16 An Investigation into the Experience of Having Multiple Readmissions to Psychiatric Hospital

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Introduction

This paper is drawn from a wider project focusing on the stories of psychiatric patients elicited from collective case studies. The stories are biographically constructed from the patients' narratives of their experience of the 'revolving door' phenomenon. This is a phrase often used in psychiatric discourse to refer to multiple readmissions to psychiatric hospital. Given that the quest for meaning in the social world is firmly embedded within its various institutional structures (and that these structures influence the resulting stories), there is a conceptual concern regarding the potential identities embodied in each patient and how they are interpreted and accommodated by the social environment.

By carrying out an integrated analysis of the experience of these patients and of the objective social structures that provide the necessary conditions for the experience, I hope to contribute to a greater understanding of how they are incorporated (or not) in their life story/sense-of-identity and how they are perceived. So far, researchers attempting to understand this phenomenon have tended to rely on quantitative and positivist research, rather than qualitative and idiographic research methods. Despite these attempts, there is still no adequate explanation for the 'revolving door' phenomenon.

In this chapter, I will focus directly on the methodological approaches involved in researching the phenomenon. I will discuss the notion that people with mental illness are too damaged by their condition to recognize what might help them with their recovery. Further, I will argue that using a positivistic approach when researching the 'revolving door' phenomenon does not provide us with enough information to fully understand the problem or the person. I will also argue that it is only when we offer patients the opportunity to tell their own stories through the use of qualitative methodologies that we begin to discern the nature of the person. I will try to show that the use of the Biographical Narrative Interpretive Method (BNIM) (Wengraf, 2001) offers a deeper understanding of a patient's personal experience. Indeed, this data collection and analysis tool provides the means for obtaining valuable

information and a unique viewpoint from which to interpret the patient's life story as it is remembered and recounted. Before embarking on this task, a brief history of the 'revolving door' problem is presented.

Historical Context of the 'Revolving Door' Problem

Over the past five decades, Western psychiatry has witnessed the deinstitutionalisation of the mentally ill (Pilgrim and Rogers, 1999). However, this period has also seen an increase in the percentage of patients being readmitted to hospital (Goodwin, 1997, p.117). Today, in accordance with the 1990 NHS and Community Care Act (Department of Health, 1990), many of the services for people with severe and enduring mental illness are provided within the community. Whilst most of these people manage to live in the community without major disruption to their lives, some experience repeat admissions to psychiatric hospital. These individuals have come to be referred to as 'revolving door' patients (Haywood, 1995, p.856).

Any crisis requiring admission to a psychiatric hospital (whether voluntary or involuntary) is more often than not followed by a period of stability of varying duration, discharge, exacerbation of the illness and then relapse, leading to re-admission (Goodwin, 1997, p.117). Not surprisingly, the revolving door phenomenon has raised many questions about the effectiveness of community care (DoH, 1994) and particularly the way that the mentally ill are regarded by society in general (Perkins and Repper, 1996; Barlett and Wright, 1999, p.vii). Certain high profile cases (DoH, 1994) have added to the debate on whether the closure of several large hospitals was indeed of any benefit to the patients themselves (Reith, 1998), particularly since stigma remains a prominent element of a patient's everyday life (Bean, 1993).

In my own research, emphasis is placed on hermeneutic inquiry, or expressed differently, the process of interpretation and the understanding (*verstehen),* of the significance or meaning that is attributed to the stories being interpreted. In biographical work, this approach can help researchers gain special insight into the unique experience of each individual (Cooper, 1990). The storied life is of particular relevance as the ideas that people construct of themselves - their image of who they are and where they fit - are, according to both Bruner (1990, p.56) and Plummer (2001, pp.233-234), based upon memories gathered from years of personal experience.

Paradoxically, revolving door patients have more often been studied in the context of medical ideology, which focuses on biological and environmental factors that account for the aetiology or maintenance of severe mental illness (Birchwood, Hallett and Pretson, 1988; Hirsch and Weinberger, 1995). They have also been portrayed as objects of the clinical gaze of mental health professionals (Pilgrim and Rogers, 1999, p.193; Foucault, 1977; 1997) as well

as the government (DoH, 1999) in The National Service Framework for Mental Health in accordance with the concept of Clinical Governance (DoH, 1998).

