationships in in-patient treatment, the alliance with the therapist might be compared to other relationships with treatment team members and be perceived as less important. Furthermore, alliance might be perceived as a patient-treatment team relationship since other treatment team members are involved in the process of negotiating the tasks and goals of treatment, which might blur the real contribution of the therapeutic relationship and a patient's outcome. It is such contextual specificities than highlight the need for further investigation of alliance in in-patient treatment and which led Munder et.al. (2010) to state that the investigation of whether and how coexisting relationships in in-patient treatment influence the therapeutic alliance in individual in-patient therapy is of value to clinical practice.

Blais, Jacobo and Smith (2010) explored therapeutic alliance in brief in-patient psychotherapy with 20 depressed in-patients receiving supportive-expressive psychotherapy. Their main finding was that for psychiatric in-patients a positive psychotherapy alliance is associated with higher levels of function. Approaching the issue through association does not, however, shed light on alliance as a phenomenon that unravels between therapist and patient, but rather looks at the end result of alliance, when this has already been cultivated. This is a consistent finding within research carried out across outpatient treatment and earlier in-patient studies on alliance, and one whereby the authors acknowledge that it is reasonable that better functioning in-patients would have a greater capacity for engaging in the type of relationship necessary for psychotherapy. Regardless of the depth of psychotherapy, this study also treated alliance as a variable being investigated quantitatively, and thus does not explore the substance of alliance, but rather proves that alliance has significant and important elements in patients' mental health. A number of studies have shown that therapists' ability to form strong working alliances with their clients is affected by their experience (Mallinckrodt & Nelson, 1991). Therefore, the finding of this study could be explained by the difficulties less experienced therapists face in developing alliances with more severely disturbed clients, compared to experienced therapists' ability to engage difficult clients in an alliance more quickly.

Taking into consideration that clients' attachment styles affect the nature of their interpersonal relationships and the interpersonal nature of the counselling process, several researchers have attempted to study the relationship between clients' attachment styles and how these clients perceive the working alliance with their therapists, though this has mainly been in traditional psychotherapy settings or with outpatients (Eames & Roth, 2000; Satterfield & Lyddon, 1998). The outcome of these studies indicates that clients' attachment styles are related to the strength of the working alliance that is created between the client and the therapist. However, studies of this interrelationship in the in-patient setting are limited. Roth and Fonagy (1996) found that psychiatric in-patients with dismissive

attachment styles and who appeared relatively indifferent to closeness with others showed greater clinical improvement than secure or preoccupied (rejection-fearing) patients. Hietanen and Punamaki (2006) investigated the association between early working alliance and adult attachment styles among 100 psychiatric in-patients and 21 case managers and found a positive association, but also noted significant gender differences. Women with a secure attachment style formed stronger emotional and relational alliances than did women who were fearfully attached, while both secure and fearful attachment styles among men were associated with strong cognitive aspects of working alliance, for example on the agreement of tasks in therapy. An important element of this study is that patients rated their attachment style in relation to same-sex as well as opposite-sex relationships and their results indicated that an association between attachment and alliance existed only when it was analysed using the same-sex attachment classifications. This finding has not been suggested in traditional outpatient psychotherapy studies, and seems to be important for the in-patient context. In critically acute phases where one's mental integrity is in danger, it may be that the same-sex relationships seem to be a less complicated and contradictory source of support than the opposite-sex relations. This study, however, focused on the alliance at early phases of treatment and as the authors acknowledge, the dynamics between attachment and alliance could show a different pattern at a later phase of treatment, once patients' old dysfunctional patterns of relating are challenged by the therapist.

A study conducted by Dozier (1990) with adults who suffered from serious psychopathological disorders found that severely disturbed individuals excessively employ avoidant strategies, in order to reject treatment. It was hypothesised that the motive behind these behaviours was a need for the individuals to prove that they did not need anything from the attachment figure, in this case the clinician, in order to avoid possible rejection. It would be important to see how these factors might operate in the in-patient context, where patients are actually mainly and mostly severely disturbed. During hospitalisation such patients are faced with the potential of multiple therapeutic relationship formations, but due to the severity of their psychopathology this therapeutic potential could be an untapped resource. As is known, patients who are severely disturbed have particular difficulties in forming dyadic relationships because close interactions generate anguish and fear in them (Pulido, Monari & Rossi, 2008). Especially, patients with fearful attachment style, who exhibit seeking reassurance, proximity behaviours and avoidant behaviours (Lopez, 1995), and suffer from greater psychopathology, have a a poorer therapeutic relationship than people suffering from schizophrenia or alcohol addiction (McCabe & Priebe, 2003). Therefore, it might be beneficial for the in-patient psychologist, especially in the early stages of therapy, to observe the client's interpersonal difficulties in action and ultimately disconfirm dysfunctional working models and interpersonal patterns which may help the client to work towards overcoming their reluctance to form a working alliance.

