University of Southampton
Faculty of Medicine, Health and Life Sciences
School of Psychology

Service Users' Experiences of Being Sectioned Under the Mental Health Act

Marianne Seebold

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General Abstract

It is important for researchers to explore what service users' think about mental health services, so that professionals can develop services that meet their needs. The first part of this thesis contains a review of the literature relating to service users' experiences of psychiatric hospitalisation. The majority of the research discussed investigated perceived coercion and the review considers how this narrow focus has not allowed for the collection of data on other elements of people's treatment experiences. The review highlights how there have been no published studies exploring NHS service users' experiences of being sectioned, which suggests that this is an area that needs to be researched.

The second part of the thesis contains a qualitative research study, which aimed to provide an understanding of how service users described their experiences of being sectioned under the Mental Health Act. Narratives were elicited in semi-structured interviews with seven individuals who had been sectioned in the past five years. The interviews were analysed using narrative analysis techniques and the narratives were categorised within four genres of *escape*, *rescue, enlightenment* and *endurance*. The narratives highlighted a complex mixture of negative and positive aspects of being sectioned. The results are discussed in relation to previous research findings and the implications for future research and clinical practice are explored. Particular attention is drawn to the clinical implications of the research considering the planned reforms to the Mental Health Act (1983), which means that non-medically trained professionals will become involved in sectioning procedures.

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LITERATURE REVIEW PAPER*

Service Users' Experiences of Hospitalisation for Mental Health Problems

Marianne Seebold
University of Southampton.

Correspondence regarding this article should be addressed to Marianne Seebold, Doctoral Programme in Clinical Psychology, University of Southampton, School of Psychology, 34, Bassett Crescent East, Southampton, SO16 7PB.

* International Journal of Law and Psychiatry has been used as a guide in determining the preparation of this article (See Appendix A for Guidelines for Authors).

Abstract

This literature review provides an overview of the research relating to service users' experiences of psychiatric hospitalisation. It does this in order to explore what is currently known and identify what is missing in the literature to identify areas for possible research.

Firstly, the review highlights the statistics on hospital admissions in England and Wales and explains the scope of the Mental Health Act (1983). Secondly, the review considers the implications of being detained involuntarily. Thirdly, the review summarises the primarily quantitative research relevant to understanding service users' experiences of hospitalisation. Fourthly, the review critically reviews these studies, focussing on methodological limitations and presents a rationale for the need to conduct qualitative research to supplement the quantitative data. Finally, the implications for further research are considered and the clinical implications of the research discussed.

Introduction

There is a growing trend within the National Health Service (NHS) to understand service users' experiences of health care. In the past 10 years, there has been a shift from dismissing the negative reports of individuals with mental health problems as a consequence of the cognitive distortions resulting from their mental health problems, to accepting their views as valid. Shields, Morrison and Hart (1988) highlight three reasons for exploring service users' views. Firstly, they are a vulnerable group owed an obligation to be treated respectfully. Secondly, they can identify cost-effective treatments and, thirdly, in a democratic society professionals can ensure the accountability of service providers by asking users what they think of services. In considering the effects of hospitalisation on individuals, there has been a shift in professionals' thinking to be concerned that this event can be traumatic. Some individuals report being traumatised by the process, which includes a loss of freedom and privacy (Sainsbury Centre for Mental Health, 1998). For those individuals who go willingly into hospital although it can still be a difficult experience, they are better prepared than individuals admitted involuntarily, who are often brought in by the police and sometimes admitted after a night in a police cell which can add to the distress experienced.

One cannot deny that some individuals receive satisfactory care that meets their needs and that there is a need for legislation, which enables individuals to be detained involuntarily in certain circumstances. Several factors lead to a situation where involuntary hospitalisation appears to be the best or last option. The individual's social network may be exhausted or absent, cooperation of the individual may be limited and risk may be present, to self or others (Bonsack & Borgeat, 2005). Due to these reasons, although involuntary treatment is criticised in most countries, it is accepted as necessary (Poulsen, 1999).

However, by reviewing Department of Health (DOH) reports one can see widespread evidence that for a significant number of individuals inpatient stays are negative experiences and the conditions of wards have a negative effect on service users' mental health (Glasby et al., 2003; Sainsbury Centre for Mental Health, 1998; Watson, 2001). A national survey of 343 former inpatients conducted by MIND (Baker, 2000) found similar reports. The study found that for many, hospitalisation was a predominantly negative experience, with 56 percent describing wards as un-therapeutic environments and complaints about the daily contact time with staff. In addition, 45 percent reported that the ward conditions had a negative effect on their mental health, and 45 percent described the wards as depressing and bleak.

How people experience hospitalisation should be a key concern for professionals because in England alone 46,700 people were detained under the Mental Health Act in 2004-2005 (The Information Centre, 2006). The good practice points outlined in the National Institute for Clinical Excellence (NICE; 2002) guidelines for schizophrenia also recommend that service users should be given the opportunity to give their account of why they are in hospital. Despite this in England, only two qualitative studies have explored what hospitalisation is like for individuals (Goodwin, Holmes, Newnes, & Waltho, 1999; Johnson et al., 2004). It is crucial to understand how people experience this process, because for many it has been a significant part of their experiences as a service user.

This review will start by exploring the statistics on hospital admissions in England and Wales and will give a definition of the legal terms involuntary and voluntary, along with an explanation of the scope of the Mental Health Act (1983). The review will then consider the implications of being detained involuntarily. Next, the review will summarise the research relevant to service users' experiences of hospitalisation, in order to explore what is known

about this topic. The review will critically review these studies, focussing on methodological limitations and presenting a rationale for the need to conduct qualitative research to supplement the primarily quantitative research. Conclusions will be drawn and the potential for further research and the clinical implications of the research discussed. The term 'service user' will be used when possible throughout the review, in accordance with guidelines to reduce bias in language (American Psychological Association, 2001). However to describe the legal status of individuals the terms voluntary and involuntary inpatient will also be used.

Admissions to NHS and Independent hospitals in England and Wales

As Scotland has different mental health legislation only data for England and Wales will be presented. The latest statistics show that there were 46,700 involuntary detentions under the Mental Health Act (1983) in 2004-2005 in England (The Information Centre, 2006). Of these 26,800 individuals were detained involuntarily and 19,900 were made involuntary after being admitted voluntarily. Data on the number of voluntary admissions is unavailable for England however general statistics for 2004-2005 stated there were 131,686 total admissions to psychiatric units (Hospital Episode Statistics, 2005) and for that year, there were 26,800 involuntary admissions, which suggested there were approximately 104,886 individuals hospitalised voluntarily. For Wales there were 2,437 involuntary detentions under the Mental Health Act (1983) in 2004-2005, 1,402 of these individuals were detained involuntarily and 1,035 were made involuntary after being admitted voluntarily (Statistical Directorate, 2005). In 2004-2005 there were also 13,710 individuals hospitalised voluntarily in Wales.

The main scope of the Mental Health Act (1983)

There are two main civil sections of the Mental Health Act (1983) used to detain an individual; 'section two' and 'section three'. The term section refers to the different parts of the Act, and involuntary detention is more commonly called 'being sectioned' in the UK. Once sectioned an individual is admitted involuntarily to hospital, because they are considered a risk to themselves or to others due to their mental state.

A section two allows a person to be detained if they are considered to be suffering from a mental disorder and need to be detained, for up to 28 days for assessment. Research supports that there has been a substantial increase in the number of section two admissions over the past decade (Lelliott & Audini, 2003). A section three allows a person to be detained if diagnosed with a mental illness, mental impairment, or psychopathic disorder, and it is considered necessary for their safety, or the protection of others. Detention can last up to six months, but the section can be renewed by six months initially and then by a year at a time.

Once sectioned individuals are detained not for having committed a crime but because deemed mentally ill and their right to refuse treatment is removed. However, the concept of mental illness has received criticism by psychiatrists and psychologists for decades because of a lack of validity and concerns about the usefulness of diagnoses (Bentall, 2004; Boyle, 1990, 2002; Breggin, 1983, 1991; Charlton, 2000; Johnstone, 2000; Newnes, Holmes & Dunn, 1999; Szasz, 1978; 2005). Critics therefore see involuntary treatment as being utilised more to control socially undesirable behaviour, rather than treat mental health problems (Mason & Jennings, 1997; Symonds, 1998).

Nearly 40 years ago involuntary hospitalisation was described as the most serious deprivation of liberty that a society can impose and the fact that no intellectual effort was directed at providing justification for it was heavily criticised (Livermore, Malmquist & Meehl, 1968). Despite this, the situation has not improved much since then, and considering the serious consequences of being detained involuntarily and the large number of people subjected to this yearly, it is shocking how few studies have researched this. Involuntary treatment has been a contentious area for decades with some academics suggesting that it should be abolished (Høyer, 2000; Szasz, 1978; 2005; Wertheimer, 1993) or failing that, a narrowing of the criteria by which people qualify for involuntary hospitalisation (Morse, 1988).

The Mental Health Act (1983) is a unique piece of legislation, as a person can be deprived of their civil liberties when they have neither committed a crime, nor appeared before a court. Once detained, a person can receive treatment normally regarded as assault, for example involuntary medication or physical treatment such as Electro-Convulsive Therapy (ECT) (Turner, 1996). Involuntary treatment has serious implications when one considers that some medications have significant side effects that include Tardive Dyskinesia (British Medical Association & the Royal Pharmaceutical Society, 1996) and that ECT can result in significant memory deficits (Breggin, 1991; Frank, 1990; Goodwin et al., 1999; Johnstone, 1999; Philpot et al., 2004)[1].

There are also many long-term social consequences of being sectioned that individuals can face, which includes losing their driving licence, increased health insurance costs, restriction on travel to certain countries, difficulties gaining employment, discrimination and stigma in society (DOH, 1999; Sayce, 2000; Secker, Grove & Seebohm, 2001). Individuals can

[1] Due to concerns over ECT, it has been completely banned in Slovenia (Smyth, 2006) and almost abolished in Italy, Holland and Germany (Bourne, 1999; Youssef & Youssef, 2006).

sometimes avoid being sectioned if they agree to stay voluntarily (Dawson, 2006). Voluntary patients can leave hospital when they desire but a doctor can stop the individual leaving if he or she thinks that the individual should be detained involuntarily.

Focus of the literature

The literature on hospitalisation has mainly explored perceived coercion and been initiated partly by concerns about the denial of people's human rights through involuntary detention (Høyer, 2000; Monahan et al., 1995; Nilstun & Syse, 2000; Szasz, 1978, 2005; Wertheimer, 1993). Perceived coercion broadly means an individual perceiving that he or she does not have the control, freedom, or choice to enter hospital (Gardner et al., 1993). An individual's perception of coercion is also used to describe how the individual feels that he or she was treated in the situation. The next section of the review will evaluate the studies that investigated service users' experiences of voluntary and involuntary treatment. The studies exploring perceived coercion are primarily quantitative and investigated this using a package of standardised tests developed specifically to assess perceived coercion by Gardner et al. (1993). The scale most frequently used in research is the Admission Experience Questionnaire (AEI), which is a structured interview that measures the individual's perception of coercion. The Admission Experience Scale (AES) is derived from the AEI and is a shorter questionnaire from which a rating of perceived coercion can be obtained.

One factor which has been found to impact on perceived coercion is the concept of 'procedural justice' which refers to how much an individual feels that he or she is part of the decision making process in hospital admission. Service users report perceiving procedural justice when they feel; that they are able to express their views, their views are considered in

clinical decisions, they are treated with respect and they are given accurate, relevant information about the procedures they are involved in (Lind, Kanfer, & Earley, 1990; Lind & Tyler, 1988). Research investigating the link between procedural justice and a subjective perception of coercion has found a strong correlation between perceptions of procedural justice and perceptions of coercion, with a strong sense of procedural justice minimising the experience of coercion (Lidz et al., 1995).

Two further factors considered to impact on perceived coercion are 'process exclusion' and 'negative pressures'. Process exclusion reflects the extent to which the individual perceives that his or her views have been heard and considered in the hospitalisation decision (Hiday et al., 1997). The final factor negative pressures refers to threats and force of any kind that indicate to individuals that they would suffer negative consequences if they resisted hospitalisation[2]. The amount of negative pressures service users report have been found to be correlated with an increased perception of coercion (Hiday et al., 1997; Hoge et al., 1997; Lidz et al., 1995).

[2] Two examples of negative pressures are a service user being told that they would lose their job, or would be sectioned if they did not agree to hospitalisation.

Overview of studies

Most of the studies investigating service users' experiences of perceived coercion used psychometric scales. Fewer studies were qualitative and explored other aspects of hospitalisation apart from coercion. Table 1 (See Appendix B) summarises the studies that investigated hospitalisation experiences. Some of the studies collected data from professionals and family members in addition to service users to compare accounts of coercion. Most participants were inpatients when interviewed, of white origin, with varying socio-economic backgrounds. Of the studies, only four were conducted in Britain, with the remainder being conducted in the USA, Sweden, Denmark, Germany, Finland, Switzerland and New Zealand respectively. Some of these factors allow for a comparison of the findings, however they also have implications for the generalisabilty of the results to NHS users.

The aims of the studies, theoretical orientation of the researchers and areas of interest vary across the studies. This is reflected in the focus of the studies, the measurements used, the language used and the way the data were analysed. Broadly, however the studies can be split into those investigating perceived coercion, those investigating if hospitalisation is traumatic and those exploring service users' hospitalisation experiences.

Perceived coercion studies

The studies described all had the same aim of investigating perceived coercion in hospitalisation, but varied in the focus of their investigation. (Bindman et al., 2005; Bonsack & Borgeat, 2005; Hiday et al., 1997; Hoge et al., 1997; Lidz et al., 2000; McKenna et al., 1999; Olofsson & Jacobsen, 2001; Poulsen, 1999; Rogers 1993). The areas explored concerned the different facets of perceived coercion and included investigating whether voluntary patients perceive coercion, what groups of patients experience the highest coercion, how people feel coerced, who coerces individuals and how to prevent coercion.

A unique study within this group was Olofsson and Jacobsen's (2001), which was the only one that did not use psychometric tests such as the AEI (Gardner, et al., 1993) to measure coercion. This study used a qualitative interview to investigate involuntary hospitalisation, which enabled a detailed exploration of involuntary care experiences, without the restraint of only being able to answer primarily forced response questions. The results highlighted primarily negative comments revealing that the participants felt disrespected, treated as inferior humans, uninvolved in their care and reported unsatisfactory care. However positive comments were also made regarding staff treating individuals respectfully, being involved in care, receiving good care, and being treated as a human.

Three of the studies were similar in that they found that perception of coercion was unrelated to psychopathology and diagnosis (Bindman et al., 2005; Hiday et al., 1997; Poulsen, 1999). This supports the validity of service users' reports on coercion despite being in a distressed mental state. Interestingly Bindman et al. (2005) found contradictory results in this respect. Although they found that those with fewer symptoms perceived higher coercion, they also

found that having a diagnosis of psychosis led to increased perceived coercion. The authors did not speculate on this contradictory finding, but this could perhaps be explained by the possibility that individuals with fewer symptoms are more aware of the restrictions and thus report more coercion, whereas individuals experiencing psychotic phenomena may have paranoid beliefs or be in a more distressed state, which results in them reporting higher perceived coercion.

Several studies investigated the concern that voluntary patients are also coerced (Bonsack & Borgeat, 2005; Hoge et al., 1997; McKenna et al., 1999; Poulsen, 1999; Rogers, 1993). All the studies found this to be the case with numbers of voluntary patients experiencing coercion ranging from 44 percent to 10 percent. Two of the studies were similar because they investigated who coerces individuals to enter hospital (Hoge et al., 1997; Lidz et al., 2000). Both studies found that professionals played the strongest role in coercing the individual and family and friends played the smallest role. Other studies yielded similar results in identifying who is most likely to perceive coercion (Hiday et al., 1997; McKenna et al., 1999), with both finding that women and those with more education perceived greater coercion. Hiday et al. (1997) suggested that these individuals have a higher status in society and thus more autonomy in their lives, which may make them more aware of coercion, and any deprivation in autonomy. Interestingly Hiday et al. (1997) also found that white individuals were more likely to perceive coercion but conversely, Bindman et al. (2005) found the opposite with non-white individuals being more likely to perceive coercion.

Summary

Common findings from the studies were that, voluntary patients reported coercion (Bonsack & Borgeat, 2005; Hoge et al., 1997; McKenna et al., 1999; Poulsen, 1999; Rogers, 1993), professionals provided more coercion than families (Hoge et al., 1997; Lidz et al., 2000), perception of coercion was unrelated to diagnosis (Bindman et al., 2005; Hiday et al., 1997; Poulsen, 1999), and white, well-educated, unmarried and female participants perceived greater coercion (Hiday et al., 1997; McKenna et al., 1999). Olofsson and Jacobsen's (2001) study was the only study to use a qualitative approach to investigate involuntary hospitalisation. The results highlighted primarily negative views revealing reports of feeling disrespected, uninvolved in care and unsatisfactory care. However, positive comments regarded staff treating individuals respectfully, involvement in care, and good care.

Trauma studies

The studies discussed both explored whether being detained involuntarily is traumatic and fulfilled the criteria of Posttraumatic Stress Disorder (PTSD) as defined in DSM-IV (American Psychiatric Association, 1994). The two studies however differed significantly in how they investigated coercion, as Priebe et al. (1998) interviewed individuals about their treatment experiences, whereas Meyer et al. (1999) did not ask service users and gained information on the amount of coercive measures individuals received from the notes only.

Despite both studies finding that involuntary hospitalisation alone did not lead to a PTSD diagnosis, the authors stressed that this did not exclude the possibility that some individuals may have developed PTSD because of involuntary hospitalisation. Meyer et al. (1999) found that 24 percent of the traumatic symptoms were related to coercive treatment, which confirmed that hospitalisation was traumatic for a significant number of individuals. In

particular those admitted for the first time showed the highest treatment related traumatisation. In Priebe et al.'s (1998) study all the participants reported negative aspects of treatment. The negative experiences included violence, noise, overcrowding and monotony on wards, unkind, rigid treatment; and lack of empathy in staff.

Summary

A common finding in the studies was that involuntary hospitalisation alone did not lead to a PTSD diagnosis (Meyer et al., 1999; Priebe et al., 1998). However, Meyer et al. (1999) found that 24 percent of the traumatic symptoms were related to coercive treatment, which highlighted that involuntary hospitalisation was traumatic for some individuals.

Hospitalisation experiences

The studies described are similar in that they explored experiences of hospitalisation and did not focus specifically on coercion. The studies looked at voluntary and involuntary patients and explored many aspects of hospitalisation ranging from the hospital environment, to staff attitudes. Overall, the studies highlighted a complex picture of individuals feeling dissatisfied with but also supported by psychiatric care.

Two of the studies were similar in exploring involuntary hospitalisation experiences (Johansson & Lundman, 2002; Joseph-Kinzelman, Traynor, Rubin, Ossa & Risner, 1994). Both found primarily negative comments with the concerns in Joseph-Kinzleman et al.'s study (1994) relating to coping with intense feelings, lack of freedom and choice, unhelpful staff relationships, boredom, unhelpful medication experiences and anger, fear, and sadness about hospitalisation. In Johansson and Lundman's (2002) study the negative comments

related to staff's inflexible attitude, coercion being negative and unacceptable, being exposed to violence and inhumane treatment, not being treated as human, not being given information about treatment, receiving treatments they did not understand, being ignored and feeling staff were uncaring. The positive comments related to being given responsibility, participating in care decisions, involuntary care being needed when a risk of self-harm, hospital being pleasant, and flexibility in care meaning that involuntarily care did not always result in coercion.

Two studies were similar because they explored service users' experiences of hospital care; however, they differed in that Goodwin et al. (1999) investigated male and female experiences, whereas Johnson et al. (2004) investigated women's experiences of admission to hospital, in comparison to a female only crisis house. In Goodwin et al.'s (1999) study a mixed methods approach was used with quantitative data being obtained through the Service Satisfaction Questionnaire (SSQ; Turpin & Sturmey, 1988) and qualitative data gained through the Survey of Patients' Views (Bond et al., 1992). Analysis of the SSQ indicated a high level of satisfaction, whereas analysis of the qualitative data highlighted the converse with predominantly negative views about hospitalisation. The possible reasons for this contradictory finding will be explored later in this review.

In Goodwin et al.'s (1999) study the negative comments related to feeling powerless and angry at being sectioned, being treated disrespectfully, hospital being compared to prison, not being given information about medication, and the majority reporting distress over involuntary treatment. The positive comments praised approachable, sympathetic staff, and help with benefits. In Johnson et al.'s (2004) study the primarily negative comments concerned the inpatients reporting; admission made the stigma of mental health problems

worse, disappointment with the amount of time staff spent talking to them, the hospital environment had a negative effect on their mental health, admission was anxiety provoking, there was little opportunity to participate in medication or care decisions, there was a lack of appropriate activities, and they would have preferred a female only setting away from frightening male service users. The positive comments concerned feeling safer from self harm in hospital and staff trying to make time to talk.

