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The experiential impact of hospitalisation in early psychosis: Service-user accounts of inpatient environments

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ABSTRACT

Early Intervention in Psychosis services aim to keep young people out of hospital, but this is not always possible. This research used in-depth interviews to explore the experience of hospitalisation amongst young people with psychosis. Findings describe fear and confusion at admission, conflicting experiences of the inpatient unit as both safe and containing, and unsafe and chaotic, and the difficult process of maintaining identity in light of the admission. We discuss the need to move from construing psychiatric hospitals as places for 'passive seclusion', to developing more permeable and welcoming environments that can play an active role in recovery.

1. Introduction

It is a central tenet of phenomenological philosophy that the relationship between person and world is reciprocal and mutually-constitutive (e.g. see Larkin and Thompson, 2011). This idea emerges in various forms in many other domains, such as phenomenological psychology, ethnography, cultural psychology, cultural geography, person-environment psychology, human systems approaches, and health geography. In the latter domain (e.g. see Cummins et al., 2007), the mutually-constitutive relationship between people and their context has been of particular interest due to a growing consensus about the impact of designed and built environments, and the human systems which shape and interact with them, upon health and wellbeing. In this paper, we explore a particular example of the relationship between environment, systems, and experience - hospitalisation during first-episode psychosis - from a phenomenological psychological perspective.

A first episode of psychosis (FEP) typically occurs in early adulthood, at a time of important psychosocial development. In the UK, Early Intervention Services (EIS) offer biopsychosocial interventions to young people with psychosis during the 'critical period' after first onset, aiming to avoid hospitalisation and foster recovery (McGorry and Jackson, 1999). However, at times of acute distress and risk, young people with psychosis are still likely to be admitted to hospital. Sometimes hospitalisation is in response to a crisis that occurs despite established EIS support, and sometimes crises may precede (and trigger) a referral to EIS. Psychiatric hospitalisation can be distressing and even traumatising for mental health service-users (see Berry et al., 2013). Little is known about its impact on young people with early psychosis, who are likely to have been hospitalised in a crisis, and who may either have believed that hospitalisation was unlikely (given the ethos of EIS) or for whom hospitalisation may have signified first contact with mental health services. This research focuses on understanding the experience of hospitalisation for these young people.

1.1. Experiences of inpatient mental health care

Inpatient care environments have been seen as less central to mental health care than they once were, given the shift to community care (Healthcare Commission, 2008). However, they remain very important for acute care and are recognised as being under-resourced for the demands placed on them (Lelliot et al., 2006). It is worth noting that many of these environments were not designed for acute psychiatric care (Jones, 2004; Von Sommaruga Howard, 2004), and that many of those which were designed for this purpose, appear

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to have been conceived with relatively limited anticipation of the impact of the environment upon its users (Von Sommaruga Howard, 2004). Curtis et al. (2009) point out that such environments have a dual effect, protecting people from social stigma, but also cutting them off from social support. Similarly, psychiatric hospitals function as a form of social control: the unique dilemma of this healthcare environment is that staff are asked “to treat people in hospital who do not want to be there, whilst constantly discharging those who would like to stay” (Turner, 2005, p. 318). Hospitalisation has featured extensively in the growing literature on psychiatric care generated by survivors and user-researchers. For example, Woodlen (2011) has written extensively about the dehumanising effects of inpatient environments. As a former patient, she has experienced the ways in which “Inpatient psychiatric staff, on a daily—if not hourly—basis, violate the social contract that exists between human beings,” and yet, as a former employee, can also recall how her own prior assumptions appear to her as “ignorant, narrow-minded and judgmental” (2011). Typically, inpatient environments are characterised in survivors' accounts as exclusively medical, overly coercive, and unempathic (Keyes, 2013). Despite this consensus, very little of this user experience literature focuses specifically upon first admissions and/or early psychosis. Most accounts that do include reflections on these issues are written from considerable retrospective distance. For example, participants in Rose (2001) and Rose et al.'s (1998) two influential reports on user experience of mental health services in London (1998 and 2001) have mean ages in the mid-40s. This may be a reflection of the time which recovery journeys can take, and also the life stage at which it can feel safe or important to share such accounts publically (e.g. see Sen et al., 2009). Thus, there is an important role for more focused, formal and anonymised forms of experiential enquiry alongside these accounts.