In reviewing the literature on psychiatric patients' experience of repeat admission to hospital it emerges that, whilst there are historical accounts of the changes in services and the treatment for mental illness, very little is recorded about the personal experience of the patients themselves (Beveridge, 1998, p.117; Canvin, Bartlett and Pinfold, 2002, p.362). Moreover, although medical researchers and pharmaceutical companies have written on the effects of medication on mental illness itself, there are no reports from the perspective of patients' lives. This adds to the view of Dahlberg, Drew and Nystrom (2002, p.212) that much of the insight of individuals with a severe and enduring mental illness remains relatively private and that, by excluding their stories, we are, in effect, omitting a large and essential body of information. Pilgrim and Rogers (1999, p.193) also argue that clinical research in the area of mental health has tended to exclude the views of patients or to portray them as passive objects of study.

At the same time, a number of reasons have been given to explain this scarcity of representation of people with mental health problems within mental health care research, such as:

- The assumption that the views expressed by psychiatric patients will be irrational or unreliable because of the state of their minds (Dworkin, 1992, pp.59, 62, 69; Rogers, A., Pilgrim, D. and Lacey, R., 1993, pp.6 -10).

- The assumption that the very fact that those receiving psychiatric treatment may have been given a diagnosis of 'mental illness' means that they will be incapable of expressing a rational opinion (Dworkin, 1992, pp.59, 62).

- The assumption that research involving mental health users may cause distress by encouraging them to recall unhappy events or experiences that they may prefer to forget (McIver, 1991, p.31).

McIver (1991, pp.8-9) identifies the vulnerability of people with mental health problems, the difficulties in achieving a representative sample and the importance of asking the right questions in an appropriate manner. However, McIver (1991) also believes that researchers can overcome these problems He states that, by using qualitative research methods, such as unstructured interviews, research can establish the service user's agenda of importance (McIver, 1991, p.12). In fact, the use of interviews gives a voice to services users who are not able to read or write, or who feel unhappy about questionnaires.

Method of Analysis

Having collected data from seven in-depth biographical interviews using the protocol of the Biographical Narrative Interpretive Method (Wengraf, 2001), I am now in the analysis phase of the research. A brief introduction to the analytical approach I am using to interpret the data from the interviews follows.

I decided to use an inductive approach to analysis, based on 'objective hermeneutics' and still within the protocol of the Biographical Narrative Interpretive Method, which, in essence, allows research findings to emerge from the frequent, dominant themes inherent in raw data without the restraints imposed by structured methodologies (Thomas, 2003, p.2). My aim is to understand the subjective understandings that patients have of their lived experiences and how these understandings inform personal constructs used for making sense of themselves.

According to in-depth hermeneutics, subjective expression is not only taken for granted, but is also allowed in order to look for meanings and implications beyond the knowledge or intent of the acting, knowing or speaking subject. Further, it conceives reality as contradictory and repressive and assumes that critical interpretations should always be an attempt to develop the underlying or repressed possible actions of the subject. From this follows a double attempt to deconstruct the meanings and actions and to 'construct' other possible meanings and actions (Schwandt, 1997).

A unique and interesting element of the Biographical Narrative Interpretive Method analysis process is the use of the reflecting team approach. This approach to data analysis facilitates the introduction of multiple voices and the opening up of interpretation possibilities, rather than relying solely on the principal researchers' interpretation of the interview. A prerequisite for the participants of the reflecting team is openness and creative imagination rather than knowledge of specific research methods (Jones, 2003, pp.60-71). In his initial work with the technique, Jones (2001) used reflective teams comprised of academics from diverse backgrounds to analyse interviews, incorporating team members' experiences to bring understanding to the interview material.