Summary

Common negative comments highlighted in the previous studies were that participants reported unsatisfactory staff relationships, unhappiness with medication or the lack of involvement in care decisions (Goodwin et al., 1999; Johansson & Lundman, 2002; Johnson et al., 2004; Joseph-Kinzleman et al., 1994), and anger at hospitalisation (Goodwin et al., 1999; Joseph-Kinzleman et al., 1994). Common positive comments concerned hospital care being valued when there was a risk of self harm (Johansson & Lundman, 2002; Johnson et al., 2004) and staff support being praised (Goodwin et al., 1999; Johnson et al., 2004).

Critical review

The next section of the review will compare and critique the literature, firstly exploring similarities between the studies and then providing a methodological critique of the studies.

Methodological similarities between the studies

Similarities between the studies can be seen in their designs, with the majority using quantitative designs (Bindman et al., 2005; Bonsack & Borgeat, 2005; Lidz et al, 2000; McKenna et al., 1999; Meyer et al., 1999; Hiday et al., 1997; Poulsen, 1999; Priebe et al., 1998), and the remainder using qualitative designs (Johansson & Lundman, 2002; Johnson et al., 2004; Olofsson & Jacobsen, 2001), or a mixture of quantitative and qualitative (Goodwin et al. ,1999; Hoge et al., 1997; Joseph-Kinzleman et al.,1994; Rogers, 1993). Within the studies that used a mixed methods approach, Goodwin et al.'s (1999) study was the only one that analysed the data with qualitative techniques (grounded theory and content analysis). The other four studies described qualitative data but did not use qualitative techniques and merely described the data descriptively.

Commonalities can also be seen in the sample of patients selected for analysis. The majority of studies investigated both voluntary and involuntary patients (Bindman et al., 2005; Bonsack & Borgeat, 2005; Goodwin et al., 1999; Hoge et al., 1997; Lidz et al., 2000; McKenna et al., 1999; Meyer et al., 1999; Poulsen, 1999; Priebe et al., 1998) with the remainder looking at involuntary patients (Hiday et al., 1997; Joseph-Kinzleman et al.,1994; Johansson & Lundman, 2002; Olofsson & Jacobsen, 2001) or voluntary patients only (Rogers, 1993; Johnson et al., 2004). For the studies that looked at both patient groups,

similarities can be seen in the findings of six studies, which found that involuntary patients perceived more coercion (Bindman et al., 2005; Bonsack & Borgeat, 2005; Hoge et al., 1997; McKenna et al., 1999; Poulsen, 1999; Priebe et al., 1998). In considering the participants' demographics, 10 studies reported that the participants' ages ranged from 17-70 years which makes these findings generalisable to NHS users (Bindman et al., 2005; Hiday et al., 1997; Hoge et al., 1997; Johansson & Lundman, 2002; Lidz et al., 2000; McKenna et al., 1999; Meyer et al., 1999; Olofsson & Jacobsen, 2001; Poulsen, 1999; Priebe et al., 1998).

Methodological critique

Although there are strengths in the studies reviewed there are also methodological weaknesses which will now be discussed. A weakness of five studies is that they do not describe the participants' ages, which makes it difficult to generalise the results (Bonsack & Borgeat, 2005; Goodwin et al., 1999; Johnson et al., 2004; Joseph-Kinzleman et al., 1994; Rogers, 1993). However, two of the studies (Goodwin et al., 1999; Johnson et al., 2004) described recruiting participants from adult psychiatric wards, which would make the data comparable. Considering the participants' gender, the majority of the studies reported this and described an equal gender distribution (Bonsack & Borgeat, 2005; Bindman et al., 2005; Goodwin et al., 1999; Hiday et al.,1997; Hoge et al., 1997; Johansson & Lundman, 2002; Lidz et al., 2000; McKenna et al., 1999; Meyer et al., 1999; Olofsson & Jacobsen, 2001; Poulsen, 1999; Priebe et al., 1998). An exception to this is Johnson et al. (2004) who investigated only women's experiences, which makes their findings gender specific. Only two of the studies (Joseph-Kinzleman et al., 1994; Rogers, 1993) did not report on gender, which highlights a limitation in these studies for generalisabilty of the results.

Unfortunately, the majority of the studies did not describe the participants' ethnicity. Only six studies reported this, with the participants being predominantly white and the percentage of ethnic minorities ranging from 15-47 percent (Bindman et al., 2005; Hoge et al., 1997; Johnson et al., 2004; Lidz et al., 2000; McKenna et al., 1999). Only in Hiday et al.'s study (1997) were the majority of the participants (66 percent) black. It is important to report on ethnicity because of the higher proportion of black service users sectioned in the UK. Research has highlighted that black individuals are three times more likely to be hospitalised and 44 percent more likely to be sectioned (Commission for Healthcare Audit and Inspection, 2005). It is also important to report information on ethnicity because the reader can then determine which studies are most applicable to the clinical population that they work with.

Another limitation is that 13 studies did not report the socio-economic background and 10 studies did not describe the participants' education. Of the three studies that reported socio-economic status, 70-76 percent of the participants were unemployed (Lidz et al., 2000; McKenna et al., 1999) and 71 percent came from working class backgrounds (Priebe et al., 1998). Of the five studies that described the participants' education the data highlighted that, the mean number of years education was 12 years (Bindman et al., 2005; Hiday et al., 1997; Lidz et al., 2000), 32 percent completed higher education (Priebe et al., 1998) and 41 percent had no academic qualifications (McKenna et al., 1999). Through reporting this, the data from the above studies can be compared to the NHS, where the majority of service users are from lower socio-economic groups. However, one note of caution is that only one British study (Bindman et al., 2005) provided information on socio-economic status by describing the participants' education, which limits the generalisabilty of the other studies.

Another limitation of the studies is that the individuals, who refused to participate in the research, may have been more coerced or traumatised, which is why they did not participate. Some studies acknowledge this in the discussion of their findings (Johansson & Lundman, 2002; Meyer et al., 1999; Poulsen, 1999) however they are the exception, as for the other studies many fail to analyse even the demographics of non-responders (Hiday et al., 1997; Hoge et al., 1997; Johnson et al., 2004; Joseph-Kinzleman et al., 1994; McKenna et al., 1999; Rogers,1993) let alone explore why people might not have not participated.

Another significant methodological weakness can be seen in three studies. In Meyer et al.'s (1999) study the weakness is that the researchers did not ask individuals about their experiences and assumed that the medical notes represented their experiences. The authors acknowledged this is a limitation and stated this may have given a limited picture of the traumatic nature of hospitalisation, and it would have been beneficial to measure subjective experiences. This is essential, as the behaviour and attitude of staff, which may be perceived as distressing, were not assessed. In Joseph-Kinzleman et al.'s (1994) study and Roger's (1993) study the weakness is that the authors do not give any demographic information, so we do not know even the participants' gender. Joseph-Kinzleman et al. (1994) do not acknowledge that this is a limitation but state that the demographic data are not discussed because they are consistent with previous research. Roger's (1993) however does not acknowledge that this is an issue, which weakens the quality of her research.

An interesting methodological issue was raised by Goodwin et al.'s (1999) study. In their study inpatients were administered the Service Satisfaction Questionnaire (Turpin & Sturmey, 1988) and completed a qualitative interview. Analysis of the quantitative data highlighted a high level of satisfaction, however analysis of the interviews highlighted

predominantly negative views on hospitalisation. The literature supports that service satisfaction questionnaires produce inflated scores relative to actual service user satisfaction (e.g. Lebow, 1982, Sabourin et. al., 1989) and that service satisfaction scores are only moderately related to the individual's view of treatment (Lebow, 1983). The reasons for this vary but include factors such as the validity of the survey instruments, the acquiescence of service users and the possibility that service users may alter their responses as they consider who will read the surveys, and how their responses will affect their care (Lebow, 1983). This suggests that service satisfaction scores should be interpreted cautiously and if possible supplemented with qualitative data, as Goodwin et al. (1999) provided.

Apart from Goodwin et al.'s (1999) study which used qualitative analysis techniques the other mixed methods studies (Hoge et al., 1997; Joseph-Kinzleman et al., 1994; Rogers, 1993) did not use qualitative techniques but reported qualitative data. Rogers (1983) and Joseph-Kinzleman et al. (1994) did not claim to perform qualitative analysis and simply described the participants' responses organising them into themes. However Hoge et al. (1997) claimed to perform qualitative analysis, but they did not do this. In their study, they reported transcribing the interviews and then dividing the answers to the open-ended question on the AEI (Gardner, et al., 1993) into either 'coerced voluntary' or 'uncoerced voluntary' groups. What Hoge et al. (1997) did through dividing the responses into the two groups was therefore not qualitative analysis and so in this respect the study is methodologically incorrect. Rather than talking about qualitative analysis, the authors should have presented their results as reporting qualitative data descriptively.

One limitation of the studies is the possibility that participants may have minimised their difficult experiences because they were currently hospitalised and feared criticising the staff,

in case this resulted in a longer hospital admission. The results therefore may illustrate the tip of the iceberg of negative experiences. In five studies (Johansson & Lundman, 2002; Johnson et al., 2004; Joseph-Kinzleman et al., 1994; Priebe et al., 1998; Rogers, 1993), the interviews were conducted after discharge in the participants' homes or in outpatient centres, so any negative effects of interviewing in hospital were reduced. However in the majority of the studies participants were interviewed in hospital (Bindman et al., 2005; Bonsack & Borgeat, 2005; Goodwin et al., 1999; Hiday et al., 1997; Hoge et al., 1997; Lidz et al., 2000; McKenna et al., 1999; Meyer et al., 1999; Olofsson & Jacobsen, 2001; Poulsen, 1999). In some studies the authors do not say if the interviewers were linked to the unit (Bonsack & Borgeat, 2005; Hiday et al., 1997; Joseph-Kinzleman et al., 1994; McKenna et al., 1999) however, the position of the researcher has a significant impact on the results.

Even if the interviewer is a researcher and does not work in the hospital just by the fact that the interviewer is a professional and the interviews are conducted in hospital, the participants may see the interviewer as related to the mental health system and be fearful of reporting negative experiences. Two of the studies were explicit about this and a strength of these studies is they acknowledged the results should be regarded as reflecting the minimum level of negative experiences that individuals are willing to report, rather than the highest level that people can experience (Bindman et al., 2005; Goodwin et al., 1999). A particular strength of Johnson et al.'s (2004) study is that the authors highlight how the participants' experiences may have been reported differently if the interviewers were service users.

Another clinical factor that could be considered to affect the responses of the participants is seen in Olofsson & Jacobsen's (2001) study. In this study, all participants were due for discharge from involuntary care in the three days following the interview. The consequence

of this may have been that the participants minimised their difficult experiences because they were worried that if they reported negative experiences and were seen to criticise their care, then the psychiatric staff may think this indicated a lack of 'insight' into their problems, which may result in them not being discharged. This is an important factor to consider in that the experiences presented may represent the minimal distress experienced. Similarly in Hiday et al.'s (1997) study all the participants were involuntarily detained and court-ordered to compulsory outpatient treatment following discharge, so would continue being monitored by psychiatric staff after discharge. This may have resulted in the participants being reluctant to criticise staff who would continue monitoring them in the future.

A limitation of the studies into perceived coercion is that the majority of the studies used psychometric scales only to measure perceived coercion and did not supplement the data with information from service user interviews. This has limited the responses that individuals could give because of the primarily forced-response questions, which leads to a risk that researchers are not collecting the full range of responses related to hospitalisation. However, there are advantages of using psychometric tests in studies such as these. Firstly, the tests are standardised validated measures, which enable them to be used in different studies to compare and replicate the findings. Secondly, the tests can be used in large-scale studies to collect quantitative data on large numbers of service users' experiences of coercion.

Olofsson & Jacobsen's (2001) study into perceived coercion is an exception to those mentioned above as it did not use psychometric tests to explore coercion and used qualitative interviews instead. In this study, detailed information was gained on the experiential aspects of coercion related to involuntary care, through a narrative interview that did not restrict the respondents to forced response answers and enabled them to tell their

stories. The data gained from this study therefore can be seen to add a richness to the quantitative research literature on perceived coercion. Roberts (2000) highlights that qualitative and quantitative approaches can sometimes appear to be in tension, or even competition, but argues that they both are necessary and complementary companions. Roberts (2000) further suggests that in an increasingly evidence-based world, the evidence from individuals' stories needs to be used in conjunction with evidence from large-scale quantitative studies, to inform best clinical practice.

Another limitation of the perceived coercion research is that the studies have primarily focussed on only exploring coercion, and have neglected other aspects of hospitalisation. Useful information however has been gained from these studies in relation to understanding coercion further. The key findings were that voluntary patients also experience coercion, professionals provide the most coercion, individuals are coerced through persuasion, force and negative pressures, white, well-educated, unmarried and female service users perceive greater coercion. However, the studies on perceived coercion have not given detailed information on other aspects of the participants' detention experiences apart from coercion.

Three exceptions to this are the studies by Johansson & Lundman (2002), Johnson et al. (2004), and Joseph-Kinzleman et al. (1994) which are the only to report information on experiences of hospitalisation apart from perceived coercion. However, the study by Joseph-Kinzleman et al. (1994) is flawed for several reasons, firstly in that the data are reported descriptively and no analysis is conducted. Secondly, there is no demographic information on the participants, which means that the reader does not even know their gender, which is a drawback as gender significantly affects hospitalisation experiences (Hiday et al., 1997; Johnson et al., 2004; McKenna et al., 1999). Thirdly, the authors do not critique their findings

or reflexively consider the position of the interviewer in the research, which limits the study's reliability (Merriam, 2002). Considering however that the study is 12 years old, a major strength was that it was the first to explore involuntary hospitalisation experiences.

Consequently, Johansson and Lundman's (2002) study is the only reliable study to give detailed data on involuntary care experiences. Unfortunately, this a Swedish study and although Sweden has a national health service, the structure of the healthcare system is very different, for example, service users pay to stay in inpatient units (European Observatory on Health Care Systems, 2002) and Sweden has different mental health legislation (Olofsson & Jacobsson, 2001). Therefore, this research cannot be directly transferable to the experiences of NHS users. This therefore highlights a gap in the literature for qualitative research relevant to experiences of involuntary NHS treatment.

Conclusions

Although there are methodological weaknesses in many of the studies reviewed, the literature, which focussed primarily on perceived coercion yielded useful information. Key findings were that, professionals provide the most coercion; white, well-educated, unmarried and female service users perceive greater coercion. When looking at all of the literature reviewed, although the studies had different research aims the majority highlighted that hospitalisation can be a negative experience, especially for those detained involuntarily. The studies that highlighted negative aspects concerned reports of staff being uncaring and disrespectful, being treated as a sub-standard human being, unsatisfactory conditions in hospital, not being involved in treatment decisions and an over reliance on medication (Goodwin et al., 1999; Johansson & Lundman, 2002; Johnson et al., 2004; Joseph-

Kinzleman et al., 1994; Meyer et al., 1999; Olofsson & Jacobsen, 2001; Priebe et al., 1998). What is particularly worrying is that two studies found that hospital had a detrimental effect on the participants' mental health because of the conditions in the NHS hospitals (Goodwin et al., 1999; Johnson et al., 2004). This confirms the findings of DOH reports (Glasby et al., 2003; Sainsbury Centre for Mental Health, 1998; Watson, 2001) and Baker's (2000) findings from his national research conducted through MIND.

However, one must remember that three studies highlighted positive aspects of care. These included, individuals feeling safer in hospital as it protected them from self-harm, sympathetic staff, staff trying to make time to talk to service users (Goodwin et al., 1999; Johnson et al., 2004), service users participating in care decisions, and flexibility in care meaning that involuntarily care did not always result in coercion (Johansson & Lundman, 2002). In order to help improve inpatient services the studies reviewed highlight a need for more research looking at service users' experiences of hospitalisation. With further research, useful information can be gained to help improve wards that provide unsatisfactory care, or use wards providing excellent care as service models that other services can visit and learn from.

Several studies found that voluntary patients also experienced coercion (Bonsack & Borgeat, 2005; Hoge et al., 1997; McKenna et al., 1999; Poulsen, 1999; Rogers, 1993) and this has clinical implications which Rogers (1993) highlighted. The Mental Health Act (1983) mainly covers involuntary patients and none of the appeal mechanisms apply to voluntary patients. Therefore, voluntary patients who perceive themselves to be in hospital under coercion have no external means of complaining and in some ways may be worse off than involuntary patients. Further research is needed to explore the prevalence of coerced NHS voluntary

patients because Rogers' (1993) study is 14 years old and the other studies were conducted outside of Britain, so are not directly transferable to the demographics of NHS users.

Concerning the experiences of different ethnic groups, two studies found that white individuals were more likely to perceive coercion (Hiday et al., 1997; McKenna et al., 1999) however; Bindman et al. (2005) found the opposite with non-white individuals perceiving higher coercion. Further research is needed to explore this contradictory finding to ensure that professionals understand why some ethnic groups perceive higher coercion, so that admission procedures can be altered to reduce this discrepancy. One major limitation of the majority of the studies is that they did not collect information on the ethnicity or socio-economic background of participants. In addition, of the studies that did report on ethnicity, only two were British (Bindman et al., 2005; Johnson et al., 2004), which limits the generalisabilty of the other studies and highlights the need for further research.

One important issue of which to be mindful when considering the literature reviewed is the negative effect that interviewing participants in hospital by professionals, has on the results. There is a possibility that participants may have minimised their difficult experiences because they feared that criticising the staff might result in a longer admission. The results therefore may illustrate the tip of the iceberg of negative hospital experiences that individuals are willing to report. One way to remedy this in the future is to employ service users as interviewers, as then professionals may gain access to information that would not to be divulged in other circumstances, where there is a power imbalance between the interviewer and the interviewee. This is something that professionals are starting to consider, however there are still very few user led studies conducted in the NHS.

Another way to remedy this is for future research to recruit participants outside of the NHS through service user organisations, as then some of the negative associations with NHS treatment will be ameliorated, as the researcher will be conducting interviews outside of the system. This will not reduce the power imbalance between interviewer and interviewee, however it may make the researcher seem more objective and if participants have had negative experiences, they may feel more comfortable disclosing them without worrying that the researcher will pass this information on to the inpatient staff.

Meyer et al.'s (1999) study suggests that there may be a significant number of NHS users traumatised by hospitalisation. Research has highlighted that when individuals complained to ward staff, some felt that their complaint was not taken seriously because they had a mental health problem (Glasby et al., 2003). This has implications for psychological interventions because the professional position of psychologists means that service users often see them as separate from ward staff. This is probably because they often work outside of wards, do not prescribe medication and do not section people. Therefore, psychologists may be the first professionals that individuals confide in about their traumatic experiences.

In order to protect some individuals from significant harm to themselves or others, there is a need for legislation that can be used, when necessary to detain people, sometimes involuntarily. It is therefore crucial that professionals understand service users' experiences of hospitalisation. Through understanding this professionals can help to develop services that better meet service users' needs. One comment that was repeatedly voiced in the studies was that nursing staff did not spend enough time talking to, or supporting service users emotionally, rather than with medication. Considering the many demands on nurses

and the fact that they work from a medical model, this seems unlikely to change in the short term however, care staff can ensure one-to-one time is still prioritised in care plans.

Unfortunately, no British study has looked into people's experiences of involuntary care. Considering that these individuals are likely to have faced the most personally violating and distressing experiences because of their involuntary status (e.g. forced medication and ECT) this highlights the need for a study looking at these experiences. A future study could do this by investigating the experiences of sectioned individuals using a qualitative interview. Through such research, important information would be gained that can hopefully make the experience more positive for the 49,134 service users in England and Wales detained involuntarily yearly (Statistical Directorate, 2005; The Information Centre, 2006).

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EMPIRICAL PAPER*

Service Users' Experiences of Being Sectioned Under the Mental Health Act

Marianne Seebold
University of Southampton.

Correspondence regarding this article should be addressed to Marianne Seebold, Doctoral Programme in Clinical Psychology, University of Southampton, School of Psychology, 34, Bassett Crescent East, Southampton, SO16 7PB.

* International Journal of Law and Psychiatry has been used as a guide in determining the preparation of this article (See Appendix A for Guidelines for Authors).

Abstract

This qualitative study used semi-structured interviews and narrative analysis techniques to explore how seven service users described their experiences of being sectioned under the Mental Health Act.

The narratives were analysed focusing on what genres of narrative, core narrative and narrative tone emerged in the participants' accounts of being sectioned. This enabled the narratives to be analysed individually but comparisons and contrasts were also made between the narratives. The narratives were categorised within four genres of *escape, rescue, enlightenment* and *endurance*. The narratives highlighted a complex mixture of negative and positive aspects of being sectioned. The researcher paid particular attention to reflect on the research process, validity issues and limitations of the study. The results are discussed in relation to previous research findings and the implications for future research and clinical implications are explored.

Introduction

It is important for researchers to explore what service users' think about mental health services, so that professionals can understand their views and develop services that meet their needs. An area where this is particularly important is regarding service users' experiences of involuntary hospitalisation considering the deprivation of liberty that occurs and the fact that people can receive treatment, such as medication and Electro-Convulsive Therapy (ECT) against their will. Interestingly there has been no published research in the UK specifically investigating people's experiences of being detained involuntarily or 'sectioned'. This is surprising when one considers that 49,134 people in England and Wales are sectioned under the Mental Health Act (1983) each year (Statistical Directorate, 2005; The Information Centre, 2006).