This is far more salient in the in-patient context where, as already mentioned, not only one therapist but also a multidisciplinary team is involved in the treatment. Therefore the therapeutic alliance concerns not only the relationship among patients and psychotherapists or psychiatrists, but also among patients and other important figures like nurses, social workers, or any other mental health operator significant for the patient (Gallop et al., 1994). As such, the in-patient psychologist needs to make this knowledge explicit to the whole team.

Few researchers have attempted to examine the relationship of therapist's attachment style and its relation to the formulation of the working alliance in traditional psychotherapy studies, and results suggest that therapist's attachment style has an impact on the formulation of the working relationship; therapists with secure attachment having been reported to have better therapeutic alliances with their clients. In contrast, therapists who were found to have higher levels of insecure attachment significantly predicted poorer general therapeutic alliances (Rubino et al., 2000 in Dinger et al., 2008). Dinger et al. (2009), in their attempt to address the ongoing discussion concerning the magnitude of therapists' and patients' effects on alliance and outcome in psychotherapy, investigated the relation between patients' interpersonal problems, therapists' attachment representations, and the development of the therapeutic alliance over time in a large German in-patient psychotherapy sample. In their study, 281 in-patients with depression or anxiety disorders were treated by 12 therapists from a psychodynamic background. The basic premise of this study was that therapists' attachment styles would predict differences in these alliance ratings, but the results did not provide clear or consistent support for such a conclusion. They found that therapists' attachment style was not related to alliance development and that insecurely attached therapists were as successful in establishing therapeutic alliances as securely attached colleagues. However, regarding the interaction of therapists' style and clients' problems on the strength of alliance, they found that higher attachment preoccupation of therapists was associated with lower levels of alliance quality when working with interpersonally distressed patients, while therapists with a low attachment preoccupation (i.e. dismissive attachment style) had better alliances when matched with patients with less interpersonal problems. Regarding the association between client characteristics and alliance quality, they found that highly distressed patients form alliances of lower quality than those with interpersonal difficulties. This study, however, has been criticised on a number of points. Silberschatz (2009) questions the study's clinical usefulness and notes that "therapists' actions, behaviours, and relational patterns that are manifested in therapy sessions provide more clinically interesting and useful information than a broad description of therapists' attachment dispositions" (p. 296). Holmes (2009) makes explicit a psychotherapeutic contextual cultural element of this study that renders the generalisability of the findings limited, since

the predominant mode of therapy in this study, and in most in-patient psychological treatment in Germany, is psychodynamic, while depression and anxiety disorders in the UK would probably be seen as more suitable for cognitive behavioural therapy than psychoanalytic-dynamic therapy.

The differences in therapeutic rationales and therapists' professional backgrounds and amount of experience may need to be studied further as research has shown that differences in therapy approach can influence alliance in the same diagnostic group. For example, Munder's (2010) study found no significant association between alliance and subsequent change with depressed outpatients receiving CBT or brief dynamic therapy. On the other hand, Muran & Barber (2010), in a sample of 88 depressed outpatients treated with psychodynamic psychotherapy, found that alliance predicted subsequent change in symptoms even after controlling for prior improvement, while McBride & Atkinson (2009), examining the link between alliance and outcome with depressed outpatients, found a strong association between quality of alliance and remission after 16 weeks of Interpersonal therapy.