The reflective team approach to data analysis can be used to facilitate distancing and openness, which Ricoeur (1991) suggests as a way for researchers to critically examine their methods and uses. Denzin, (2003) encapsulates the importance of using multiple perspectives to interpret a single set of data in what he calls triangulation (2003, pp.66-67). In the broad context of this method, triangulation refers to the play between the interviewee, the interviewer and the reflecting team. As the team can consist of three or more members from diverse backgrounds and perspectives, another opportunity for triangulation takes place at this micro level. These triangulated, reflective

processes represent an attempt to secure an in-depth and broad understanding of the phenomenon in question.

Interpretations

I will start this final section by reflecting upon my own interpretive process which I have been engaged in from the very beginning of the study and have found instructive, in that it is not only helping me to understand others but myself as well. I will then continue by examining conclusions so far drawn from the interviews conducted and I end with some thoughts about the journey ahead, in particular, working with reflective teams and the challenges and opportunities this is likely to offer.

I originally started my metaphorical journey in many ways like a true explorer with apprehension and anxieties simultaneously exciting and daunting, not knowing what lay before me in terms of possibilities for discoveries. But being motivated largely by a desire to understand more of the processes that make individuals and society in general work, and by an aspiration to make the world more intelligible by adding something to the field of knowledge.

Notably, the human aspect of listening to patients' stories has made the interviewing most fascinating and often, emotionally touching. A common theme that emerged from the narratives was that admission to psychiatric hospital is an emotional event. What Pillemer (1998) refers to as 'personal event memories'. The concept of 'personal event memory' is described by Pillemer as having five distinct features. The personal event memory must:

- Be a specific event that took place at a particular time and place.
- Contain a detailed account of the person's personal circumstances at the time of the event.
- Evoke a feeling of re-experiencing or reliving the event.
- Link its details and images to a particular moment or moments of phenomenal experience; and
- Be believed to be a truthful representation of what actually transpired (1998, pp.48-51).

According to Pillemer (1998) analogous events or episodes that are readily compared with similar other events to suggest a pattern or theme that runs through the person's life story are seen to be most instrumental in self-definition.

McAdams (2001) suggests that, 'when a person experiences emotion in a given life scene, he or she has already made an implicit appraisal of the scene's meaning in terms of its causes and probable consequences and the extent to which goal attainment may be furthered of frustrated' (2001, p.109). As a mental health social worker I am aware that I have pre-conceived socially constructed ideas based on what admission to psychiatric hospital represents for patients. For example, conceptualising that frequent and repeated admission to hospital is a process that can bring with it periods of change and discontinuities. And that these periods have the potential for identity to become fragmented and fragile as a consequence of the disruption of biographies. Indeed, many of the stories told in the interviews reflected this understanding. However, being always open to fresh interpretation through questioning and not necessarily relying on my own perspective not only allows me to exercise my critical voice, but also gain insight into the differences between interpretations and how they are arrived at.

Finally, I regard the use of reflective teams in the analytical phase of the study as an important next step, the strength of which, I envisage will offer a wider perspective to view the phenomena under investigation, bringing different interpretations to the interview material. For the reflective teams I plan to use professionals from multi-disciplinary teams (ie. doctors, psychologists, nurses) and lay members as it would be interesting to find out their perspective on what was going on in each of the chosen cases to be analysed.

Conclusion

In this chapter, I have demonstrated the fact that the experience of having multiple readmissions to psychiatric hospital has not been addressed in-depth and in a meaningful way within medical and sociological research spheres. Quantitative and positivistic approaches have been criticised and I have tried to highlight the need for qualitative methodological approaches to help us understand the experiences of a disparate group of people such as those suffering from mental illness.

I have also shown that the Biographical Narrative Interpretive Method belongs to a growing branch of qualitative methods that focus on the story, its composition and its telling, and is a useful data collection and analysis tool for understanding the psychology/subjectivity of the individual. While there are some barriers to interviewing this particular research group - such as the possible difficulties of narrating a coherent story in times of crises when personal identity is necessarily in a state of confusion and flux - I argue that the Biographical Narrative Interview Method is a means by which people can

relate experiences from everyday life and, in this way, provide opportunities for us to come to a modicum of understanding of what those experiences mean.

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