Involuntary treatment is an area that has created divided views within mental health, with some academics accepting that it is necessary (Hoge et al., 1997; Bindman, 2005; Poulsen, 1999; Priebe, 2002) and others arguing that it should be abolished as it is in conflict with people's human rights (Høyer, 2000; May, 2005; Nilstun & Syse, 2000; Szasz, 1978, 2005). However, in order to protect individuals from significant harm to themselves or others, there is a need for legislation that can be used when necessary to detain people involuntarily. Due to this reason, although involuntary treatment is often criticised in most countries, it is accepted as necessary (Poulsen, 1999). It is therefore crucial that professionals understand service users' experiences of involuntary hospitalisation. Although there has been no research specifically looking at experiences of being sectioned in the UK, other research into hospitalisation has provided relevant data, which will now be explored.

The literature investigating service users' experiences of involuntary hospitalisation primarily focussed on perceived coercion, with the remainder of the literature exploring whether involuntary hospitalisation is traumatic, or studies focusing generally on service users' experiences of hospitalisation. Perceived coercion relates to individuals perceiving that they do not have the influence, control, freedom, or choice to enter hospital (Gardner et al., 1993).

The main findings from the perceived coercion literature were: voluntary patients reported coercion; involuntary patients reported less improvement than voluntary; professionals provided more coercion than families; white, well-educated, unmarried and female service users perceived greater coercion; and involving individuals in the admission process reduced coercion (Bonsack & Borgeat, 2005; Hiday et al., 1997; Hoge et al., 1997; Lidz et al., 2000; McKenna et al., 1999; Poulsen, 1999; Rogers, 1993). Only one qualitative study investigated service users' thoughts on coercion (Olofsson & Jacobsen, 2001) and the results highlighted primarily negative comments revealing that participants felt: disrespected; treated as inferior humans; uninvolved in their care and reported unsatisfactory care. However, positive comments concerned staff treating individuals respectfully, being involved in care, good care, and being treated as a human.

Research in Germany by Meyer et al. (1999) investigated whether being detained involuntarily fulfilled the criteria for Posttraumatic Stress Disorder (PTSD) as defined in DSM-IV (American Psychiatric Association, 1994). The study found that hospitalisation alone did not lead to a PTSD diagnosis however, 24 percent of the traumatic symptoms were related to coercive treatment. This was particularly prevalent in people involuntarily admitted for the first time and confirmed that hospitalisation was traumatic for a significant number of individuals. This therefore highlights the need for similar research to be conducted in the UK.

Other research looked generally at hospitalisation experiences and yielded primarily negative comments. Goodwin et al. (1999) investigated voluntary and involuntary patients' experiences of hospital and found that sectioned people reported less satisfaction with services. Johnson et al. (2004) investigated women's experiences of voluntary admission to hospital, in comparison to a crisis house and found that people preferred the female only crisis house. Joseph-Kinzleman et al. (1994) and Johansson and Lundman (2002) conducted two particularly relevant studies, as they explored service users' perceptions of involuntary care.

Common recurring themes are seen in the results of the above studies, with participants reporting unsatisfactory relationships with staff, unhappiness with medication or the lack of involvement in care decisions (Goodwin et al., 1999; Johansson & Lundman, 2002; Johnson et al., 2004; Joseph-Kinzleman et al., 1994), feeling that the conditions of NHS hospitals had a detrimental effect on their mental health (Goodwin et al., 1999; Johnson et al., 2004), and anger at hospitalisation (Goodwin et al., 1999; Joseph-Kinzleman et al., 1994). The finding that hospital conditions negatively affected the individuals' mental health confirms DOH reports (Glasby et al., 2003; Sainsbury Centre for Mental Health, 1998; Watson, 2001) and Baker's (2000) research conducted through MIND. These findings emphasise the urgency for further research exploring the effects of hospitalisation on service users.

However, one must remember that three of the studies highlighted positive aspects of care. These included, individuals feeling safer in hospital as it protected them from self-harm, sympathetic staff, staff trying to make time to talk to patients (Goodwin et al., 1999; Johnson et al., 2004); participating in care decisions, and flexibility in care meaning that involuntarily care did not always result in coercion (Johansson & Lundman, 2002). These positive findings

are encouraging and it is helpful to learn that through staff working flexibly service users do not feel coerced and report benefits from hospitalisation. With further research on service users' experiences, services providing excellent care can be identified and used as service models from which other services can gain clinical expertise.

Unfortunately, the study by Joseph-Kinzleman et al. (1994) is flawed for several reasons, the most significant reasons being that no data analysis is conducted and no demographic information is provided. Considering that the study is 12 years old, a strength of the study is that it was the first to explore service users' experiences of involuntary care. Despite interesting information being gained from Goodwin et al.'s (1999) and Johnson et al.'s (2004) studies, not everyone was sectioned in Goodwin et al.'s (1999) study and in the 2004 study by Johnson et al. all of the participants were voluntary so the data is not transferable to sectioned service users. In addition to the above points, there are several other methodological limitations in the literature on hospitalisation, which will now be explored.

Methodological limitations

A weakness of the majority of the studies reviewed is that they do not describe the ethnicity, or socio-economic background of the participants (Bonsack & Borgeat, 2005; Goodwin et al., 1999; Johansson & Lundman, 2002; Joseph-Kinzleman et al., 1994; Meyer et al., 1999; Olofsson & Jacobsen, 2001; Poulsen, 1999; Priebe et al., 1998; Rogers, 1993), which makes it difficult to generalise the results. It is especially important to report on ethnicity because in the UK, black individuals are three times more likely to be hospitalised and 44 percent more likely to be sectioned (Commission for Healthcare Audit and Inspection, 2005). This highlights a need for further research that reports on the ethnicity and socio-economic status of individuals to ensure that research is relevant for the demographics of NHS users.

Another limitation of the literature is that in the majority of the studies participants were interviewed in hospital, resulting in possible response bias (Bindman et al., 2005; Bonsack & Borgeat, 2005; Goodwin et al., 1999; Hiday et al., 1997; Hoge et al., 1997; Lidz et al., 2000; McKenna et al., 1999; Meyer et al., 1999; Olofsson & Jacobsen, 2001; Poulsen, 1999). Even if the interviewer is an external researcher, the fact that the interviewer is a professional and the interviews are conducted in hospital means that the participants may associate the interviewer with the mental health system and be fearful of reporting negative experiences. This highlights the need for research to be conducted outside the NHS, to ameliorate any possible negative associations individuals may have due to previous treatment experiences.

Because of the methodological problems of Joseph-Kinzleman et al.'s (1994) study Johansson and Lundman's (2002) study is the only reliable study to give detailed data on a range of service users' views of involuntary care. However, the study was conducted in

Sweden and although Sweden has a national health service, the structure of the healthcare system is very different, for example, service users pay to stay in an impatient unit (European Observatory on Health Care Systems, 2002) and Sweden has different mental health legislation (Olofsson & Jacobsson, 2001). Therefore, this research is not directly transferable to NHS service users and highlights a gap in the literature.

In conclusion, the majority of research focussed on exploring perceived coercion and this narrow focus has not allowed for the collection of data on other elements of people's treatment experiences. This highlights a need for further research to complement the literature, as the bias towards investigating coercion means that research on other aspects of involuntary care is still in its infancy with only one well designed study (Johansson & Lundman, 2002) investigating this. However, a valuable consequential finding from the perceived coercion literature is that service users gave reliable reports on coercion regardless of their diagnosis, as the information they reported was corroborated by professionals (Bindman et al., 2005; Hiday et al., 1997; Poulsen, 1999). This supports the validity of service users' reports on being sectioned and highlights that people can give powerful insights into their experiences, regardless of their mental state.

Given the lack of research, this study aims to add to the literature by investigating how people describe their sectioning experiences. This study's focus is also consistent with the NICE guidelines for schizophrenia (2002) which recommend that service users should be given the opportunity to give their account of why they are in hospital. Due to concerns about any possible negative associations with the NHS, participants are recruited through service user organisations. This study focuses on service users' experiences using a qualitative approach to convey a more elaborate understanding of the issue and capture a range of

experiences. Considering that these individuals are likely to have faced the most personally violating and potentially traumatic experiences because of their involuntary status (e.g. forced medication and ECT) this highlights the need for research exploring this.

Chosen methodology

This study uses narrative analysis to explore experiences of being sectioned. Narratives are essentially stories people tell about their lives and have been described as the principal way by which people create meaning in their lives, as narratives organise experience into meaningful episodes (Polkinghorne, 1998). Polkinghorne (1988) further argued that psychology cannot be complete without an acknowledgement of the importance of language, meaning, and interpretation, as this shapes how humans think, feel and act. How individuals think about and structure their experiences in terms of narrative affects, and can determine how these experiences impact on their lives (Crossley, 2000; Gergen 1992; Lieblich, Tuval-Mashiach, & Zilber, 1998; Polkinghorne, 1988; Riessman, 1993; Sarbin, 1986).

Casey and Long (2002) highlighted how important it is that people share their narratives, so they can make sense of distressing experiences, maintain their self-identity and connect with others. If individuals have disjointed narratives, their sense of coherence is lost, which can be a feature of experience following trauma (Crossley 2000; Herman, 1994; White, 1995). Narrative analysis is useful for researching areas where powerful meta-narratives dominate society, through which individuals must traverse with their narratives (Crossley, 1999; Plummer, 1995; Ridgway, 2001; Stern et al., 1999; Thornhill, Clare, & May, 2004). It is particularly useful in mental health research because it enables the exploration of personal narratives, which deviate from the meta-narrative that pathologises mental distress.

Relevance of research

This study is particularly relevant to mental health professionals considering the planned reforms to the Mental Health Act (1983). In the Draft Mental Health Bill (2002), the professional group responsible for the care of detained individuals is changing from Registered Medical Officers, to a new role termed Clinical Supervisors, which will include non-medically trained professionals. This planned change has already divided the profession of clinical psychology into those who welcome the role, as they believe it will help to reduce the monopoly of the medical model, and those who will avoid getting involved, as they believe it will damage therapeutic relationships (Gilmer, Roberts, Chisholm, & Taylor, 2005; Harper, 2006; Pilgrim, 2005).

Therefore, it is imperative that professionals understand how being sectioned feels from the service user's perspective. Although there are presently no published UK studies, which have explored this, in addition to this study there is a study currently being conducted by Professor Stefan Priebe called the Outcomes of Involuntary Admissions in England (Involve). This study is investigating people's experiences of being sectioned at different time points in the process and is primarily a quantitative study. It is hoped that the data from this qualitative study in addition to the findings from the Involve study will add to the literature on being sectioned and help to inform clinical practice. After reviewing the literature on narrative methodology and considering previous studies, the following research question was asked:

How do service users describe their experiences of being sectioned under the Mental Health Act?

METHOD

Methodological approach

Narrative analysis was chosen as the most appropriate approach as its focus on subjective experience matched the research aims, which were to explore experiences of being sectioned. Narrative analysis has been described as a theoretically rich methodology, which can enable research to inform practice, something that is crucial in clinical research (Andrews, Day Sclater, Squire & Treacher, 2004; Crossley, 2000). Through using narrative analysis, the study aimed to analyse narratives individually but comparisons and contrasts were also made between the narratives.

Design

This was a qualitative study employing semi-structured interviews that investigated how people described their experiences of being sectioned. The study used narrative analysis to analyse the data.

Participants

Recruitment

As participants in this study were not recruited through the NHS, LREC approval was not required. University of Southampton School of Psychology Ethics Approval was obtained

prior to recruiting (see Appendix C). Due to the sensitive information that participants divulged careful attention was paid to the concepts of informed consent, the possibility of participants becoming distressed, risk issues, and confidentiality throughout the research.

The researcher recruited participants from service user organisations because as an NHS employee, interviewing in the NHS may have resulted in participants associating the researcher with their treatment. This could be problematic if participants had negative experiences, as they may have felt uncomfortable talking openly. The researcher is aware that the sampling method resulted in the study representing the views of those involved with service user organisations and in the discussion considers whether this represents a different population to those only involved with the NHS.

The inclusion and exclusion criteria

The inclusion criterion was that participants had been sectioned in the past five years and the exclusion criterion was that individuals were not currently sectioned. There were no exclusions on diagnoses, partly to get a range of service users' views, and also due to the disagreement within mental health surrounding the validity and usefulness of diagnoses (Boyle, 1990, 2002; Charlton, 2000; Johnstone, 2000; Newnes, Holmes & Dunn, 1999).

Sample size and characteristics

Seven individuals (six males and one female) were recruited from Rethink's branches in Weymouth, Yeovil, Southbourne and Bournemouth and the West Dorset Mental Health Forum in Dorchester. The sample size was considered sufficient because the researcher

conducted detailed interviews and the population targeted was hard to access[3]. Despite the researcher approaching seven centres across two counties, only five centres found suitable participants. Three additional individuals originally agreed to participate, however due to the mental health of two individuals deteriorating, their workers considered them unsuitable. The other individual, who agreed to participate, requested an interview at his home, which was not an option offered due to concerns about possible risk.

Details of participants

In keeping with the narrative approach, Table 1 overleaf provides brief descriptions of the participants (for detailed summaries see Appendix F). For confidentiality, all names are pseudonyms and any identifying information has been omitted.

[3] Narrative studies typically have small sample sizes and several studies within mental health have conducted narrative analysis on less than six participants (Casey & Long, 2002; Gray, 2001; Johansson & Lundman, 2002; Nicholas, 2005).

Table 1-Brief descriptions of the participants

Participant	Age, sex & ethnicity	Diagnosis	Education & profession	Involuntary admission(s)
1: John	23 year old British white man.	Schizophrenia and OCD	College. Currently unemployed.	Four admissions, after 'lots of cannabis' led to becoming 'deluded'. Mixed view on hospital as helped 'sober up' but took too long to get out.
2: Daniel	26 year old mixed race Caribbean man.	Paranoid schizophrenia and psychosis	School. Prior retail work, but now a student.	One admission after being arrested for assault. Angry about section and 'having a label slapped on me'.
3: Vincent	54 year old English white man.	Schizophrenia	School. Was a cleaner. Now a volunteer.	Six admissions. First aged 16 because acted 'strangely' after religious concerns. Never enjoyed hospital but saw it as 'God's plan'.
4: Darren	22 year old British white man.	Schizophrenia	College. Unemployed. Previously a labourer.	One admission. Sectioned after becoming paranoid from cannabis use and found 'running from people trying to kill' him. Felt hospital really helped.
5: Jacob	43 year old Northern European white man.	Paranoid schizophrenia	School. Was a manager. Now University student.	Four admissions. First aged 29 after breakdown. Hospital 'worst place ever but saved my life'. Strongly disliked forced medication.
6: Graham	48 year old white English man.	Progressive Depressive Disorder	School. Unemployed Was merchant seaman.	One admission. Sectioned after Became suicidal. Felt needed hospital but critical about care and ECT.
7: Alice	27 year old white British female.	Paranoid schizophrenia	University. Unemployed.	'Three/four' admissions. First aged 19 after a sexual assault. Felt staff 'tried to help' but did not want to be there.

Procedure

Information sheets describing the study (see Appendix D) were distributed to the managers of Rethink and the manager of the West Dorset Mental Health Forum. The managers then approached suitable individuals. Before interviewing, the researcher spoke to a worker at the organisations, to enquire about any concerns about the individual's mental health. Consent forms (see Appendix E) were administered at the start of the interview.

Participants were informed before the interviews commenced that they could withdraw at any point, and informed if the researcher became concerned about their distress (or if they disclosed that they wished to harm themselves or others), a staff member at the organisation would be notified to offer further support. In addition to this, the researcher gave all participants numbers of helplines, such as Samaritans and MIND.

The interviews were tape-recorded and each interview lasted between 35 to 90 minutes. Where necessary short breaks were provided throughout the interview. After the interviews, participants received a verbal debrief and were given a debriefing handout (see Appendix H). The researcher offered a further optional meeting to discuss the analysis, which six participants requested. This final meeting was offered to involve the participants in the research process and followed recommendations that research should involve service users wherever possible (DOH, 2005). In this meeting, the researcher read out each narrative summary (see Appendix F) and explained her analysis[4].

[4] A summary of the findings will be sent following the written completion of the study. All the participants indicated that they found this an acceptable time to wait for a summary of the results.

Measures

A semi-structured interview with open-ended questions was used to elicit a narrative account of the individual's experiences of being sectioned (see Appendix G). The interview began with the following open question: "As you know the conversation we are about to have is part of a study to try and help understand how people feel about being sectioned. To begin with could you tell me something about yourself, and what has brought you to the point of sitting here talking to me today about being sectioned".

This question was designed to elicit a narrative account however where necessary additional questions were asked to clarify information or facilitate the conversation. The researcher was particularly conscious to utilise her clinical skills by using open-ended prompts and non-leading questions when asking additional questions if participants did not give detailed narrative answers. This was to ensure that the participants were given the chance to give their accounts of being sectioned without leading their narratives in a particular direction.

Data management and analysis

Transcription

The interviews were transcribed following Thornhill's (2002) transcription format, which involved careful attention to language but not the detailed recording of linguistic features of

speech, such as intonation. A consistent approach to identifying aspects of the narrative was followed, for example, "....."refers to a pause, "(?)" refers to words which are inaudible. Paraverbal features of the narrative were placed in bold and brackets e.g. "**(laughs)**". To ensure confidentiality any names of people or places were omitted and replaced with a "_____". Italics and question marks were also used to indicate special emphases.

Data analysis

Rather than selecting discrete sections of the transcripts, the researcher looked at the narrative accounts as a whole to identify features of the narratives as recommended by Fludernik (1999). The transcripts were read several times so the researcher became familiar with the narratives. The researcher analysed the narratives using a range of narrative techniques focussing on genre (Gergen & Gergen 1983; Lacey, 2000; Mishler, 1986; Todorow, 1990), tone (Crossley, 2000; McAdams, 1993) and core narrative (Mishler, 1986).

Identification of narrative tone, core narrative and narrative genre

Narrative tone

Crossley (2000) and McAdams (1993) suggested the first focus of a narrative analysis should be on narrative *tone*, which is an attempt to characterise something about the narrative as a whole. Crossley (2000) explained how narrative tone is the most persistent

feature of a narrative, expressed both in the content of the narrative and in the way in which it is told. Features of what each participant said, the tone of voice used and how the narrative was structured were considered in identifying narrative tone[5] (See Appendix I for the paper trail of the tone analysis).

Core narrative

In order to identity the *core* narrative (Mishler, 1986), the researcher summarised the participant's narrative in a few words, to illustrate the main point of the narrative. As in the analysis of tone, considering the full content as well as the narrative structure was integral to this analysis. Mishler (1986) explained that identifying the core narrative is conducted in the early stages of the analysis and to identify the core narrative one also needs to consider the tone, which is often reflected in the core narrative[6].

Genre

Closely linked to the previous narrative aspects was the analysis of *genre,* which was informed by theories of narrative genre (Gergen & Gergen, 1983; Lacey, 2000; Mishler, 1986; Todorow, 1990) and by studies that have previously used this method (Crossley, 1999; Frank, 1995; Gray, 2001; Plummer, 1995; Thornhill, 2002). For this analysis, the

[5] For example, Vincent's narrative was characterised as thoughtful as he appeared thoughtful and reflected on how mental health problems enriched him emotionally and spiritually.

6 For example, in Vincent's narrative, the core narrative was identified as being sectioned was God's will. This fitted with the content of his narrative and was reflected in the thoughtful narrative tone.

transcripts were initially read thinking about what type of story it was[7]. Analysis of the genre involved; identifying key generic features of the plotline for each genre; identifying specific features of the plotline of the narratives in this study; considering if the narratives could fit another genre and highlighting quotations to illustrate features of the genre (See Appendix J for the paper trail of the genre analysis).

[7] For example, Vincent's narrative was categorised as fitting an enlightenment genre, as he believed that mental health problems enriched him spiritually.

Validity

The researcher took measures to ensure quality in the research by following qualitative guidelines (Elliott, Fischer & Rennie, 1999; Stiles, 1999; Yardley, 2000). Supervision was used throughout the research to ensure the comprehensiveness of the narrative interpretations. In particular, supervision was used to reflect upon and limit the effects of the researcher's biases. In addition to this, other narrative researchers not involved in the study were consulted during the research. The researcher's supervisor scrutinised the researcher's 'paper trail' through the analysis for verification and read drafts of the results.

The researcher offered the final meeting to involve the participants in the analysis (DOH, 2005), but also as a way to utilise 'member checks' (Russell & Gregory, 2003) and 'testimonial validity' (Stiles, 1999). These two terms describe similar steps taken to ensure validity in qualitative research, which involves researchers asking what participants think about the interpretation of their narrative and allows the researcher to check for any factual errors. Through doing this, the researcher aimed to ensure the analysis fully represented the participants' reports. The six participants who requested this meeting agreed with the researcher's analysis and their comments were considered in the analysis.