6. Systemic mental health care alliance

It has been acknowledged that there has been a failure in planning in-patient services, as attention has focused on new developments in community care. Lelliott (2006), in his study on acute in-patient psychiatry in the UK, characterised in-patient wards as having poor design, maintenance and ambience, a lack of therapeutic and leisure activities for patients leading to inactivity and boredom, and frequent incidents of aggression and low-level violence with a resulting concentration of a more challenging group of patients and problems with staffing. Similarly, Green (2009), studying the last decades' decline of NHS in-patient psychiatry in England, notes that the massive investment in community care treatment teams for "severe and enduring mental illness" has led to a reduction in hospital admissions and thereby prompted mental health beds to be further reduced. Increasing community team expenditure (e.g. on crisis resolution teams) and the fall in in-patient admissions has been an assumed to be a causal relationship (Green, 2009), though it does not take account of the simultaneous and dramatic fall in capacity on admission rates and reduction of in-patient beds during the last decade. Increasingly, people with acute and severe mental illness are admitted for short periods of intense treatment and are discharged quickly back to community-based care. Thibeault et al. (2010) suggest that the reduction in average lengths of stay for psychiatric in-patients has been accompanied by a marginalisation of the concept of therapeutic milieu in the mental health discourse. Interestingly, it has been argued that the deinstitutionalisation movement may have disadvantaged some patients by removing the 'attachment figure' provided by the institution, with many of them unable to recreate a network of emotional bonds in the community (Catty et al., 2012). On the other

hand, from this author's experience of working in the community, clients' hospitalisation can be perceived as a significant rupture on outpatient therapeutic alliance. Therefore, the concept of alliance could have further clinical implications in negotiating and bridging gaps between community and in-patient services with the aim of therapeutic continuity of care across the whole system.

The hospital's intensive therapeutic care, the multiple interactions, and the removal of external pressures during admissions could make hospitalisation one of the most efficient agents to increase motivation and therapeutic change. As Clarke (2011) has noted in her study of therapeutic alliance with co-morbid substance abuse in-patients, research has shown that percentages of drop out are lower in in-patient settings compared to outpatient, suggesting this can be attributed to the hospitals' intensive individual and group therapy structure (Clarke, 2011, p. 18). This study used repeated measures of variance analysis and multiple regression analyses in order to examine the relationship between alliance, motivation, treatment group, and psychological functioning at discharge. What resulted was that alliance and readiness to change do play a significant role in improving outcomes for women after an acute psychiatric in-patient hospitalisation, despite the patients in question having a substance abuse history. Nonetheless, more studies would be needed to explore how alliance, readiness to change, and treatment outcomes may link together in order to promote recovery.

In the UK, mental health service practice emphasises care by a multidisciplinary team; an extension of this emphasis appears to be a recent line of research emerging in the UK that distances itself from the dyadic phenomenon of therapeutic alliance concerning only two individuals, i.e. patient-therapist. Simultaneously, the term 'institutional therapeutic alliance' has emerged to describe the alliance developed among a patient and the whole staff involved in the patients' treatment (Pulido, 2008). This concept appears to be a clinical extension of Bordin's earlier work, where a team is engaged in the patient's therapeutic process. This transition from one individual to a whole team appears to be highly clinically relevant in institutional settings such as the in-patient treatment setting, as it captures two different levels of relationships: at one level a relationship of the patient with a single therapist and at another level with the institution. These two could be "dissociated or fused, forming a synergistic or a conflictive rapport" (Pulido, 2008, p. 279).

The parallel co-existing relationships that occur in the in-patient milieu and how this factor correlates with alliance is of importance as research has shown that ward atmosphere is an important factor for the outcome of treatment of psychiatric patients. Indeed, a big part of a patient's experience of psychiatric hospitalisation involves nursing interaction, because of nurses' daily personal engagement with the patient and his/her recovery process. The relevance of the alliance development is a well-

known topic and a well-researched theme in the psychiatric nurse-patient practice, but far less so in the in-patient psychologist's practice. It is an acknowledged fact that psychiatric nursing staff are quite pressured in terms of time spent on administrative tasks, formal observations and risk management issues. Since they rarely have protected time, the additional task of listening to clients talking that could form quality of relationship and communication becomes a low priority. This may have a detrimental effect on the care provided on in-patient units. Cameron et al. (2005), in their paper on a human relations perspective of the nurse-patient relationship, notes that in psychiatric nursing the potential to use powerful therapeutic resources with patients is underused as a nurse's time involves a lot of administrative work and nurses have little theoretical information to produce therapeutic interactions with patients (Cameron et al., 2005, in Pulido et al., 2008).