Inpatient services are frequently constructed as a topic of concern in mental health research and policy, often in response to service-users' reports. Reviewing the literature, Quirk and Lelliott (2001) conclude that service-users experience wards as unsafe, boring, and lacking in amenities. We can situate these concerns in the wider context of findings on the relationship between environment and wellbeing. While it can sometimes be difficult to tease out relationships between specific environmental features and specific health consequences (Cummins et al., 2007), and may even be difficult to make sense of such relationships when they emerge (e.g. see Weich et al., 2002), the general patterns in the literature are clearly relevant to this setting. For example, Evans (2003) shows three important features of the psychosocial environment with positive benefits for wellbeing: the affordance of personal control over one's own experience; access to supportive relationships, and opportunities for restorative engagement with the natural world (see also Jackson, 2003). All three of these levels of interaction between person and world are under threat in typical acute care settings. Encouragingly, positive attempts to address these threats, through anticipatory design of the physical and systemic environment, appear to improve people's experiences of these settings (e.g. see Curtis et al., 2007). The overarching concerns about acute care environments are summarised very clearly in the literature on therapeutic landscapes and psychologically-informed environments, where writers have emphasised the mutually-constitutive relationship between the environment, what happens in that environment, and our experience of it. That is, on the one hand, “Place becomes meaning-filled through experiencing agents” (Fenner, 2011, p. 852), and on the other hand, certain kinds of meaning and experience are afforded by certain kinds of places and spaces (Nova, 2005).

Advocates of psychologically-informed environments (Johnson and Haigh, 2011) extend this rationale to argue that the physical and social organisation of healthcare environments should thus be informed by a set of common psychological principles, in order to ensure that the environment does foster the appropriate behaviours and interactions from those who interact with it. The recommendations made in both of these fields highlight that acute care remains some distance from the ideal (Muijen, 2002) and that it has progressed very little on those issues which are most important to user experience (Lloyd-Evans et al., 2010; Csipke et al., 2014), such as improved communication and empathy, more personal one-to-one care, and fewer restrictions on personal freedom.

The breadth of such concerns perhaps serves to emphasise the importance of understanding the needs of particular populations in relation to inpatient care. A younger population, who may be using adult mental health services for the first time, may be particularly impacted by hospitalisation. One concern is the context of the psychiatric hospital as a site of inevitable stigmatisation (McGrath and Reavey, 2013), which may have particularly strong consequences for young adults at an important stage of identity development (something also a concern for parents of service-users with early psychosis; Hickman et al., in submission). Warner et al. (1989) highlight that self-esteem was particularly low among those who perceived high levels of stigma attached to their mental health issues. Roe (2003) suggests that some forms of treatment, including hospitalisation, convey a powerful negative statement about competence and thus challenge an individuals' self-esteem; adolescent service-users in a psychiatric facility have been shown to report more negative self-descriptions than controls (Bers et al., 1993). In addition, hospitalisation is linked to post-traumatic stress disorder (PTSD): Morrison et al. (1999) found 44% of people admitted to an inpatient psychiatric unit subsequently exhibited PTSD symptoms. Trauma can compound the difficulties associated with psychosis and hamper recovery and the work of EIS. Traumatic aspects of hospitalisation, for example restraint and exposure to violence, should be minimised (Craig and Power, 2010).

1.2. *First person accounts of psychosis*

Quirk and Lelliott (2001) argue that there is a need for qualitative research to explore the meanings of hospitalisation. This study uses the qualitative psychological approach Interpretative Phenomenological Analysis (IPA; Smith et al., 2009). IPA is concerned with understanding the perspective of the ‘person-in-context.’ It draws on hermeneutic phenomenology to focus researchers' attention on identifying and interpreting the ‘perspectival’ qualities of each participant's relationship to the ‘things that matter’ to them and which constitute their world Larkin and Thompson, 2011. Thus, the approach is committed to the examination of how people make sense of major life experiences, in detail and depth. IPA has been employed to investigate a variety of experiences within psychosis (e.g. Newton et al., 2007). In one relevant example, Perry et al. (2007) investigated experiences of ‘hope’ in FEP. They report that hospitalisation was associated with hopelessness, being treated without respect, not having control, and having a lack of information. This study aimed to extend these limited findings by directly exploring what it was like for young adults to be hospitalised for early psychosis.

2. Method

2.1. *Context*

This paper reports upon one part of a larger ‘multiple-perspective design' study (Larkin et al., 2013), which uses semi-structured interviews and IPA to explore three different perspectives of hospitalisation for early psychosis: parents (Hickman et al., in submission), staff (Thompson et al., in submission), and in this