Reflexivity

Qualitative researchers stress the importance of reflexivity in qualitative research, which is the process of examining one's effect as a researcher in the research process (Elliot et al., 1999; Stiles, 1999; Yardley, 2000). This involves the need for researchers to acknowledge their values, assumptions and beliefs that may affect the interpretation of the data (Elliott et

al., 1999; Stiles, 1999; Yardley, 2000). The researcher had the following beliefs; that understanding sectioning experiences was essential for professionals to empathise with service users and necessary to improve services; and that professionals should use sectioning as a last resort. The researcher had the assumptions that; the participants would narrate meaningful accounts of their experiences; several individuals would describe difficult sectioning experiences; and anger would be voiced towards the mental health system.

Through undertaking each interview, the researcher reflected on her emotional responses as the individuals narrated their stories and on the impact of hearing the sometimes distressing narratives. The researcher is a trainee clinical psychologist and was able to identify her responses in a similar way to how she would identify personal reflections in a therapy session. This was important in ensuring that her responses to the narratives did not interfere with her ability to listen and comprehend them. The researcher also reflected on how her position as a psychologist was influenced by a number of psychological theories and models including cognitive-behavioural, social constructionist, narrative and systemic.

The researcher kept a reflective journal (see Appendix K) throughout, in which she reflected upon her motivation to carry out the research, responses to the interviews, and how personal biases and assumptions may have affected the research process. In addition to this, the researcher reflected on her experiences of mental health problems outside of her professional life and how this had shaped her beliefs. The researcher has a close family member with mental health problems, which has resulted in him being sectioned several times. The researcher considered how this experience in addition to her clinical experience working with sectioned individuals for the past eight years has motivated her interest in the potentially traumatic nature of being sectioned. Holistically, this experience has fuelled her

interest in psychosocial conceptualisations of mental health problems and in giving service users a 'voice' in a system where historically they have been silenced (Crossley & Crossley, 2001; Goodwin et al., 1999; Hyden, 1995).

The researcher's personal experience has given her an added perspective of the mental health system, which can be seen to motivate a more thorough investigation and a deeper understanding of the research subject (Stiles, 1999). Stiles (1999) also explains how personal involvement and commitment to a topic can bring enmeshment and distortion. This distortion is reduced by the researcher revealing their personal commitments to the investigation, so that readers can consider this and adjust their understanding to compensate for the researcher's biases. Through transparently revealing rather than avoiding any personal involvement, the researcher aimed to ensure validity in her research.

Results

This study used narrative analysis to explore the following research question: *How do service users describe their experiences of being sectioned under the Mental Health Act?*

For the purposes of analysis, this question was divided into the following questions: Which genres of narrative, core narratives and narrative tone emerge in the individuals' accounts of being sectioned, and what does this tell us about being sectioned?

This section describes the results of the analysis of core narrative, narrative tone and narrative genre. The narratives were categorised within genres of *escape*, *rescue*, *enlightenment* and *endurance*[8].

[8] Frank (1993) explained how the identification of genre allows narratives to be read whilst paying attention to similarities and differences between the narratives, but this does not suggest it is the only way the narratives could be categorised.

Core narratives, narrative tone and narrative genre.

The table below illustrates how the core narrative, tone and genre were categorised for each participant.

Table 2: The participants' core narrative, narrative tone and narrative genre.

Participant	Core narrative	Tone	Genre
P1: John	Too much cannabis provoked a nightmare experience.	Normalising/ distressed	Rescue
P2: Daniel	I tried to suppress anger so could get out of hospital.	Angry/ disbelieving	Escape
P3: Vincent	Being sectioned was God's will.	Thoughtful	Enlightenment
P4: Darren	Scared but hospital was a safe haven.	Scared	Rescue
P5: Jacob	Saved my life but hospital worst place ever experienced.	Protesting/ resigned	Escape
P6: Graham	I needed help but it wasn't handled well.	Critical/ educating	Escape
P7: Alice	I didn't want to be there but they tried to help me.	Unsure/ thoughtful	Endurance

Narratives of escape

The majority of the narratives were categorised primarily as narratives of *escape* (Thornhill, et al., 2004) and fit the escape genre, which includes books about escaping a wrongful imprisonment such as *The Shawshank Redemption* (King, 1995). The key elements of escape narratives involve the individual feeling imprisoned and reporting anger or frustration at detention. The aim is to develop a plan to escape hospital and crucial to this was telling professionals what they thought they wanted to hear concerning treatment they did not like, but realised that they had to accept, to escape hospital. Central to these narratives was the imagery of imprisonment and punishment being compared to care, as Daniel stated:

> "I'd never experienced anything like it really. Never been locked away for months on end, I mean it was, I wouldn't say it was like prison, 'cause I've never been to prison but, if felt like restricting on myself and I've never felt like that before" (8, 393-395).

In Jacob's narrative, his comments about involuntary treatment evoke imagery of an unjust punishment:

> "I hated it with a vengeance, especially umm compulsory treatment, forced medication, you know being pinned down by 6 members of staff and being injected against my will when I didn't think I was doing, I hadn't committed any crime" (1, 24-27).

Graham's comments on being sectioned also focus on an unjust punishment: "I've committed no crime" and I refused to go" (2, 80).

In these narratives, there is a desire to escape from; the stigma of diagnosis; services perceived as un-therapeutic; and from the negative role of a patient stuck in the system. Daniel described how through his diagnosis he felt different:

> "Having a label slapped on me that I didn't want...I just felt really down because I thought "ohh this is gonna stop me doing loads of different things" (5, 208-210).

After initially feeling angry Daniel decided he did not want to become stuck in hospital:

> "Listening to some of the other people in there they'll say, "Oh, you never gonna get out of the mental health system when you get into it" and it was all doom and gloom and stuff and I was like "I don't wanna be like that" (9, 400-402).

Jacob questioned his diagnosis but accepted that he has mental health problems:

> "I recognise now that I have been ill and I don't think of myself as, you know I question the diagnosis of paranoid schizophrenia because I don't really think that I am schizophrenic but I can understand why they called, called it that" (6, 263-265).

All three participants reported wanting to escape services perceived as un-therapeutic with Daniel explaining:

> "You have to sit down and just stew it out, take your medication and...It was *frustrating* really 'cause there wasn't a lot to do, all we had to do was watch TV or read" (10, 471-476).

Jacob illustrated his view by the following comments:

> "They didn't cure me or anything you know, but they did get me on the medication which is....it's their one defining thing" (6, 278-279).

> "The staff don't talk to you enough in hospital, they observe you and they make comments about your behaviour" (11, 521-522).

Similarly, Graham's comment highlighted his view:

> "All we were doing was just making collages and playing hangman and I thought "well how is this doing for me?" It's doing nothing, it's making me worse, you had no one-to-one discussions with people, with none of the nurses" (2, 64-67).

Daniel and Jacob's narratives have similar plots of fighting the system and feeling angry and resisting medication but then realising that to get out, you have to do what the professionals want and tell them what they want to hear. This can be seen in Daniel's narrative:

> "I didn't want to take the strange drugs that I didn't understand, and when they first said that I had to take medication I was like "no way, I don't want to take the medication". They said 'you have to take it' and I was like "ahhh" and then I got angry" (3, 125-127).

However, Daniel soon realised his approach to involuntary treatment was not helping: "I just thought I don't want to be restrained again so I just calmed down about it" (3, 132-133).

Daniel described telling staff what they wanted to hear to get his section removed:

> "That was basically because I said "I accept the medication and umm I accept the fact I have to be treated" and he said "If that's the case then you can go on voluntary" (4, 158-160).

In Jacob's narrative he described a similar resistance to medication in particular "forced medication" but explained how over the years he accepted it because:

> "They're not going to let you out until you toe the line, so in the end I give up and agree to take medication and...do everything they want me to...with a view to getting out of hospital as soon as possible" (4,189-191).

Jacob was critical of nurses because of their practice of involuntary medication and portrayed hospital as an un-therapeutic place:

> "People think psychiatric nurses are caring, compassionate people but if the psychiatrist says "Pin him down and inject him" they'll do just that" (3, 187-188).

> "How you can possibly do well in a hospital I don't understand, you know, because to me it's not a restful or a therapeutic place, its, it can be a dangerous place, you know I've been assaulted on a couple of times when I've been in hospital....There's nothing to do, you just have to sit there and... stew in your own juices (7, 299-303).

Jacob explained how he became mute, as it was the only way he could "fight" the system:

> "It was the only way I could fight them back, fight back you know. And so once I knew that the psychiatrist was, had...wasn't, wasn't any wiser than anyone else then or, you know, I thought "well I can start talking now" (8, 378-380).

Within two of the narratives was a striking sense of relief voiced when the participants left hospital. Jacob in particular described never wanting to be sectioned again:

> "I won't stop taking the medication because I couldn't cope with another admission into hospital" (6, 263-264).

This was also important for Daniel:

> "I felt relieved. Its like 'yeah I'm out of their little system' and I was like that really, really did make me feel better about it really. It's like 'ohh that's all over now, let's start again'. And umm I just felt that it was a big weight being lifted off my shoulders" (7, 348-350).

Graham's narrative was less disapproving of involuntary care and the content of his narrative was different in that he primarily offered thoughtful suggestions on how to improve psychiatric care, for example by using a two-way mirror in ward rounds rather than having several professionals in the room. However, he still described negative aspects of care and explained how he escaped from unhelpful staff interactions by: "Just saying yes to any of the psychiatrists questions just to get out of there (3, 126-127).

Graham voiced substantial concerns about how ECT had affected his memory:

> "It's taught me never to have ECT treatment again, because of the umm...memory loss. I'm still suffering from it" (6, 280-281). "I was really *shocked* at the loss of memory" (6, 288).

Unlike Daniel and Jacob, Graham did not resist medication but still described wanting to get out of hospital, as he believed the time taken to treat his mental health was too long:

> "12 and a half weeks to finally get the help and support I think I needed and got. It took too long. 'Cause all you was doing in the day was sitting in the lounge smoking cigarettes and then and again I was offered OT making collages again" (4, 173-175).

Graham explained that he did not disagree with his hospitalisation because: "I knew I needed help so yeah, I accepted being sectioned" (4, 183-184). However after his health improved, he was keen to leave, so he: "Agreed with everything the psychiatrist said, just to get out of there" (5, 235-236).

Despite the comments being primarily negative, all three participants accepted on some level that they needed help and Jacob described sectioning as life-saving:

> "My attitude now towards being sectioned has changed somewhat uhh, from hated to one that I think it saved my life. I think I'd probably be dead now if I hadn't had the intervention of the medical profession, but umm, I still don't like forced medication" (1, 29-32).

In these narratives, the overarching theme of *escape* is linked to a type of care described as un-therapeutic. The main tone of these narratives is anger or protest at psychiatric care. However, Jacob's narrative also had elements of a resistance narrative as he "fought" the system. The core narratives capture the essence of these stories with Daniel's being: "I tried to suppress anger so could get out of hospital", Jacob's being: "Saved my life but hospital worst place ever experienced" and Graham's: "I needed help but it wasn't handled well".

Narratives of rescue

Two of the narratives were categorised primarily as narratives of rescue and fit the rescue genre, which includes biblical stories about being saved from something that poses a danger to the person. The stories also fit the common narratives in self-help groups such as *Alcoholics Anonymous* (AA). The key elements of these rescue narratives involve the individual facing something that poses a danger to them, getting involved in a chaotic lifestyle, the individual's mental health deteriorating and being rescued by hospitalisation.

The two narratives were very different in their plots but a similar theme was that the participants viewed a deterioration in their mental health as a consequence of doing too many drugs and therefore being sectioned is valued, as it allows time to "sober up" (John) and provided a "safe haven" (Darren). Consequently, involuntary care is viewed akin to being in a drug rehabilitation unit rather than a prison as in the escape narratives.

John explained that he was sectioned four times because he drunk too much and smoked too much cannabis. He described his first admission as:

> "I was having quite chronic hallucinations and stuff and umm, it just felt like I was smoking so much and drinking so much that it all built up, and that I wasn't very sober even if I wasn't doing it, and I woke up in the morning and I was still de-toxicated every day" (1, 38-41).

John described heavy drug and alcohol use preceding each admission and believed that being sectioned helped him, as it stopped him using drugs and alcohol temporarily. This was

illustrated by his comment: "Hospital is definitely good to sober up and make you feel a bit more like what life is about" (11, 571).

However, he voiced distress over the length of time that it took to get out of hospital:

> "Every time I go there it's a bit of a personal nightmare because you think that if you're there for weeks and you see the doctor, once you've seen the doctor you know nothings happened you know its going to be a whole another week...It's just...it is quite heartbreaking 'cause like it's so boring there" (2, 65-68).

Throughout John's narrative, he normalised his experiences as related to drinking and smoking too much cannabis:

> "They let me go after a couple of weeks 'cause I was fine and had sort of sobered up and they could tell I was quite sensible and a normal sort of person" (1, 47-49).

> "They think I'm a bit of a character probably but hopefully they think of me as like not too insane, just sort of like 'cause I maybe smoked a lot" (9, 14-16).

John reported good relationships with the staff and described feeling comfortable in hospital:

> "Like now I've been in there a few times, I don't quite like to say it, but if feels a bit more homely" (8, 380-381).

For Darren being sectioned rescued him from both a drug misusing lifestyle and from his paranoid state of mind, which at the time led him to think that people were trying to kill him:

"I always thought too much about stuff, that's all...I mean when I go out my mates and that back then I sit around thinking and that like **(laughs)**, smoking weed and just sitting there on my own thinking, getting paranoid" (1, 59-62).

Darren described feeling relieved and terrified after being sectioned:

"Quite frightening really 'cause at first I didn't think I had a problem....and I was still thinking people were after me. I thought at _____**(local hospital name)** they took me there to protect me from people and urr, I dunno I thought it was some sort of divine intervention sort of thing **(laughs)** like to get me away from drugs" (2, 90-96).

This mixture of fear and relief led to him to experience hospital as:

"Terrifying at the time **(laughs)**. I didn't know what to do, but when I got to uhh_____**(local hospital name)**, it was like some sort of safe haven, sort of place. Somewhere to recover and get my thoughts back together again" (2, 57-59).

Throughout Darren's narrative being sectioned was described as something positive that saved him from his lifestyle and his mental health problems, as he further explained:

"It felt like a safety net sort of thing actually. With the support and people around me if I got a bit weird you can go and talk to people" (3, 116-117).

Darren described many benefits of hospital and reported positive relationships with the staff:

"There's loads of people trying to help, you know genuinely trying to help me and that was really nice of them. Well I just liked it, well it was good the way like the system worked" (9, 421-422).

He further explained how being sectioned motivated him to make positive changes:

"Taking to people that was a big change, getting comfortable with people around me and stuff and umm...umm...got me to think bit more positive and it gave me time to get myself together and to get away from doing drugs" (10, 444-446).

In these narratives, the overarching theme of rescue is linked to sectioning saving John and Darren from a substance misusing lifestyle. Therefore, hospital is primarily experienced positively, providing a "safe haven" and space to "sober up". "The main tone of Darren's narrative was scared as he narrated the frightening paranoia that led up to him being sectioned. John's tone conversely was primarily normalising (Crossley, 1999) as he related his problems to substance misuse and appeared to experience hospital like a drug rehabilitation centre. However John's tone was also distressed when he described the length of time it took to leave hospital which his "personal nightmare". The core narratives capture the essence of these stories with John's being: "Too much cannabis provoked a nightmare experience" and Darren's being: "Scared but hospital was a safe haven".

Narrative of enlightenment

One narrative was categorised as an enlightenment narrative (Thornhill, 2002). This genre has also been called a "quest narrative" (Frank, 1995) or a "conversion or growth" narrative (Crossley, 1999). This narrative fits the enlightenment genre, which is common to biblical stories, and medieval tales, such as the quest for the 'Holy Grail' (Thornhill, 2002). Key elements of this genre include the individual gradually gaining understanding and spiritual growth through adversity. This understanding helps individuals to grow from having mental health problems, as they gain emotional and spiritual insights from their experiences.

Vincent explained that before each of his six breakdowns there was a period of:

> "Real encouragement...it's just before that time when you feel, really feel up with, with God or something but and then it seems to lower and you seem to go right down" (10, 461-463).

He described his first admission in 1969 as the worst due to the conditions and the staff attitudes towards service users, which were:

> "They're mental, they're not really human" (10,479-480) and the conditions: "I was put in a cell one day and night and I banged at the door and then this chap came in and threw me to the ground **(laughs)** and twisted my arm around my back and I didn't.....there was no bed I think, I can't remember any toilet facilities so....it was a horrific experience" (10, 481-484).

Throughout Vincent described experiences that he did not like such as, being put in a straight jacket and a padded cell, but explained why he accepted these experiences:

> "I didn't object to it I just felt that maybe that's God's part of like, he's put me for a reason, I don't quite know why I've been ill but its probably best for me to be here and although I didn't like it" (6, 296-298).

The enlightenment in Vincent's narrative follows difficult times in his life and relates to a sense of renewed faith in the meaning of life, intrinsically related to his spirituality:

> "'The Lord has helped me through times which I could have been a lot worse, been worse if it wasn't for a Christian" (7,335-336).

> "Its been a uhh gradual process of growing through bad experiences and I think sometimes difficult experiences help you to mature and grow and if you had things easy all the time, things would probably...you'd be a very weak person, but because you've had trouble and difficulties these builds you up (8, 379-382).

In this narrative, the overarching theme of enlightenment is linked to Vincent's spiritual growth gained through his distressing experiences. Hospital was experienced primarily negatively but because of his faith, he regarded it as a necessary experience that had to be endured in order to grow spiritually. The tone of his narrative was thoughtful throughout as he considered what he learnt and the core narrative: "Being sectioned was God's will" illustrated the enlightenment narrated in his story.

Narrative of endurance

The final narrative was categorised as an *endurance* narrative (Thornhill, 2002). This genre has also been called an 'accommodation' narrative (Bell, 1999). This narrative shares some similarities with the medical model that constructs mental health problems as an illness, which someone is unlikely to make a full recovery from and must endure. Key elements of this genre include the individual's acceptance of life as a struggle and in endurance narratives, the medical model holds an important but sometimes conflictual position.

Alice described "three or four" involuntary admissions, with the first occurring after she was raped and the third occurring after she was sexually assaulted a second time. Alice's narrative had elements of being disjointed and she frequently seemed unsure of what to say. For example in the following response to the researcher asking how she felt:

> "I felt like...umm.....uhh....umm...it's difficult...umm... **(sighs)**...no I'm sorry, I can't" (8, 377-378).

This aspect of her narrative is consistent with someone traumatised, as trauma damages an individual's sense of narrative coherence (Crossley, 2000; Harvey, Mishler, Koenen & Harney, 2000). Alice explained that the second time that she was sectioned was easier:

> "The next time that I got sectioned it wasn't as bad 'cause I'd, somehow I'd managed to settle into it and I knew that they were there trying to help me" (2, 60-61).

Alice further explained that in all of her admissions she thought that she did not need to be there but explained that this was because: "At the time I'm obviously unwell" (2, 99-100).

Despite Alice explaining that she now takes medication, she has resisted this in the past:

> "I stopped taking it because I didn't think I needed it. And umm... gradually after, after about a month....I was thinking "Yeah I feel really, really good" and I'm glad I come off them but it takes about a month or something to come out your system. So after a month I started going a bit downhill again" (4, 173-180)

Although Alice voiced frequently that she did not want to be in hospital: 'I didn't want to be in there at all' (6, 290) her narrative did not have the same sense of anger identified in the escape narratives. Alice appeared to endure hospital in a more dissociated way:

> "A lot of the time it was like "I'm feeling so alone...even though there's loads of people around me and I thought that being sectioned seemed to have...made me feel worse" (8,361-363).

In this narrative, the overarching theme of endurance was linked to Alice's acceptance of life as a series of difficult events that she had endured. Although at times she did not want to be in hospital, she described it primarily positively. The tone of her narrative was frequently unsure as she struggled at times to vocalise her story, however the tone was also thoughtful as she considered what led to her mental breakdowns. Her core narrative: "I didn't want to be there but they tried to help me" illustrated the endurance in her story.

Discussion

The discussion will firstly focus on the results of the narrative analysis, paying particular attention to the issues highlighted by the genre analysis. Secondly, it will link the qualitative findings with previous research. Thirdly, the discussion will reflect on the research process exploring validity issues and limitations of the study. Finally, the discussion will review the implications for future research and consider the clinical implications of the findings.

This study aimed to provide a detailed account of how people described their experiences of being sectioned using a narrative approach to convey a detailed understanding of the issue. From the analysis, it emerged that the narratives could be categorised within four genres of escape, rescue, enlightenment and endurance. The narrative tone was related to the genre in that an angry, protesting or critical tone was identified in escape narratives, a distressed or scared tone in the rescue narratives, a thoughtful tone in the enlightenment narrative, and an unsure tone in the endurance narrative. The core narratives reflected the genre and tone, for example, Daniel's core narrative was identified as 'I tried to suppress anger so could get out of hospital', the tone was angry/disbelieving and the genre escape.