Johansson and Eklund (2004) conducted an exploratory study with the intention of examining how these phenomena, helping alliance and the treatment milieu, operate to promote a good psychological encounter both at the individual as well as ward level, focusing on the establishment of the helping alliance in an acute in-patient Swedish psychiatric setting. In their study, the authors conceptualised therapeutic relationship as belonging to the staff group and not a particular individual. Their findings emphasised that support – whether patients perceived the social climate in the ward as encouraging and supportive and whether there was clarity and stability in treatment relationships – was a dominant component in the establishment of, or functioned as a part of, the helping alliance. The authors drew on the psychodynamic concept of psychological "holding" (Winnicott, 1960/1971) as a necessary function in acute in-patient settings, where most patients go through regressive processes and experience chaos and confusion. Therefore, a psychologically holding environment is critical in the establishment of a positive, helping alliance and subsequently in in-patients' recovery. Methodologically, this research used questionnaires to assess ward atmosphere and patients' psychosocial functioning in relation to helping alliance, and therefore it is limited by its hypothesis to establish a causal relationship; and not to explore the phenomenon of alliance.

A systemic conceptualisation of alliance that takes a holistic approach, including all different therapeutic agents of psychiatric in-patient wards contributing to clients' treatment and recovery processes, allows counselling psychologists to have an essential therapeutically unifying role in in-patient service, extending psychological impact to the whole ethos of the institution. Counselling psychology principles, acting away from the biomedical model that prevails in wards, can be ideally suited to combine individual client work with input to the psychological thinking of the whole team, in the form of consultation, supervision and reflective practice.

7. Conclusion

The review of the studies that have examined the role of therapeutic relationships and the formation of the working alliance in in-patient settings implies that alliance should be seen as an interpersonal process that can act as a guide on the therapeutic interventions of therapists working in such contexts. From the studies reviewed in this paper it seems that therapeutic alliance, an engagement between patient and therapist with regard to the tasks and goals of treatment together with a quality bond between them, encourages the therapeutic process. It has also been shown that the establishment of therapeutic alliance in in-patient psychological work poses specific challenges to the in-patient psychologist compared to other traditional psychotherapeutic settings. Given the whole network of professionals contributing to the relational and social recovery process of a patient, and the emphasis of the UK mental health care system on the interdisciplinary staff approach, where not only the psychiatrist and the psychologist are the main crucial figures in a patients' treatment but each and every member of the therapeutic staff, it makes clinical sense to explore alliance formation among all the various figures involved in treatment. Counselling psychologists could have a leading role in increasing these relationships' therapeutic potential in order to create more cohesive and unitary therapeutic systems and avoid internal fragmentation of subservices, such as nursing, occupational, psychological, and psychiatric inputs. Such fragmentation may well negatively influence a patient's mental health care experience and possibly hinder their recovery process.

As has been shown, alliance has been considered as an element of the process that influences treatment outcome. However, when it comes to the in-patient context, evidence suggests that alliance can be considered to be an outcome factor itself. In other words, as in Priebe & McCabe (2008) ask, is the therapeutic relationship in psychiatry only the basis of therapy or is it therapy in and of itself? Further research and empirical evidence on the role of alliance and therapeutic relationships in the in-patient context from a psychological stance is needed. In-patient alliance research may be facilitated by qualitative approaches that emphasise the perceptual worlds of clients and therapists by taking into account the full complexity and contextual relatedness of the therapeutic process involved in counselling. Such an approach may offer a richer understanding and greater clinical relevance of the phenomenology of alliance, that is, "the clinical reality of the phenomenon as it is understood and experienced in the actual therapeutic encounter from the perspective of the involved participants" (Bachelor, 1995).

The existing evidence suggests that staff forming positive therapeutic relationships and engaging with patients in a meaningful way in psychiatric in-patient units is extremely beneficial for both patients

and professionals. If, as stated earlier, the in-patient experience is to be seen as providing a psychologically holding environment where staff are to serve as an emotional and reflective container, then the in-patient psychologist has a dual role to play. In psychological work with in-patients she/he has to promote his/her resources into cultivating a therapeutic ward climate in the unit, as well as to balance esoteric micro-processes that hinder alliance development in the in-patient context. More holistically, as she/he is closely associated with the overall service, working and acting professionally from the context of the whole health care institution, she/he has to identify and promote therapeutically effective elements of relationships in order to optimise the milieu's therapeutic potential. Therefore, these acts of balance in relation to alliance may be considered to be an important part of the counselling psychologist's work in NHS in-patient and outpatient settings.

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