The main genre of escape was previously identified in Thornhill et al.'s (2004) psychosis research, which identified that people reacted primarily negatively to being sectioned, and used language that evoked imagery of imprisonment. These comments made the narratives similar to imprisonment narratives (Langer, 1991; Young 1988) and illustrated similar concepts to Foucault's (1965) and Goffman's (1961) theories, which compared mental hospitals to prisons. Involuntary treatment has been described as an instrument of social control (Mason & Jennings, 1997; Symonds, 1998) and considering the deprivation of liberty

that occurs, it can be seen to parallel experiences of imprisonment. Foucault (1977) highlighted the surveillance functions of institutions and previous studies have found that service users are aware of this surveillance (Goodwin et al., 1999; Thornhill, et al., 2004). This was clearly apparent for Jacob who commented:

> "They observe you and they make comments about your behaviour, but your behaviour is in a completely artificial situation" (11, 522-523).

All of the escape narratives contained complaints of: a lack of information concerning treatment; staff not spending enough time talking to service users; and a lack of emotional support. The complaints support previous research, which highlighted that service users complained about the lack of time staff spent talking with them (Baker, 2000; Goodwin et al., 1999; Johansson & Lundman, 2002; Johnson et al., 2004; Joseph-Kinzleman et al., 1994; Lapsley, Nikora & Black, 2002; McIntyre, Farrell, & David, 1989; Thornhill, et al., 2004; Olofsson & Jacobsen, 2001).

In two of the escape narratives the concepts of mental illness, forced medication and being labelled with a psychiatric diagnosis were questioned. The notion that service users search for alternative explanations to explain their difficulties has been found in previous studies (Casey & Long, 2002; Lapsley at al., 2002; Thornhill et al., 2004) and highlights how alternate narratives are used to make meaning from mental distress, which deviate from the dominant bio-medical narrative. Criticisms of forced medication and psychiatry's over-reliance on medication have been identified in previous studies (Goodwin et al., 1999; Greenberg, Moore-Duncan & Herron, 1996; Haglund, Von Knorrin, & Von Essen, 2003; Johansson & Lundman, 2002; Johnson et al., 2004; Joseph-Kinzleman et al., 1994; Olofsson

& Jacobsen, 2001, Thornhill, et al., 2004). Forced medication is still a routine practice in psychiatric hospitals used when an individual refuses medication. Considering the distress that some individuals report, this is an area that warrants further research.

In the escape narratives, although Daniel and Jacob described accepting that they were "ill" their ambivalence towards a medical conceptualisation of their difficulties was apparent. Their acceptance of having an illness appeared to have been related to their strong desire to get out of hospital, and the process of agreeing with what staff say to get out of hospital has been found in previous research (Goodwin et al., 1999; Olofsson & Jacobsen, 2001; Thornhill, 2002) and termed 'playing the game' by Chamberlain (1985). A third aspect of the escape narratives was voiced by Daniel who described wanting to escape from the identity of the psychiatric patient and voiced concerns about "having a label" which he feared would affect him gaining employment. This concern about stigma following hospitalisation supports previous research (Goodwin et al., 1999; Johnson et al., 2004; Thornhill, et al., 2004).

Despite primarily negative comments about involuntary care being voiced in the escape narratives, positive features were also identified. This was particularly salient for Jacob who reported hating being sectioned, but claimed it saved his life. Despite Daniel voicing the most anger towards being sectioned, he also reflected on how it made him re-evaluate his life and he acknowledged that his previous behaviour of staying in his bedroom alone smoking cannabis, led to being sectioned. For Graham although he criticised the care he received, he described being suicidal before hospitalisation, so accepted the need for being sectioned.

The rescue genre has not been identified in previous studies but shares similarities with rescue narratives found in biblical stories. In these narratives, Darren and John described

their mental health deteriorating because of substance misuse and reported benefits of being sectioned, primarily in that it stopped them misusing drugs. For Darren hospital was also experienced as somewhere to recover from his paranoia and his description of it as a "safe haven", and "somewhere to recover and get my thoughts back together" (2, 59) supports the traditional notion of the asylum as a place of safety. Both participants reported positive relationships with staff and their comments are supported by previous research, which identified that: staff treated individuals respectfully and provided good care (Olofsson & Jacobsen, 2001); participants described feeling safer in hospital and praised sympathetic staff (Goodwin et al., 1999; Johnson et al., 2004).

However, some negative comments were reported by John who voiced distress over the amount of time it took to get out of hospital and criticised the time (up to two months) it could take for an independent assessment of whether a section could be rescinded. This was a criticism voiced across genres appearing in one rescue and two escape narratives, which created a barrier to participants appealing their sections and supports findings from previous studies (Goodwin et al., 1999; Rogers, 1993; Thornhill, et al., 2004).

The genre of enlightenment was identified in Thornhill et al.'s (2004) psychosis research and was similar to illness or trauma narratives identified in previous research, such as the conversion/growth genre (Crossley, 1999) and quest narrative (Frank, 1993). They share the emphasis on a journey involving a search for meaning (Crossley, 2000; Kleinman, 1989). For Vincent the main emphasis throughout his narrative was on how his spirituality helped him make sense of his difficult sectioning experiences.

Vincent described spiritual euphoria preceding his breakdowns, and research supports that spiritual preoccupations are common in individuals diagnosed with schizophrenia and breakdowns are often preceded by an experience of unity with God (Chadwick, 1992; Clarke, 2001; Jackson & Fulford, 1997). Vincent believed his spirituality helped him through primarily negative treatment experiences and research suggests that a religious interpretation of unusual experiences can help to achieve meaning, self-esteem and a sense of control, which increases coping behaviour (Jackson & Fulford, 1997; Peters, Day, McKenna, & Orbach, 1999).

An element identified in both Vincent and Graham's narratives was their description of memory damage, which they related to ECT. This finding corroborates the results from previous studies, which highlighted significant memory problems after ECT (Goodwin et al., 1999; Johnstone, 1999; Philpot et al., 2004; Thornhill, et al., 2004).

The final narrative genre of endurance was identified in Thornhill et al.'s (2004) psychosis research and is similar to Bell's (1999) accommodation narrative. This also shares similarities with the medical model, which constructs mental health problems as an illness to be endured. For Alice her experiences of being sectioned were described as negative

events, which she endured due to her mental illness. Although Alice described never wanting to be in hospital, she mainly reported acceptance of her need for treatment. She perceived staff as "trying to help" her which supports previous research findings (Goodwin et al., 1999; Johnson et al., 2004). Alice's narrative had elements of being disjointed throughout which was consistent with someone traumatised after sexual assaults (Crossley, 2000; Harvey et al., 2000). Alice described "feeling so alone" in hospital despite having people around her and commented that being sectioned made her feel worse. The description of feeling alone whilst living in hospital has been identified in previous research (Johansson & Lundman, 2002; Pejlert, Asplund, & Norberg, 1995) and perhaps related to Alice's traumatised state of mind, as well as her desire not to be hospitalised.

To summarise, the research identified a complex mixture of negative and positive aspects of being sectioned. This mixture of views mirrors the mixed views identified by the Swedish qualitative studies, which interviewed detained individuals (Johansson & Lundman, 2002; Olofsson & Jacobsen, 2001), and research investigating detained and voluntary service users (Goodwin et al., 1999; Thornhill et al., 2004; Johnson et al., 2004). However, new aspects of being sectioned were identified in this research, which have not previously been reported. These were that individuals described being sectioned as the event that: shocked them into re-evaluating their lives; provided a safe haven for them to recover their thoughts; stopped them misusing drugs; saved their life but was also the worst experience in their life; made them feel closer to God; and made them feel alone. The results also highlighted that people with mental health problems (primarily diagnoses of schizophrenia), gave rich, thoughtful accounts of their sectioning experiences. This supports the findings from previous studies (Bindman et al., 2005; Hiday et al., 1997; Poulsen, 1999).

Limitations of research

The participants interviewed in this study were primarily male and therefore the one female narrative cannot be seen to represent women's experiences fully. However, the sample is representative of the population as the latest statistics show that nearly twice as many males (9,600) as females (5,100) were detained in psychiatric units (The Information Centre, 2006). In addition to this, the majority of the participants were white and British and therefore the one mixed-race Caribbean and one Northern European participant cannot be seen to equally represent the views of ethnic minorities. The ethnicity of the sample does however represent the population in Dorset and Somerset, which are predominantly white British.

Similarly, through the researcher being a female interviewing a predominantly male sample, the narrative co-constructed between the interviewee and interviewer may have been significantly different if the interviewer was male. This also applied to the analysis, which may have been interpreted differently if analysed from a male perspective. Previous research has suggested that the gendered lens of research may pose some limitations, in terms of a female researcher attempting to represent male experiences (Nicholas, 2005).

The research represented the views of individuals retrospectively remembering their sectioning experiences. Research has highlighted that people show retrospectively positive changes in attitudes to coercive treatment (Lucksted & Coursey, 1995; Kaltiala-Heino, 1996) so therefore this study may not represent the most negative views on involuntary treatment.

The participants were all involved with a service user organisation as well as the NHS, which may represent a different population to those only involved with the NHS. Interestingly less

critical views were identified in this research to Thornhill et al.'s (1994). This is perhaps because in their research they recruited individuals active in service user organisations critical of psychiatric services, whereas Rethink's position can be seen to mirror the views of the NHS more as individuals are encouraged to take medication. Rethink use the term "mental illness" in their literature, which is very different to Mind, who use "mental distress". Their language along with their positions as organisations could thus be seen to reflect their different conceptualisations of mental health problems.

The interview questions were distributed to the managers of the organisations, which resulted in two participants (Graham and Alice) having rehearsed their answers to the questions before they were interviewed. This appeared to make these narratives less free flowing than the researcher hoped, but alternatively this prior rehearsal of the narratives could be seen to have helped them reflect on their sectioning experiences in further detail.

The participants who engaged in the research could be considered as being more motivated, representing those more traumatised by their experiences, or more confident in speaking about their experiences. Despite these limitations, the narratives highlighted previously unheard views on NHS sectioning experiences, which is important for informing the direction of future research and clinical practice. These areas will now be explored.

Implications for future research

Considering that there was only one female participant it is important to conduct further research into female experiences. The female narrative was qualitatively different to the male narratives and was the only one, which had elements of a trauma narrative. Previous research has highlighted that women frequently report sexual harassment, sexual assault and being frightened by male service users on inpatient wards (Baker, 2000; Cohen, 1992; Copperman & Burrows, 1992; Johnson et al., 2004; Warner & Ford, 1998). This has serious implications for how women experience being sectioned if they have already been a victim of sexual assault, as they may face further abuse or re-traumatisation through hospitalisation.

The way in which the information was narrated and interpreted by the researcher may have been very different if conducted by a service user, as the reduced power imbalance may have allowed access to different narratives of being sectioned. If more time had been available for the research, it would have been helpful to conduct the research with a service user researcher.

Only one mixed-race person was interviewed, which suggests a need for further research exploring the sectioning experiences of ethnic minorities, as in the UK black individuals are 44 percent more likely to be sectioned (Commission for Healthcare Audit and Inspection, 2005). Further research is needed to explore the views of individuals from different ethnic backgrounds to ensure that the narratives represent our multi-cultural NHS users.

Another implication for future research is to compare the sectioning experiences of individuals involved with a range of different service user organisations. In this research, the

participants were primarily recruited through Rethink, which has a particular position on mental health problems and therefore different views may be gained if recruiting through organisations which are more politically active such as Mad Pride or MIND.

Considering the distress two participants reported over forced medication and the impact this had on their therapeutic engagement, this area warrants further research. Related to this is the need for research exploring service users' views on Community Treatment Orders (CTO's). Despite research failing to support CTO's efficacy to reduce hospital re-admission, length of stay, or treatment compliance (Churchill, Owen, Hotopf, & Singh, 2007) look set to be made legislation soon. CTO's will effectively provide similar compulsory powers to sectioning, as individuals will be forced to take medication in their own homes.

The Involve team led by Professor Stefan Priebe are currently conducting a multi-centre study exploring sectioning experiences. Considering however that the Involve study is primarily a quantitative study, there is a need for multi-centre qualitative research exploring service users' views to gain a range of detailed accounts.

Clinical implications

Considering the transferability of these results to previous studies the data from this study has wide-ranging clinical implications. Several participants complained that the main preoccupation in hospital was on taking medication, staff did not give enough information concerning treatment, and staff did not spend enough time talking to service users. This supports previous research (Baker, 2000; Goodwin et al., 1999; Johansson & Lundman, 2002; Johnson et al., 2004; Joseph-Kinzleman et al., 1994; Lapsley et al., 2002; McIntyre et al., 1989; Olofsson & Jacobsen, 2001; Thornhill, et al., 2004) and suggests the need for, alternatives to medication, care staff to ensure one-to-one time is prioritised in care plans, good communication between staff and service users, and the importance of including individuals in their care to relieve any treatment anxiety.

This could be achieved by ensuring that where possible, individuals have access to alternate treatment options to medication (for example psychology or art therapy); individuals are informed why they are sectioned, and understand their right to appeal. However, one must consider that in any narrative we are only hearing one side of the story and staff may have offered all of the above, but this may not have been accepted or remembered because of the individuals' mental state, the individuals resented being detained, or they were heavily medicated or receiving ECT, which may have affected their memories.

All the participants commented that it was helpful talking about their experiences and this was the first time they had talked in detail about being sectioned. The benefits sharing a narrative has on helping to make sense of disconcerting experiences has been highlighted in previous research (Casey & Long, 2002; Lapsley at al., 2002; Ridgway, 2001; Stern et al.,

1999; Thornhill at al., 2004). This is particularly important in mental health where the dominant medical narrative can suppress service users' attempts to make sense of their experiences. This has implications for how inpatient staff can help individuals make sense of their experiences, by allowing them the time to share their narratives in one-to-one time.

Previous research has highlighted that individuals use a variety of frameworks for understanding mental distress and exploring how people make sense of their experiences has been found to help to promote recovery (Dillon & May, 2002; Lapsley et al., 2002). This suggests that it may be beneficial to offer service users a therapeutic group focussed on exploring their hospitalisation narratives after discharge. A narrative therapy (White, 1995) approach would be particularly suited for such a group and considering that Meyer et al. (1999) found being sectioned was traumatic for some individuals, this adds further support for such a group. Some individuals may have negative associations with hospital, so the group would ideally be located in a neutral setting such as a room hired in a GP's surgery.

Another clinical implication is to develop a group to support service users' concerns about stigma following hospitalisation, which was a concern identified in this study and previous studies (Goodwin et al., 1999; Johnson et al., 2004; Thornhill, et al., 2004). A psychologist and an occupational therapist could facilitate such a group, for support with the emotional and occupational barriers that may restrict people accessing employment or education.

Graham described how intimidating it was facing a panel of several professionals during a ward-round, which resulted in him agreeing with everything the psychiatrist said to escape the anxiety-inducing situation. Graham offered useful suggestions to improve ward-rounds

by using a "two way mirror or CCTV". Whether this is used, or the number of professionals in a ward-round is reduced, this could help make the experience less intimidating.

Several participants commented that they would have liked alternatives to being sectioned and never wanted to be sectioned again. Although it is not always possible due to risk, professionals ideally, should use detention as the last resort. Some psychologists currently work with staff and service users to increase community support and prevent sectioning (Holmes, 2002; May 2005). In addition to this, the proposed changes in legislation will mean that Clinical Supervisors will have the power to both stop individuals being sectioned and section people. Some psychologists thus see the clinical supervisor role as a chance for psychological factors to be considered more in the sectioning process (Pilgrim, 2005).

Three participants complained about the length of time it took for an independent assessment of whether their section could be removed, which supports previous studies (Goodwin et al., 1999, Rogers, 1993; Thornhill, et al., 2004). This highlights an area that could be improved as it can take eight weeks for a hearing (Mental Health Review Tribunal, 2007), which is a long time for individuals receiving treatment against their will.

Critical Reflection

Interviewing

As the researcher transcribed the interviews, she became aware that in Alice's interview, she unconsciously helped Alice name her experiences. Alice's narrative was disjointed in places and she frequently struggled to vocalise things. This can be seen in the extract below:

P7: I felt like.....umm.....uhh.....umm.....it's difficult,.....umm..... **(sighs)**.....no I'm sorry, I can't.

MS: Can't what, did you mean?

P7: I can't.

MS: Can't explain it, or?

P7: No I can't explain it (8,377-386).

Harvey et al. (2000) highlight how common it is for therapists to help make sense of difficult experiences in interviews, as this is their role in clinical practice. Langer (1991) termed this a 'listener's problem' which refers to the extent that listeners prefer coherent stories and trauma narratives resist these forms of emplotment. From the above interaction, the researcher's therapeutic training can be seen to affect Alice's attempt to make sense of her experiences. Reflecting on this the researcher considered how the narratives might have been narrated differently if the interviewer was a service user rather than a professional. For example, the narrative may have sounded more disjointed, if the researcher was not a professional who inadvertently helped Alice name her experiences.

Reflexivity and Validity

The researcher took measures to ensure quality in her research by following qualitative guidelines (Elliott et al., 1999; Yardley, 2000). Considering Elliott et al.'s (1999) guidelines firstly, they suggest that: researchers should own their perspective in the research, situate the sample adequately, ground the data with examples, provide credibility checks, present the research coherently, accomplish the research tasks (with regard to general versus specific questions), and the research should resonate with readers.

Considering these guidelines, the researcher owned her perspective, which led her to designing this research, and described how her assumptions were upheld and challenged by the analysis. The interviews were a co-constructed dialogue to which the researcher contributed, and interviewees could be considered to be giving responses, which they thought the researcher wanted to hear. However, the researcher was conscious to try to not influence participants' responses by using non-leading questions to ensure that the participants were given the chance to give their accounts of being sectioned, without leading their narratives in a particular direction.

The researcher situated the sample in the method and discussion sections, discussing how participants were recruited and giving demographic information. Although the participants were involved with service user organisations they could be considered to represent similar views to those only involved with the NHS, because they were primarily recruited through Rethink, which as an organisation is not as critical as other groups like MIND. The researcher aimed to ground all her statements with examples, using quotations to illustrate the narratives and highlight how the analysis was grounded in the data.

The researcher used credibility checks, supervision and member checking (Russell & Gregory, 2003) to verify her interpretations of the participants' experiences which gave the analysis testimonial validity (Stiles, 1999). The researcher accomplished the research task, which was to answer the specific question *how do people describe their experiences of being sectioned*. This involved the researcher presenting and interpreting seven detailed case studies and the researcher reflected on the limitations of extending the findings from this specific research to other instances. Considering coherence the researcher aimed to present the data in a way that could be read coherently and integrated the results through a comparison of narrative genre, whilst still illustrating the individual differences in the narratives. Finally, the researcher was careful to use the participant's words to label the core narrative and used quotations throughout in an attempt to capture the essence of the narrated experiences.

Yardley's (2000) guidelines suggest a high-quality qualitative study should have sensitivity to context, commitment and rigour, transparency and coherence, impact, and importance. Following these guidelines, the researcher considered sensitivity to context and this has already been discussed in terms of the participants' and the researcher's characteristics. Due to concerns about interviewing in a NHS context all interviews were conducted in a non-clinical setting in an attempt to remove any potential negative associations with treatment. The researcher previously discussed how through the participants talking to a professional, this may have evoked different narratives than if the researcher was a service user.

Considering commitment and rigour, the researcher has been committed to researching this area since she first started working in mental health eight years ago. The researcher hoped that through researching this area she could help give NHS service users a 'voice', in a

system where their stories had not previously been researched. Considering rigour, the analysis of narrative tone, genre and core narrative were undertaken across all interviews. The narrative analysis enabled the narratives to be studied holistically, and comparisons to be made between the narratives through the genre analysis. The researcher aimed for transparency by giving a detailed description of how the participants were recruited, and provided a 'paper trail' highlighting each stage of the narrative analysis in the appendices.

As the results of the analysis emerged, the researcher found that assumptions she held previously were confirmed and challenged. The confirmed assumptions were that, the participants narrated meaningful accounts, and some individuals described difficult experiences and voiced anger towards the system. Although the researcher anticipated positive descriptions of being sectioned, she did not expect participants to describe entirely positive experiences of services as Darren did. Another assumption was challenged by Jacob who described sectioning as something he hated and would "fight" in the future, but was something, he believed saved his life. This highlighted the range of contrasting views that individuals can hold on distressing events. The researcher therefore has been transparent in considering how her assumptions might have influenced the research.

Considering coherence the aim was to explore a range of experiences of being sectioned and a narrative approach enabled this without restricting answers to pre-conceived notions of coercion. Finally, considering impact and importance, it is too early to judge the impact and importance of this study as it has not been published. However, the study is clinically relevant considering the planned reforms of the Mental Health Act (1983) and the new legislation which will include Clinical Supervisors and CTO's.

Conclusion

It is important for these findings to be disseminated to inpatient staff in order to enhance the understanding of the varied issues related to being sectioned. Although negative comments criticised medication and staff, there were also positive comments praising staff and highlighting that sectioning protected individuals. Through staff understanding individuals' views, they can continue offering the good care they provide and improve services by listening to what service users require. The ability of service users to thoughtfully reflect on being sectioned was highlighted by this research, which is contrary to some assumptions made about the validity of sectioned individuals' reports (Poulsen & Engberg, 2001). It is important that these findings are communicated at a wider societal level to help develop a more accurate understanding of sectioned individuals' experiences in order to reduce stigma, and within clinical settings to reduce the discrimination, which means some individuals are screened out of research because of a diagnosis of schizophrenia.

Finally, it is important to acknowledge the participants who made this study possible. It involved them recalling distressing information and their narratives highlight that individuals can provide rich accounts of being sectioned. It is hoped that this research communicated their experiences and further research will be conducted into this important area. It is also hoped that the findings of this study will further the discussion about how to achieve the difficult balance between respecting people's rights and sectioning when necessary.

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List of Appendices **Page**

Appendix A: Guide for Authors (International Journal of Law and Psychiatry)

INTERNATIONAL JOURNAL OF LAW AND PSYCHIATRY
The Official Journal of the International Academy of Law and Mental Health
Guide for Authors

Manuscript Submission

1. Manuscripts and editorial communications should be addressed to: Editor-in-Chief, International Journal of Law and Psychiatry, Faculté de médecine, Université de Montréal, C.P. 6128, Succ. Centre-ville, Montréal, Québec H3C 3J7, Canada.
2. Submission of a manuscript to the Journal clearly implies commitment to publish in it. Articles previously published and those under consideration by another journal are unacceptable.
3. Submit three high-quality copies of the manuscript, plus one set of camera-ready figures or photographs (original artwork or glossy prints). Retain the original manuscript for your files. Manuscripts will not be returned.
4. If applicable, include written permission of authors(s) and publisher(s) to use any previously published material (figures, tables, or quotations of more than 100 words).
5. Authors will be required to transfer the copyright of their accepted article to the publisher. Papers cannot be published until the copyright transfer form is received.
This transfer will ensure the widest possible dissemination of information.
Preparation of Manuscript/Disk
Type the manuscript (typeface font: 12-point Times New Roman) on 8.5 x 11-inch (21.5 x 28 cm) white bond paper with 1" margins. Use double spacing throughout, including the reference section. Conciseness in writing is required. Do not repeat data (i.e., generally use either tabular or graphical presentation of a set of data, not both). Organize the manuscript in the order indicated below, with each component beginning on a separate page and with a running title and page number typed in the upper right-hand corner of each page.
1. Title Page: Page 1 should include: (a) the title of the article (80 spaces maximum); (b) the authors' full names with degrees; (c) affiliations (department [if any], institution, city, and state or country where the work was done), indicating which authors are associated with which affiliations (use *, +, +, §, *, ¶, **, etc.); (d) shortened running title; and (e) the name, address (including city, state, zip code, and country), telephone and fax numbers, and E-mail address of the corresponding author. Please notify the editor of any change of address that occurs while an article is in the process of publication. Acknowledgment of grant support, and/or individuals who were of direct help in the preparation of the paper should be placed as an unnumbered footnote on the title page.
2. Major Headings: Please make sure that all major headings (level 1) are typed in the same font and style, so that it is apparent that they are major heads. Likewise, other descriptive subheadings, which may be used if appropriate, should be typed in the same font and style (e.g., all level 2 heads should appear the same, and be distinguishable from level 1 heads and level 3 heads, etc.), so that the manuscript is coded and typeset correctly.
3. Text: Follow the Publication Manual of the American Psychological Association for style of specific elements in text.• Numbers: Whole numbers from one to nine are to be spelled out, unless used with the word "percent," contained within a direct quote, used to identify variables, or used in a list of more than three numbers or number ranges, in which one is over nine.

• Abbreviations: Use abbreviations that appear as word entries in Webster's New Collegiate Dictionary, and for standard Latin terms, statistics, and reference terms in parenthetical material (e.g., i.e.,). Terms appearing frequently within a paper may be abbreviated, but should be spelled out at first mention, with the abbreviation following in parentheses.
• Article/Paper: The text of the article is to refer to itself as an article or study, but never as a paper (i.e., "This article measures..." rather than "This paper measures...").
• Present/Past Tense: It is incorrect to use the present tense when referring to a past study (e.g., "This study examined factors..." not "This study examines factors..."). The study has already been completed; thus, the information and results are in the past tense. It is acceptable to use the present tense when referring to results (i.e., "The results indicate...") since these are present-day hypotheses that are being discussed in the present. Specific results, however, are written in the past tense. This rule applies when discussing an "article" as opposed to a "study." The study examined, but the article (which is present now) examines.
• Quotations: Quotations should be checked for accuracy. Square brackets should be used to indicate insertions into the original text. Omissions from the quoted text should be marked by ellipses.
4. Notes: Notes will be called out in the text using sequential superscript numbers, and the corresponding footnotes will fall at the bottom of the page on which they are cited. Footnotes can be both Harvard style references (see below), and general information notes, and should be ordered in sequence, not separated out. General information notes should be kept to a minimum and used only for substantive observations.
5. References: This journal follows two reference styles:
(A) If the references are to be published as a list at the end of the article, follow the APA Publication Manual. Identify all source references at the appropriate point in the text by the author/date system, and list the references at the end of the manuscript in alphabetical order, double spaced. All references that are cited in text must appear in the reference list. Conversely, all references that appear in the reference list must be cited in text. It is imperative that all information is accurate. Make certain that the text citation and reference list entry are identical in spelling and year (this includes the spelling of all authors' names). Entries in the reference list should contain the following: (a) all authors of the work, with surnames and initials (not full name); (b) the year of publication; (c) title of article, chapter, or book; (d) facts of publication (for journals—complete journal name, volume number, inclusive pages; for books—city of publication and complete publisher's name). Examples follow (for others, consult the APA Manual):

Book: Gunderson, M., Mayo, D. J., and Rhame, F. S. (1989). AIDS: Testing and privacy. Salt Lake City, UT: University of Utah Press.

Journal: Blumberg, M., and Langston, D. (1991). Mandatory HIV testing in criminal justice settings. Crime and Delinquency, 37, 5-18.

Article in Edited Book: Felkenes, G. (1992). Affirmative action: Concept, development, and legality. In G. Felkenes and P. Unsinger (Eds.), Diversity, affirmative action and law enforcement (pp. 129-146). Springfield, IL: Charles Thomas Publisher.

Misc./other: Steele, L. T. (1995). The standard of care: Police attitudes on hot pursuit policy. Unpublished master's thesis, University of Maryland: College Park, MD.

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Clark, W. B., and Midanik, L. (1982). Alcohol use and alcohol problems among U.S. adults: Results of the 1979 national survey. In National Institute on Alcohol Abuse and Alcoholism (Ed.), Alcohol consumption and related problems (Alcohol and Health Monograph No. 1., DHHS Publication No. ADM 82-1190) (pp. 4-13). Washington, DC: U.S. Government Printing Office.

(B) If the references are to be published as footnotes, then the reference will be called out in the text using sequential superscript numbers, and the corresponding footnotes will fall at the bottom of the page on which they are cited. Footnotes in this style of article can be both reference citations and general information footnotes, and should be ordered in sequence, not separated out. Reference footnotes will follow The Bluebook: A Uniform System of Citation, published by the Harvard Law Review, with one exception: set authors' names in book citations cap/lowercase (not cap/small caps). Examples follow (for others, consult The Harvard Bluebook):

Book: H.L.A. Hart, THE CONCEPT OF LAW 119-21 (1961).
Journal: Carolyn Heilbrun & Judith Resnik, Convergences: Law, Literature, and Feminism, 99 YALE L.J. 1913, 1942 n. 122 (1990).

Article in Edited Book: Reynolds Robertson & Francis R. Kirkham, JURISDICTION OF THE SUPREME COURT OF THE UNITED STATES § 445 (Richard F. Wolfson & Philip B. Kurland eds., 2d ed. 1951).

(C) All court cases, laws, and statutes will be cited using footnote format, even in articles that use the APA format for references. For references to legal cases in the text, the case name is followed by the source, which includes the volume, reporter, and page reference, and in the first reference only, the year, for example, Wood v. Ostrander (879 F.2d 583, 1989). Subsequent references to the case in the text should include the case name and the page reference in parentheses, for example, Wood v. Ostrander (584). The full case citation should be set as a numbered footnote typed at the bottom of the page of its first occurrence.

1 Micallef v. Miehle Co., 39 N.Y.2d 376, 348 N.E.2d 571, 384 N.Y.S.2d 115 (1976).

2 Wood v. Ostrander, 879 F.2d 583 (9th Cir. 1989), cert. denied, 498 U.S. 938 (1990).

3 Cordero v. Coughlin, 607 F.Supp. 9 (S.D.N.Y. 1984).

4 Judd v. Packard, No.S.87-1514, slip. Op. (D.C.Md. Sept. 24, 1987).

6. Tables: Type each table, double spaced, on a separate sheet of paper (not on disk) and place at the end of the manuscript following the references. If the table must exceed one typewritten page, duplicate all headings on the second sheet. Very wide tables are difficult and expensive to typeset and should be avoided by dividing the data into smaller tables. Every table should have a title, and every column in the table, including the left-hand column, should have an abbreviated heading. Define all abbreviations, and indicate the units of measurement for all values. Use only horizontal rules to separate sections. Explain all empty spaces or dashes. Indicate footnotes to the table with superscript letters (a, b, c, etc.) cited in alphabetical order as you read the table horizontally. Use *, **, ***, etc., for statistics in the

table body and footnotes. If data from any other published source are used, obtain permission for their use and cite the source in a footnote to the table. All tables must be cited in the text. Number tables in the order in which they are cited in the text. All data cited in the text should be checked carefully against the data in the tables to ensure that they correspond.
7. Figure Legends: Legends should be typed double spaced and numbered with Arabic numerals corresponding to the illustrations. All figures must be cited in the text. Number figures in the order in which they are cited in the text. When symbols, arrows, numbers, or letters are used to identify parts of the illustration, each should be explained clearly in the legend. The legends should permit the figures to be understood without reference to the text. If the figure has been previously published, obtain permission for its use, and include a credit line.
8. Figures: Line diagrams should be produced on a high-resolution printer (600 dpi or greater) or in the form of glossy prints. Half-tone pictures should be supplied as original artwork or glossy, black-and-white 5 x 7-inch photographs in a protective envelope. Letters, numbers, and symbols should be clear throughout and should be large enough to remain legible if reduced for publication. Be sure that all spelling is correct, that there are no broken letters or uneven type, and that abbreviations used are consistent with those in the text. Figures should be identified on the reverse with figure number and author(s)' name, and when necessary, the top should be clearly marked. Do not write directly on the back of the photographs. Do not trim, mount, clip, or staple the illustrations.

In order to speed publication and ensure accuracy, authors are requested to submit a computer disk (3.5" HD/DD disk) containing the final version of the paper (i.e., after acceptance) along with the final double-spaced manuscript on paper to the editorial office. Instructions will be supplied once a manuscript has been reviewed, revised, and accepted. Authors should observe the following criteria: (a) Only hard copy should be sent when first submitting the paper for review. (b) When the paper has been reviewed, revised if necessary, and accepted, the author should send a computer disk containing the final version along with the final hard copy. The disk and hard copy must match exactly. (c) The software used must be specified, including which release (Microsoft Word 6.0 or Word Perfect 6.0, for example). (d) The computer used should be specified (either IBM-compatible PC or Apple Macintosh). (e) The file should follow the general instructions on style and format, and in particular, the reference style of this journal as specified above. (f) The hard copy should be double spaced, while the electronic file should be single spaced and the wraparound end-of-line feature should be used (i.e., no returns at the end of each line). All textual elements should begin flush left, with no paragraph indents. Place two returns after every element such as title, headings, paragraphs, and figure legends. (g) Automatic numbering or footnoting features must not be used. (h) A backup disk for reference and safety should be maintained.

Sources

The Journal follows the guidelines of the Publication Manual of the American Psychological Association (5th edition, 1994, Washington, DC: APA). Use this manual while preparing your manuscript. The following are also useful for reference: Webster's The New International or New Collegiate dictionaries for spelling and hyphenation (Merriam-Webster Inc., Springfield, MA), and The Merriam-Webster Dictionary of English Usage for grammar (Merriam-Webster Inc., Springfield, MA).

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Appendix B: Table of studies that investigated hospitalisation experiences

Table 1: *Summary of the studies investigating hospitalisation* experiences

Author(s) & Country	Participants	Aims	Method	Findings
Bindman et al. (2005) England	-100 (45 women & 55 men). -61 voluntary & 39 involuntary.	(1) Are non-white individuals more likely to perceive coercion? (2) Is high perceived coercion a predictor of poor engagement?	-Quantitative. Interviewed using AEI & AES (Gardner, et al. 1993). -Staff monitored service engagement after discharge. -Data analysed using univariate analysis and logistic regression.	-Involuntary care strongly associated with coercion. -¼ of voluntary patients felt coerced. -Participants with greater age, non white ethnicity, psychosis, low symptom score, low insight and objective coercion perceived higher coercion. -1st hypothesis supported as non-white ethnicity led to increased coercion. -2nd hypothesis rejected as high perceived coercion did not predict poor engagement after discharge.
Bonsack & Borgeat (2005) Switzerland	-87 (47 women & 40 men). -57 voluntary & 30 involuntary.	-Assess perception of admission. -Hypothesised coercion independent from legal context of admission.	-Quantitative. Interviewed about; legal status, agreement with hospitalisation, perceived need for hospitalisation and improvement . -Data analysed with Pearson's correlations.	-33 % voluntary patients felt admission not voluntary. -44 % involuntary felt admission voluntary. -74% of patients reported being under pressure to accept hospitalisation. -86% of voluntary and 40% involuntary felt they needed hospitalisation. -11% of voluntary and 40% involuntary felt they had not improved.
Goodwin et al. (1999) England	-110 inpatients (56 female & 54 male)	-Qualitative analysis of views of psychiatric hospital.	-Mixed design. Interviewed with Service Satisfaction Questionnaire (SSQ; Turpin & Sturmey, 1988) and Survey of Patients' Views (Bond et al., 1992). -Qualitative data analysed by grounded theory & content analysis.	- On quantitative data mean SSQ score was 63 indicating high satisfaction. -Analysis of qualitative data highlighted primarily negative findings. Negative comments: feeling powerless and angry at being sectioned, being treated disrespectfully by uncaring staff, hospital compared to prison, not being given information about medication and distress over involuntary treatment. -Positive comments: approachable, sympathetic staff, help with benefits being valued, and hospital activities being praised.

Author(s) & Country	Participants	Aims	Method	Findings
Hiday, Swartz, Swanson & Wagner (1997) USA	-331(178 male & 153 female). -Previously involuntary.	-Understand perceptions of coercion. -Young, male, African-American, unmarried, and low educated predicted to report more negative pressures.	-Quantitative. Interviewed with MacArthur Interpersonal Relations Scale (Gardner, et al. 1993) measured: coercion, negative pressures & procedural inequity. -Data analysed by proportional odds ordinal logistic regression.	-Being male, African-American, and married/cohabiting associated with lower perceived coercion, and higher education higher coercion. -White, female, unmarried and more educated more likely to perceive coercion, and negative pressures. -Neither diagnosis, severity of symptoms, nor number of admissions affected how viewed admission. -Using force and including patients in admission process most important factors in coercion.
Hoge et al (1997) USA	-157 (92 males & 65 females) - 91 previously voluntary & 66 involuntary.	-How common are coerced voluntaries and uncoerced involuntaries? -When, how & whom coerces patients?	-Mixed. Interviewed by AEI. -Analysed by univariate analysis. -Qualitative data from AEI transcribed into either coerced voluntary or uncoerced voluntary.	- Analysis found that coercion not related to legal status.10% voluntary felt coerced and 35 % of involuntary did not feel coerced. - Involuntary: formal (professional) relationships= 66 % coercion, informal (family/friends) = 34%. Voluntary: formal= 60%; informal=40%. -46% voluntary patients and 32 % involuntary reported persuasion. -Involuntary more likely to report force 40%, compared to 3% voluntary.
Johansson & Lundman (2002) Sweden	-5 (3 women & 2 men) -Previously involuntary.	-Understanding of involuntary care experiences.	-Qualitative. Interviewed with semi-structured interviews. -Analysed with phenomenological hermeneutic method.	-Analysis highlighted complex picture of feeling supported & violated. -Positive comments: participating in care decisions, involuntary care needed for self-harm, involuntarily care did not always mean coercion. -Negative comments: staff's inflexible attitude, coercion being unacceptable, being exposed to violence & inhumane treatment, not being treated as a human, not being given information about treatment, being ignored and uncaring staff.

Author(s) & Country	Participants	Aims	Method	Findings
Johnson et al. (2004) England	- 50 women (30 admitted to crisis house & 20 admitted voluntarily to hospital).	-Compare experiences of admission to women only crisis house and acute wards.	-Qualitative. Semi-structured interviews explored experiences of the 2 services. -Analysed by qualitative content analysis.	-Primarily negative findings related to hospital. Negative comments: admission made stigma of mental health problems worse, hospital environment had negative effect on mental health, admission anxiety provoking, disappointment with amount of time staff spent talking to patients, wanting an all women ward, little opportunity to participate in care decisions, and a lack of meaningful activities. - Positive comments: feeling safer from self-harm in hospital, staff trying to make time to talk, and finding occupational therapy beneficial.
Joseph-Kinzelman, Traynor, Rubin, Ossa & Risner (1994) USA	-15 (previously involuntary).	-Explore perceptions of involuntary hospitalisation	-Mixed. Semi-structured interviews on involuntary experiences. -Analysed by descriptive statistics and data divided into themes.	-Concerns identified: coping with intense feelings (100%), lack of personal freedom and choice (87%), unhelpful staff relationships (87%), boredom (73%), and unhelpful medication experiences (60%). -Main feeling reported anger (60%) then fear, sadness and being trapped. -60% wanted following from staff: talking, empathy, explaining rules and medication, respect & kindness.
Lidz et al (2000) USA	-147 patients (54% male & 46% female) -66% voluntary, 33% involuntary.	-Describe sources of coercion in admissions.	-Quantitative design. Patients interviewed using AEI, clinicians also interviewed -Data analysed by regression.	-Every case involved admission staff, but other health professionals in 63%, family/friends in 57%, and police/security in 34%. -Strongest effect for coercion was force used by admitting staff, next was negative pressure from other health professionals, and lastly family and friends.

Author(s) & Country	Participants	Aims	Method	Findings
McKenna, Simpson & Laidlaw (1999) New Zealand	-138 inpatients (80 male & 58 female). -69 involuntary & 69 voluntary.	-Compare involuntary and voluntary perceptions of coercion.	- Quantitative. Interviewed with AES. -Analysed with Spearman's Rho, ANOVA and linear regression.	- Involuntary have stronger sense of coercion but voluntary also felt coerced. For involuntary, 56% coercion predicted by procedural justice, feeling happy at admission, perception of "negative pressure," and feeling angry. For voluntary, 53% predicted by procedural justice, happy at admission and diagnosis of psychosis. -Females and more educated perceived greater coercion.
Meyer, Taiminen, Vuori, Äijälä & Helenius (1999) Finland	-46 (28 women & 18 men). -26 involuntary & 20 voluntary.	-Determine which symptoms and treatments are traumatic & compare impact of psychosis & coercive treatment	-Quantitative. Semi-structured interviews & coercive measures taken from notes. Trauma rated by IES-R (Weiss, 1996) & CAPS (Blake et al., 1990). -Data analysed by correlations and regression analysis.	-No one met criteria for PTSD on traumatic aspects of hospitalisation alone. -Coercive measures can be traumatising as 24% of traumatic symptoms related to coercive measures. -Treatment-related traumatic stress significantly associated with involuntary admission and curfew. -Involuntarily admitted for the first time showed higher levels of treatment-related traumatisation on IES-R.
Olofsson & Jacobsen (2001) Sweden	-18 involuntary patients (12 women & 6 men).	-Explore experiences of coercion.	-Qualitative. Used narrative interviews. -Analysed using qualitative interpretive content analysis.	-Primarily negative comments highlighted participants felt disrespected, treated as inferior humans, felt uninvolved in care and unsatisfactory care. -Positive comments highlighted staff treating individuals respectfully, being involved in care, receiving good care, and being treated as a human being.

Author(s) & Country	Participants	Aims	Method	Findings
Poulsen (1999) Denmark	-143 patients (74 men & 69 women). -47 involuntary, 48 detained after being voluntary & 48 voluntary.	-Investigate difference in perceived coercion between; involuntary patients, voluntary patients later detained and voluntary.	-Quantitative. Interviewed with AES. -Analysed using chi-square, t-test, Mann Whitney & linear regression.	-Coercion higher for involuntary, compared to voluntary later detained. -The voluntary group also reported significant coercion. -Among the voluntarily admitted, those later detained had higher perception of coercion than voluntary patients. -No significant difference found for levels of psychopathology and perceived coercion.
Priebe, Bröker & Gunkel (1998) Germany	-105 (55% male & 45% female) with schizophrenia. -60 previous involuntary & 45 voluntary.	-Investigate whether involuntary admission fulfils PTSD criteria	-Quantitative. -Interview about treatment & given PTSD Interview (Watson et al., 1991). -Data analysed using Pearson's correlations.	- PTSD symptoms not associated with involuntary admission. -All individuals, including voluntary patients reported negative aspects of past treatment. These included violence; noise; overcrowding and monotony on wards; unkind, rigid, and formal treatment; and lack of empathy and support in staff. -Involuntary patients reported more negative experiences than voluntary.
Rogers (1993) England & Wales	-412 previously voluntary.	-Examine voluntary patients' perception of coercion. -Explore what differences exist between genuinely voluntary patients versus those who felt coerced.	-Mixed design. Interviewed with fixed choice responses. -Quantitative data analysed by cross tabulation and chi-square test. -Qualitative data on coercion reported descriptively.	- 44% did not regard hospital as a genuine choice. -Genuinely informal reported coercion in 21% of cases compared to the 'forced' informal who reported this in 80% of cases. -In the 'forced' informal group 64% felt professionals and 36% felt family/friends responsible for coercion. -Genuinely informal group reported less unwanted treatment than the 'forced' informal (47% compared to 71%).

Appendix C: Ethical approval letter

Dear Marianne,

Re: Service users' experiences of being sectioned under the Mental Health Act.

The above titled application was approved by the School of Psychology Ethics Committee on 8 June 2006.

Should you require any further information, please do not hesitate in contacting me. Please quote reference CLIN/04/15.

Best wishes,

Kathryn

Miss Kathryn Smith
Secretary to the Ethics Committee
School of Psychology
University of Southampton
Highfield
Southampton SO17 1BJ
Tel: 023 8059 3995 Fax: 023 8059 2606
Email: kms@soton.ac.uk

Appendix D: Information sheet

Research study into "Service Users' Experiences of being sectioned under the Mental Health Act".

Have you been sectioned under the Mental Health Act in the past five years? If you have I would like to talk to you to find out how you feel about this.

Hello, my name is Marianne Seebold and I am a Trainee Clinical Psychologist at the University of Southampton. I am doing a study looking at how people feel about being sectioned. Everyone feels different about being sectioned, so it would help professionals to understand how people feel about this. With a better understanding we can hopefully help to reduce any distress that people experience.

You will need to meet me for an interview at Rethink's office in Bournemouth. The interviews should last between 45 minutes to 60 minutes. The interview can take place over two sessions if that is better for you. I will then need to meet you once more to discuss the main points from your interview.

I understand that being sectioned is a very personal experience so want to let you know that your personal information will not be given to anyone. Any names or personal information will be changed so that you can not be identified in the written report of the study.

If you are interested in taking part please speak to Pauline Sparks at Rethink who will contact me. I will then come and talk to people who are interested and can answer any questions that you have.

Thank-you for your time.
Marianne Seebold
(Trainee Clinical Psychologist).

Appendix E: Consent form

"Service Users' Experiences of Being Sectioned Under the Mental Health Act". Consent Form for Research Participants.

Information Sheet

My name is Marianne Seebold and I am a Trainee Clinical Psychologist at The University of Southampton. I am asking for your help in a study which is looking at "Service Users' experiences of being sectioned under the Mental Health Act". This will involve you taking part in an interview which will last between 45 to 60 minutes. You will be asked to talk about being sectioned so that we can understand how people feel about this. With a better understanding of this professionals can help to reduce any distress that people experience when sectioned. Your personal information will not be given to anyone. Any names or personal information will be changed so that you can not be identified in the written report of the study.

Taking part in the study is voluntary and you may withdraw from the study at any time. A feedback statement will be supplied if you would like one after the interview. If you have any questions please contact Marianne Seebold on 01305 266011 or e-mail: mes304@soton.ac.uk.

Thank-you for your time.
Yours Sincerely,
Marianne Seebold

Statement of Consent

I understand that I may withdraw my consent and stop taking part in the study at any time without any penalty to myself. I understand that information collected as part of this study will be treated confidentially. This means that any names or personal information will be changed so that I can not be identified in the written report of the study. Signing this consent letter does not affect any of my legal rights. A copy of this consent letter will be offered to me so that I can keep a copy.

I _____ have read the above information sheet

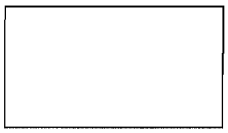
(Please write your initials in the boxes below to show that you agree with the following statements)

I give consent for the researcher to speak to a member of staff at Rethink/West Dorset Mental Health Forum if they are concerned about my emotional state after the interview. This will allow a staff member to offer me further support if necessary.

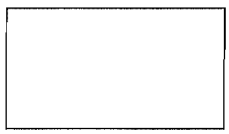
I give consent for my interview to be audio-taped.

I understand that the audio-tapes will be destroyed after the research study finishes.

I give consent for the researcher to use the words I have said in the interview as examples of people's experiences in the written report. Any personal information will be changed to protect my identity.



I would like a summary of the research findings after the study ends.



Signature.....
Date.....

Print Name here.....

I understand that if I have any questions about my rights in taking part in this research I can contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ. Telephone: 02380 593995.

Appendix F: Participants' narrative summaries

P1: **John** is a 23 year old British white man who is currently unemployed but was previously a student. He described four involuntary admissions to hospital. He reported being sectioned for the first time in 2003 after being arrested and spending a night in a police cell. This happened after drinking and smoking lots of cannabis and becoming confused about his thoughts and feeling that the television was giving him messages. This was followed by three other involuntary hospital admissions, each time after John described smoking too much cannabis and then "doing and saying funny things". John was diagnosed with schizophrenia and OCD. John described mixed feelings about being in hospital as it was good to help "sober me up and make me feel more what life is about". However he also described it as his own "personal nightmare" because it takes so long to get out of hospital each time.

P2: **Daniel** is a 26 year old mixed race Caribbean man who is currently a student at college. He described one involuntary admission to hospital in 2005 after being arrested for assaulting his mother. Daniel described having an 'over-aggressive nature' and described being confused and shocked when he was first told he was 'mentally ill' in the police cell. Daniel was diagnosed with paranoid schizophrenia and psychosis. Daniel described being angry about being sectioned and 'having a label slapped on me' that he didn't want but realised that getting angry didn't help and resulted in him being restrained. Daniel then decided to try to stay calm and accept the medication so that he could get out of hospital.

P3: **Vincent** is a 54 year old English white man who worked as a cleaner for most of his life but is currently doing voluntary work. Vincent described six involuntary admissions throughout his life with the first happening when he became 'unwell' aged 16. Vincent described running away and pulling a train's brake because "God told me to do that" and then being sectioned and later diagnosed with schizophrenia. Vincent described his first admission as the worst because of the 'horrific' conditions in the hospital which was like 'being locked in a cell and treated as mental and not really human'. The second admission was also triggered by religious concerns and Vincent thinking that it was the end of the world. Vincent had difficulties separating the details of the third, fourth and fifth admissions due to memory loss from ECT. Although Vincent never enjoyed being in hospital, he described not objecting to being sectioned and seeing it as 'God's plan at the time'. After his last admission in 2003 which was triggered by work pressures Vincent described being well for the last three years.

P4: **Darren** is a 22 year old British white man who is currently unemployed but previously worked as a labourer. Darren described one involuntary admission in 2004. Darren described hearing voices for the past three years but reported that it got uncomfortable after smoking lots of cannabis and he become paranoid that people were trying to kill him. Darren was arrested after being caught trying to leave the country illegally and spent a night in a police cell before being admitted. Darren was diagnosed with schizophrenia. Darren described being frightened at being sectioned initially as he thought people were 'after him' and he was in hospital for protection, so felt 'safe but scared'. Once Darren started trusting staff he felt that hospital really helped him as it stopped him doing drugs and the staff made him talk about his thoughts and his difficult childhood, which helped him feel more comfortable around people.

P5: **Jacob** is a 43 year old Northern European white man who is a mature student. Jacob described four involuntary admissions with the first occurring when he was 29 years old. Jacob described having a 'breakdown' aged 28 as a result of stress at work but did not seek professional help. Jacob recovered but later 'relapsed' and went voluntarily into hospital, but after refusing medication was sectioned and diagnosed with paranoid schizophrenia. Jacob described hospital as the 'worst place I've ever experienced' but realised that the way to get out of hospital was to take medication. However once discharged he would stop medication, then would stop talking to people because he felt no one was listening and would be sectioned again. This happened three times and over the years Jacob realised that he had to take medication even though he didn't want to, in order to stay out of hospital. Jacob also described running away from hospital on the third time that he was sectioned and the police bringing him back to the hospital. His attitude towards being sectioned has changed over the years from 'hating it to thinking that it saved my life', but he still dislikes forced medication.

P6: **Graham** is a 48 year old white English man who is currently unemployed but was previously a merchant seaman for most of his life. Graham described one involuntary admission in 2004 which occurred after he became depressed and suicidal. Graham was sectioned after he stopped attending the day-centre and was found by the coast where he was contemplating suicide. Graham was diagnosed with Progressive Depressive Disorder. Graham accepted that he needed help and did not object to being sectioned but was critical about the admission process and the 'ward rounds' which he found anxiety inducing and un-therapeutic. Graham gave thoughtful suggestions to help improve these procedures for patients. Graham also voiced concerns about ECT which he believes caused his severe memory problems.

P7: **Alice** is a 27 year old white British female who has been unemployed since she left University because of mental health problems aged 19. Alice described 'three or four' involuntary admissions with the first occurring after she became depressed and started self-harming after being sexually assaulted. Alice described the first admission as the worst because she was 'very paranoid' and thought staff were bugging her room. Alice was diagnosed with paranoid schizophrenia. However the second time that she got sectioned although she did not want to be in hospital it was easier as she knew staff 'were trying to help'. Alice was sectioned a third time after being sexually assaulted again. Alice described running away from hospital one time that she was sectioned and the police bringing her back. Alice felt that not taking her medication led up to her getting sectioned most times. Alice had difficulties separating her feelings about the second, third, and fourth admission but described a lot of the time 'feeling so alone even though there's loads of people around me'.

Appendix G: Semi-structured Narrative Interview Schedule

Semi-structured narrative interview schedule.

As you know the conversation we are about to have is part of a study to try and help understand how people feel about being sectioned. To begin with could you tell me something about yourself, and what has brought you to the point of sitting here talking to me today about being sectioned....

Where necessary the researcher will prompt with questions relating to the following pre-identified topics:

How many times have you been sectioned?

What do you feel led up to you being sectioned?

If the individual has been sectioned more that once, extra questions will be asked below:

1. What lead up to you being sectioned the first time?

2. Can you tell me about the more recent times?

3. What was the worst time?

4. What was the best time?

What was being sectioned like?

What did you think about it?

How did you feel?

Did you talk to anybody in hospital about being sectioned?

How did you feel by the time you were discharged from hospital?

Where there any particular turning points in your life that happened whilst you were sectioned?

Appendix H: Debriefing letter

Feedback Statement

The aim of this research was to look at "Service users' experiences of being sectioned under the Mental Health Act". This involved you taking part in an interview and talking to me about your experiences of being sectioned. The information you gave was really helpful as it will help our understanding of how people feel about being sectioned. With a greater understanding of this professionals can hopefully help to reduce any distress that people may experience when they are sectioned.

The results of this study will not include your name or any other identifying details. You can have a summary of the research findings once this study has finished. If you have any further questions please call Marianne Seebold on 01305 266011 or e-mail: mes304@soton.ac.uk.

Thank-you for time and for helping with this research.

Signature _____ Date _____

Name

If you have any questions about your rights from taking part in this research, or if you feel that you have been placed at risk, you can contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ. Telephone: 02380 593995.

Appendix I: Paper trail for the analysis of narrative tone

Identifying narrative tone

Interview 1-John

John's narrative tone was categorised as **normalising/distressed**. His tone was identified as primarily normalising because he minimised his mental health problems throughout and narrated them as being a consequence of drug and alcohol misuse. This was the most persistent feature of his narrative, which was expressed in the content of the narrative and in the way in which it was told (Crossley, 2000). However at times his tone was also distressed at the fact that he was detained in hospital and that it took so long to get out each admission.

The following extracts of the narrative highlight his normalising tone:

"I got a bit lazy in the end of 2002 basically, and I smoked a lot of cannabis and drinking a lot and I sort of like sort of got a bit confused about my thoughts about I couldn't think very clearly about the situation and that, felt like the TV was giving me messages and stuff like that, and um got into a bit of trouble and ended up being in a cell all night and then going to _____**(first hospital)** at the beginning of 2003" (1, 6-10).

"Yeah it's been a bit weird at home, strange and that and my mum got a bit worried about me. Umm and then I was in a cell over night but I was quite delusional, I was having quite chronic hallucinations and stuff and umm, it just felt like I was smoking so much and drinking so much that it all built up, and that I wasn't very sober even if I wasn't doing it, and I woke up in the morning and I was still de-toxicated every day. But umm, I went to _____**(first hospital)** and they put me on a section" (1, 37-42).

"They let me go after a couple of weeks 'cause I was fine and had sort of sobered up and they could tell I was quite sensible and a normal sort of person" (1,47-49).

"Then I got this flat and umm, it just feels a bit depressing though 'cause it real small and stuff and it made me turn back to smoking again and so I started smoking a lot more. Umm then at the end of 2003 I got my new flat, but as soon as I moved in a couple of weeks later Doctor_____ come round with my local doctor with umm some other people, with some police officers and umm took me back at the end of 2003" (1 & 2, 50-55).

"It's mainly just 'cause I was doing some odd things down _____**(supermarket name)** and stuff like that and somebody reported it, but the last time I went in there and sobered up and come out now and I just feel so much more normal" (2, 90-92).

"Then I stopped going to college when I should have been going to college and I was smoking quite a lot again last year 'cause I was with a lot of friends who were smoking quite a bit and um...Basically Doctor_____, I'm not sure if it was Doctor_____ or it was another Doctor who come round again and my GP came and seen me one day, with like a couple of others later and then he come with some police officers and then said umm... I don't know actually how they found out that I was smoking I must not have been doing it very

well, maybe mum told them or something but they took me back to the _____ **(first hospital)** anyway" (3,114-121).

"It's only 'cause like, obviously cannabis is illegal and people worry about people get affected different and they reckon I get a bit active imagination and stuff sometimes, especially if I spend a lot of time on my own and that" (4, 151-153).

"Just over a year ago I was fine although I was smoking I was doing things and all the thoughts, all the funny thoughts were out of my head and everything but when I went away on this holiday I drunk lots of alcohol and then when I come back I started drinking and smoking and then I sort of started skipping college. I just felt like I was in contact with people like Henry the 8th and stuff, people who had died, famous figures and stuff and it sounds a bit bizarre but when it's going on in your mind you really do believe things are going on" (5& 6, 249-255).

"Yeah, I just seeing as I've been sober for a few weeks um months even, I sort of like have a smoke of cannabis and I think to myself umm, one I think it's quite strong if I haven't done it for a while but then I gets vibed like, ohh I remember being like this for weeks and weeks sort of thing, you get that vibe you sort of like, it closes you off and the more you smoke it, it makes you feel more normal anyway sort of thing. But I'm just really trying not to now" (6, 273-278).

"I don't know, they think I'm a bit of a character probably but hopefully they think of me as like not too insane, just sort of like 'cause I maybe smoked a lot and my history and stuff doesn't help me too much" (9, 416-418).

"A couple of months after being at _____**(first hospital)**, umm so I was quite drunk anyway, I was very drunk when I got there and my sister drove me up there and that and I was all like crying and being a bit stupid (11, 500-502).

"Hospital is definitely good to sober up and make you feel a bit more like what life is about" (12, 571).

The following extracts of the narrative highlight his distressed tone:

"So it was a bit of a nightmare really" (2, 56).

"I thought it was just going to be just a couple of nights, but I was there for another five months...Every time I go there it's a bit of a personal nightmare because you think that if you're there for weeks and you see the doctor, once you've seen the doctor you know nothings happened you know its going to be a whole another week.. It's just...it is quite heartbreaking 'cause like it's so boring there... It's alright if there is a couple of people your age, to chat to and stuff and some of my mates and that are in there, but it's really like, it gets really repetitive and I don't know, the staff are nice but they're basically there to do a job and when you're staying there you're like...I don't know....it's a bit upsetting sometimes, like a bit of a personal nightmare sort of thing" (2, 64-72).

"I did feel like, yeah like umm I don't know it's seeing the Doctor and seeing asking him how long its going to be and they never really give you much like, a decision really and they just say like "oh it could be a couple of weeks, could be three, four weeks we're not sure yet" sort of thing and so its just.....and they tell you to get up at 9 o' clock in the morning and that's quite harsh as well, as I like to have long lie ins" (5, 211-215).

"The time sort of like it wears thin thinking "oh yeah" I'll be home soon, and it wears real thin that does, cause it just goes for months and months and by the time you get out everything's all new and everything feels a bit different" (3,125-128).

"Seeing the uhh.. OT centre which is like a children's classroom, being locked up and everything it just really upset me and at first I was kicking off and making a lot of fuss umm...but when I got out after a couple of weeks after the first time, I just felt really upset about having been there and that" (4, 165-168).

"I don't know you tell them they 'cause I kept on having my OCD and I think they, 'cause I was in there it stressed me out and I if don't feel happy it makes my OCD worse" (9,411-413).

"But by the time you do that you're still in there for a few weeks so you come out not quite as positive, cause it takes such a long time" (12, 572-573).

Interview 2-Daniel

Daniel's narrative tone was categorised as **angry/disbelieving.** His tone was identified as primarily angry because his anger at being sectioned was the most persistent feature of his narrative. His tone was also disbelieving at the fact that he was labelled as mentally ill and was sectioned, and the tone of his voice mirrored the disbelief and shock in his narrative.

The following extracts of the narrative highlight his angry tone:

"I felt anger towards it really I didn't really like it. I didn't like being in this enclosed area where you're not allowed to go outside and you have to stay in. I was really really annoyed by that, I kept looking back and thinking what have I one to get in here then? I kept looking at it and it just made me more irritated with it" (2, 91-94).

"I got really angry, I got angry about having to take medication, I didn't want to take the strange drugs that I didn't understand, and when they first said that I had to take medication I was like "no way, I don't want to take the medication". They said "you have to take it" and I was like "ahhh" and then I got angry and I threw somebody on the floor and stuff and they umm eventually had to restrain me because I got *really* angry getting told that I had to go on a section three and I got put, they gave they tried to give me umm some blue tablets, so I think it was Temazepam or something and I was like "Nah, I'm not taking it" and knocked it out of his hand so they restrained me and injected me so uhh..that time, then I just said uhh, I just calmed down about it really and I just thought I don't want to be restrained again so I just calmed down about it and I managed to" (3,124-133).

"So I tried not to get angry at him...like moments where I was just getting angry at people and stuff" (4, 159-160).

"Just really angry really, just not really wanting to umm admit that I was mentally ill" (4,191)

"I was just trying to be calm about everything but, I wasn't" (4, 193)

"I was really angry about getting sectioned over my mum and when they put a section three on me I got really, really angry about it. I was really angry about it, it was like "I don't want to be here anymore really. Why am I here?" (6, 261-263).

"And they were like, "You're gonna have a section three" and they never really gave me much reason for it, apart from to say that, "ohh we feel you're really unwell" and I was like "That's not good enough". I just really did not like getting section three put on me to be honest. But, I had to deal with it in the end" (6, 266-269).

"I just, when I felt I was getting angry about things I just relaxed really and just tried to relax. It's frustrating sitting in an enclosed area but umm I just tried to relax and not get frustrated about stuff. I was really restless as well, kept punching the air and stuff like" (6, 289-291).

"They explained what a section three is, but they didn't explain why they thought I was someone to put on a section three, and I just thought that was a bit annoying really" (7, 309-311).

"Well, some of them were crazies like, they tore the doors of the hinges and stuff, but when you talked to them, you sat and talked to them on a level they were alright to get on with, but otherwise their anger was more at the staff like mine was" (9,444-448).

"Yeah, if you get sectioned, try not to be get, like go mental about it. Try and keep calm about it because it does help. At the end of the day when you get really wound up about it you end up just like going crazy really, which just makes it worse" (10, 481-483).

"So umm to find somebody you can talk to about it and get a load off your chest about it really does help aswell, otherwise you just bottle it up and that just adds to the frustration. And adds to the anger of it really if you get angry about it. Some people don't, some people do, but I felt a lot of frustration at getting sectioned, whilst I was there. (11, 501-504).

The following extracts of the narrative highlight his disbelieving tone:

"Not understanding why I was mentally ill because I'd never discussed it with a doctor or nothing, I never had anyone come up to me before and say ohh you're mentally ill till I was sitting in a cell in the police station and the social worker comes in and says "I think you're mentally ill", and I was like "why am I mentally ill?" (1, 33-37).

"They said it was partially due to drug use that umm my mental condition changed although I never quite believed that but they said that was something that I'd have to urr come to terms with really. But other than that I wasn't able to discern why they thought I was mentally ill to be honest" (2, 62-66).

"My mum's like "ohh you're not like you used what you used to be sort of thing" "you're not really well she'd say to me" and urr...she obviously felt there was something wrong. But I never really felt there was something wrong I just got on with it really (2, 70-73).

"I kept looking back and thinking what have I done to get in here then? (2, 93)

"I was very confused about...being sectioned, being described as mentally ill and I didn't like it" (2, 94-95).

"I mean, some people were knocking the doors of the hinges and stuff while I was in there and I was thinking I don't behave like that so why are they saying that I'm so mentally ill because they said that I was quite ill when I got sectioned and I didn't believe that but obviously the doctors and the staff thought I was mentally ill. I was quite thin and I didn't eat too much and I wasn't used to having three meals a day and like they eat three meals a day and go to sleep at more sociable hours but I wasn't used to that. I was used to going to work at like late times in the night and coming home in the morning, quite early in the morning so I...I was just like, it just stunned me to be honest, I was quite shocked" (2, 96-104)

"I just kept going through scenarios in my mind that like I was gonna get...like umm that I was just gonna go and turn around and they'd say "ahh you don't have to be here anymore" and it was just coming to the realisation that that wasn't gonna to happen really. I kept looking into appealing against it but I didn't think the appeal would go through" (3, 115-119).

"All I could ever think about was you know "how come I managed to go through all of that? I wish I'd done a few things a bit differently, but I still probably would have ended up going in a mental hospital at some point because they said I was really unwell, but I didn't feel really unwell in myself I just felt like I'd been put in all these situations by some person that decided that I was mentally ill" (4, 117-181).

"And they're like "you know you've gotta talk to us, so we can understand how to help you" and I was like "ahh, you're not really helping me, at all really, I don't see why I need help". And that was what my emotion was really, I was like "well why do I need help, I don't see why I'm here" (4, 197-200).

"So you know, if I had weird thoughts, I'd just put it down to, uhh I'd just laugh about them. You know, I wouldn't think that I was going to get sectioned or anything about it, I just like carried on really" (5, 246-248).

"Why am I here? You know I've just been sitting around not having, smashing doors of hinges or getting really angry at people. I've been trying to sit here calmly, get on with it, I go to the OT, I go to the dinners and I eat all the time, so what's the problem?" (6, 263-266).

"So I was just trying to understand it all really and I was like, really a major turning point was being sectioned really, because I'd never *ever* felt anything like it, I was like "What? What do you mean?.... I'm gonna have to go through this now, aren't I sort of thing. I didn't really understand, it was like, well I'm just gonna have to really live with it now aren't I?" (8, 394-398).

Interview 3-Vincent

Vincent's narrative tone was categorised as **thoughtful.** His tone was identified as thoughtful because of his reflection on what had helped him recover from mental health problems and on how having mental health problems changed him for the better. This was the most persistent feature of his narrative and was expressed in his slow thoughtful style of speech.

The following extracts of the narrative highlight his thoughtful tone:

"I have benefited from a Christian upbringing which I think has helped me in my, in my mental illness to uhh get better really, because people have been praying for me over the years and especially when I was ill and I'm sure I'm as well really because of god's goodness and grace that I've uhh been able to get better, as I have, you know" (1, 13-17).

"I'm sure it made me more mature, it made me uhh...better, to experience what other people are going through, through my experience. I mean, having that I can probably understand people who've had mental illness themselves" (8, 378-380).

"Since that time, I've not been back in, I've not gone back into _____**(second local hospital name)**, so that did the trick of getting me, out of the environment of_____ **(second local hospital name)**, because you tend to get into a rut, don't you, if you're not, therefore you're just, if they keep feeding you, rather than you looking after yourself and umm...so I just uhh, managed to uhh....get out of that rut"(5, 229-233).

"I didn't object to it I just felt that maybe that's God's part of like, he's put me for a reason, I don't quite know why I've been ill but its probably best for me to be here and although I didn't like it, I you know I didn't particularly" (6, 296-298).

"I mean my parents have been a great support to me and I'm sure it must have grieved them as much as it did me to find myself in the situation I was in, but I, I look back, I've umm, I look back over so many other people who've had illnesses and they've not just uhh, they've not had to kept a job and I know one person, who uhh I still, still see a lot but he's never had a job in his life and he's been ill all his life and he's never had a job. You know, he's just used to it, but he's come to accept, he gets all the payouts and **(laughs)** not, he's never had that effort of work, which I've had, which I've kept a job for about fifty-two years"(7, 313-20).

"I think its been good to be working even though you might not feel like getting up in the morning and getting out of bed, its...its...you make yourself do it and it keeps you going I think sometimes 'cause I....I find it a bit difficult now, with the structure being such that I don't have to get up early every day. You need to keep working, keep occupied because you just become like a cabbage otherwise, I've seen it in so many people who've had mental illness they make like that an excuse to not do anything and just uhh...sit on their backsides, and.... maybe their's is an excuse not to do anything worthwhile, but because I think I've been a Christian I think I've been, the Lord has helped me through times which I could have been a lot worse, been worse if it wasn't for a Christian" (7, 328-336).

"I'm sure it made me more mature, it made me uhh...better, to experience what other people are going through, through my experience. I mean, having that I can probably understand people who've had mental illness themselves and that have had difficulties in that way,

although I don't....its been a uhh gradual process of growing through bad experiences and I think sometimes difficult experiences help you to mature and grow and if you had things easy all the time, things would probably...you'd be a very weak person, but because you've had trouble and difficulties these builds you up and I think that's what's, there's a verse in the bible which says "All things work together for good to them that God called upon to his purpose" and I think that's certainly true of me, I mean things, although bad experiences at the time, has helped me to grow in my Christian life and helped me to umm, be the person I am today" (8, 376-386).

"It often happens that there's a time of real encouragement, it's just before that time when you feel, really feel up with, with God or something but and then it seems to lower and you seem to go right down and I think...often it's the case, that I've had this before I was ill, I've had times of sleepless nights and I've umm, I've had to watch when I'm not getting sleep because that's a sign that I could be going ment... if you're very excited and your mind's going round in circles you've got to beware that you're not, over, knocked over"(10, 461-467)

"I don't think I objected as such, at being where I was I just felt it as God's plan for me at that time, that I,I should be there to get well. They're trying to help me so, I've got to be where God has put me there for a reason, so you know even if it is to uhh....make me more like him, in some ways, make me more understanding of what other people go through when they're in that situation" (13, 632-636).

"The turning point when I came out of hospital was when my brother came to stay with me, that was when I really improved I think, you know. That was when I started shopping and doing the things I was doing before, and even sort of advising my brother how to cook, he's not a very good cook so **(laughs)** I was able to say "Hey, that's not right, you don't do that ,you do that" and I started to show him the way to cook , you know 'cause he's got a wife, to do, for his cooking, I've had to do it myself you know" (13 & 14, 648-653)

"Each day comes as a challenge and you know it's a day at a time, to live every day at a time, you know if you take one day at a time and don't expect to worry about the extra. You know, it's not happened yet, we can face it when we come and God gives us the grace to face each day, not a week in advance but each day" (14,679-642).

Interview 4-Darren

Darren's narrative tone was categorised as **scared**. His tone was identified as scared as he nervously narrated the frightening events that led up to him being sectioned and how he believed people were trying to kill him whilst he was hospitalised. His scared tone was expressed most notably in his shaky voice and frequent nervous laughter.

The following extracts of the narrative highlight his scared tone:

They held me in a cell overnight and they sent me to _____**(local hospital name)** and I spent several months at _____**(local hospital name)**, six to seven months I think and uhh... it was quite scary at first really, at the time. I thought uhh they caught me so they could protect me from people so I was really paranoid for quite a long while really (1, 29-31).

"Yeah it was terrifying at the time **(laughs)**. I didn't know what to do, but when I got to uhh_____**(local hospital name)**, it was like some sort of safe haven, sort of place. Somewhere to recover and get my thoughts back together again" (2, 57-59).

"I thought I was mad, **(laughs)** I thought I was going crazy like **(coughs).** Yeah it was quite frightening really 'cause at first I didn't think I had a problem really you know...But then umm, I dunno, it was quite hard coming to terms with what was going on and my family were worried and that and I was still thinking people were after me" (2, 90-93).

"I was like safe and scared though, I was still really scared. Yeah, I started putting stuff in front of the door like just so, 'cause I thought people come in and hurt you in the night and jab me or something. So I used to put my chair in the way of the door and everything **(laughs)** just to stop people from like coming in" (3, 101-104).

"Confusing and scared, umm probably a bit paranoid aswell **(laughs)** like. It was just weird, I didn't expect myself to ever get in that position really. But, I, I was, I was quite scared of it at first and that, was quite worried about stuff aswell" (3,114-115).

"I was terrified really, I mean I went to someone's place and uhh... I did a....I did a bong but when I got there he went out and cleaned it out and that and then come back and then one person did it and he didn't breathe in all the smoke, he just puffed it all out straight away and another person did it and did the same and then another person did it and then I did it and I did it alright, and then about half an hour after that I started coming up off something and it wasn't being stoned it was something more like. So that made me think that maybe they spiked it or something to try and like kill me or something, 'cause my heart was racing after that for ages, for about four days straight. But the next morning after that happened I went to my other friend's and uhh...I looked away and felt something splash on my face and about five minutes later it started going really numb, where it splashed on my face so I was thinking, how could it be, uhh....or you know what could that be really. I thought he like flicked acid at me or something like to try and mess my head up. So umm...that was terrifying and I was just on my own though that's the thing" (6, 266-278).

"It seemed like I was hanging around with a bit of a dangerous lot of people. That's what I thought after a while and then I just started getting really scared and trying to find out what

was going on like and I kept going to all these people's places and that and everything was getting really weird and scary and I thought people was doing stuff to me and spiking me and stuff. So umm, plus I tried...uhh...that's why I tried topping myself" (6, 282-286).

"I was high as a kite for like four days straight. I thought I was dying though, I thought it was slowly killing me. So I was just... I thought yeah, if I go, If I'm gonna die, ahh...I don't want to die around here either. If I could escape, I could escape and that...I was really bad, I mean I was convinced. I mean I was lying in the cell and someone in the other cell was yelling **(laughs)** "Don't go to sleep, don't go to sleep, you'll die" and I'm like "*Oh no*" (8,378-382).

"'Cause I was really scared to talk to people, like I didn't, I thought that people were constantly judging me and stuff"(9, 438-439).

Interview 5-Jacob

Jacob's narrative tone was categorised as **protesting/resigned**. His tone was identified as primarily protesting because his disdain for involuntary treatment was the most persistent feature of his narrative. However at times his tone was also resigned as he described having to accepted medication and involuntary treatment which he did not like but realised he had to take in order to avoid being sectioned again. This was reflected in the tone of voice which sounded flatter when he discussed medication.

The following extracts of the narrative highlight his protesting tone:

"At first I hated it with a vengeance, especially umm compulsory treatment, forced medication, you know being pinned down by 6 members of staff and being injected against my will when I didn't think I was doing, I hadn't committed any crime, you know and I didn't think it was necessary so I fought medication for many years" (1, 24-28).

"So for the first two weeks I was just sitting around in hospital at _____**(local hospital)** they asked me to take some medication, I didn't want to and then I had a choice between taking some tablets or having an injection and I agreed to hep the nurse out by letting him give me an injection and then when they came a week later to give another one I refused and I ended up being taken to _____**(second hospital)** which was a worse place than _____**(local hospital)** .**(Coughs)** and umm I was...forced to have an injection there and then I agreed to take medication in, in order to be let out of hospital. 'Cause hospital to me is the worst place I've ever experienced, you know, and I hate it. So I'd do anything to get out of hospital and the way to get out of hospital is to take medication, so I've always agreed to take it, but then once I'm out, after a few months I stop taking the medication, things went alright for a few months and then I would be sectioned again" (2, 87-98)

"I thought I was coping alright and then to suddenly find yourself in hospital and not allowed to leave, made me realise that perhaps, all wasn't well you know. So it was a shock and it was unpleasant being in with a lot of ill people and you know the forced medication which happened on two occasions" (3,114-117).

"Umm...well, only, only that I realised that's something was wrong for me to end up in there you know and the, the worst part about it was that I wasn't allowed to leave, I wasn't free to leave you know, and if I'd run away the police would have come and got me, which I did do on one occasion. **(Coughs)**. So but whether it fundamentally changed the course of my illness, or anything like that I don't think it did no...And umm.... I still don't really think that it was, part of me doesn't feel it was necessary for me to have to go into hospital. But uhh, they thought it was necessary. And that's, that's the same on every, on every time, all the four times I've been sectioned I've never really agreed that it's been necessary. It's only with hindsight you can see that perhaps it was. But at the time I'm against the nurses and you know people think psychiatric nurses are caring, compassionate people but **(coughs)** if the psychiatrist says "Pin him down and inject him" they'll do just that. So I was, I had a thing about the staff, but in the end you know, you can't go anywhere, they're not going to let you out until you toe the line, so in the end I give up and just agree to take medication and...do everything they want me to do and with a view to getting out of hospital as soon as possible" (4, 178-191).

"Umm, no not really, umm you couldn't have a conversation with the other patients because they all had their own problems you know, it's a bit isolating, you know, you're sat in, in either in the smoking room or the lounge with nothing to do and yet they're observing you and writing up reports about you to the psychiatrist you know and they say "Ahh, he's doing well" or "he's had a dip" and that, you know, but how you can possibly do well in a hospital I don't understand, you know, because to me it's not a restful or a therapeutic place, its, it can be a dangerous place, you know I've been assaulted on a couple of times when I've been in hospital, you know so you've got to be wary of the other patients. There's nothing to do, you just have to sit there and... stew in your own juices sort of thing, you know. So...if ever I was threatened with...touch wood it will never happen, but if ever I was threatened with umm being sectioned again I would fight it, I would, I thought about going to the advocacy service they offer, but it usually takes a month anyway for them to come around and by that time, you know you either want to be let out straight away or if you're going to be there a month you might aswell just go a long with them till they let you out, you know. So that's one issue that don't like about the, the length of time it takes for your case to be independently assessed" (5 & 6, 295-310).

The following extracts of the narrative highlight his resigned tone:

"Four years ago I came round to the way of thinking that I needed the medication and my attitude now towards being sectioned has changed somewhat uhh, from hated to one that I think it saved my life. I think I'd probably be dead now if I hadn't had the intervention of the medical profession, but umm, I still don't like forced medication" (1, 28-42).

"Yeah, there's no point in being angry, first of all, anger is the first reaction for being sectioned and then its sort of acceptance really" (5, 200-201).

"The reason that I stopped talking is they ask you so many questions, they ask you question after question after question and you're answering these questions and they just fire another one at you and in the end it breaks down your... will, well you know and umm...So that was uhh...quite difficult but as I say I probably would be dead, I'd have either killed myself or been killed if it hadn't been for the intervention of the...NHS and the services" (5, 229-233).

"Unless they'd have made it compulsory. I wouldn't have gone in voluntarily or, the doctor tried to get me to take Prozac in, at the start of it, I wouldn't take that and uhh it was only by compulsory treatment that they could get me to take medication you know by making me stay in hospital and not allowing me to leave. And the only way to get out was to take the medication" (6, 254-256).

"And I recognise now that I have been ill and I don't think of myself as, you know I question the diagnosis of paranoid schizophrenia because I don't really think that I am schizophrenic but I can understand why they called, called it that you know. And...it's just something that I've got to live with I suppose you know. I'll take, I won't stop taking the medication because I couldn't cope with another admission into hospital, I thought the third time would be the last time so the fourth time was a real disappointment" (6, 263-268).

"They didn't cure me or anything you know, but they did get me on the medication which is....it's their one defining thing, you must take the medication you know that's how they, that's what they, that's what they want you to do" (6, 278-279).

Interview 6-Graham

Graham's narrative tone was categorised as **critical/educating.** His tone was identified as primarily critical because his criticism of the treatment he received was the most persistent feature of his narrative. However at times his tone was also educating as he described alternatives to psychiatric practice to make inpatient care less anxiety inducing. This was reflected in the reasoned educating tone of his voice.

The following extracts of the narrative highlight his critical tone:

"I want to share my experiences and the bad experiences which led up to me being sectioned and the way it was handled" (1, 7-8).

"He said just "I want you to sign these forms" and he didn't explain it or anything, so I just sat there and he said "Wait there I'm just going to call one of the doctors from your local surgery" so I sat there and he wasn't speaking to me at all and I was feeling really emotional, nervous, anxious. You know I didn't know what the hell was going on" (1 & 2, 48-52).

"All we were doing was just making collages and playing hangman and I thought "well how is this doing for me?" It's doing nothing, it's making me worse, you had no one-to-one discussions with people" (2, 63-65).

"Well he said we'll take you straight to _____**(local hospital name)** so there must have been a bed there for me, it was on _____ward and when I got there was a complete wreck, anxious, nervous, emotional and I was told to sit outside the office in a corridor for 60 minutes which I did and all the nurse kept on coming out of the office and saying "Oh, we're trying to find you a bed." Why did they take me there in the first place if there wasn't a bed? So that made me even worse" (3, 110-115).

"But uhh no 12 and a half weeks to finally get the help and support I think I needed and got. It took too long. 'Cause all you was doing in the day was sitting in the lounge smoking cigarettes and then and again I was offered OT making collages again" (4, 171-173).

"I felt like, when I was being taken there, when you first arrive to be left in the corridor outside the office is...well that's completely wrong. Surely I could have been taken to a quiet room with a nurse, meeting a nurse there, you know and just... give me reassurance I 'spose, instead of you're just another number sir, a statistic, you know, not being left in the corridor and seeing all the other patients coming down just staring at you all the time, you know, which was making me feel even worse" (6,251-256).

"It's taught me never to have ECT treatment again, because of the umm...memory loss. I'm still suffering from it" (6, 278-279).

"The psychiatrist said "look we, all we're doing is chopping and changing your medication all the time" and I agreed with him. We was trying one tablet this week, one tablet that week "He said, look we're getting nowhere, try ECT." So I agreed with him and it did bring me up on a high afterwards, but I was really *shocked* at the loss of memory" (6, 283-286).

The following extracts of the narrative highlight his educating tone:

"You had to see the specialist every Monday morning but what I found was umm...you were sitting there and there was a semi-circle in front of you of psychiatrists, SHO's, is it ?, trainee doctor, couple of CPN's, couple of students...And all staring at me, I found it totally intimidating and so I was just saying yes to any of the psychiatrist's questions just to get out of there. So it wasn't any good because umm...he wasn't getting the right things out of me, I just wanted to get out of the situation because I felt so intimidated and I thought would it be better if they had a two way mirror or a CCTV you know, something like that, so they could observe outside instead of so many people being in there (3, 118-129).

"Sometimes umm...when you're in the ward and umm...another patient just kicks off and you're, the nurse comes in they lock you in the lounge. Now that makes everybody frustrated and so everybody's kicking off, yet all their attention is on this one patient who's kicking off, though by locking you in one room, with saying its too dangerous to get out and you cant do this, couldn't they just take a patient away from the, this situation and away all the people, so the other people wouldn't get so frustrated and anxious and wound up, you know, there's no need for it" (6 & 7, 298-304).

Interview 7-Alice

Alice's narrative tone was categorised as **unsure/thoughtful.** The tone of her narrative and voice was frequently unsure as she struggled to vocalise her story, and seemed unsure of what to say. However, the tone was also thoughtful as she considered carefully what led to her mental health breakdowns. Her thoughtful tone was also reflected in her frequent pauses to consider her answers to the questions.

The following extracts of the narrative highlight her unsure tone:

"Mmmm, I don't know.....I'm not very useful, helpful am I?" (6, 257).

"Umm.....mrnm.....umm.....ummn.....yeah, it's difficult **(laughs)** this one.....I was sexually assaulted *again*....." (6, 268-269).

"Umm.....umm.....**(laughs)**. Can we start that one again?" (7, 336).

"It probably did actually, but umm, it's a bit difficult to explain.....umm.....mmm.....sorry **(laughs)** I don't....."(8, 367-368).

"I felt like...umm.....uhh....umm...it's difficult.....umm.....**(sighs)**.....no I'm sorry, I can't" (8, 377-378).

"No I can't explain it"(8,386).

"There's no way I'd like to go back in there anyway but you know, umm.....it was.....umm.....hard times" (9, 415-416).

"Umm.....I'm not sure actually 'cause I.....while I, when I was living at my Mum's, think it was after the first time I was sectioned.....umm I'd go into_____ **(hospital name)** for day hospital to do OT and that's what, mmm so that you know, could get my, could get out of myself and do something but umm.....mmmm.....I've forgotten what I was going to say **(laughs)** sorry" (454-458).

"Not this.....August what's the.....if I've been here, oh right, been here two years"(10, 477).

"Mmm.....uhh.....don't know....." (13, 631).

The following extracts of the narrative highlight her thoughtful tone:

"I'm here today because um....._____**(Rethink manager)** asked me if I was in....interested in sharing my umm, my views yeah and umm I wasn't sure at first but I thought 'oh why not', you know 'cause umm its quite interesting going over it all anyway" (1, 11-13).

"And other times I used to drink a lot, I *mean* a lot and I used to mix..mix it with my pills and I used to be on a lot of drugs and I thought "Ohh, you know If I'm ill then, you know there isn't much I can do about it" so I thought I just...I turned to drugs most of the time but...umm and

that didn't help and then when I was in hospital I was doing a lot of drugs as well. Which isn't too good" (5, 2123-216).

"When I'm in, when I was in hospital I was, I was also drinking a lot aswell, I was smuggling it in, so **(sniffs)** you know. But umm.....I don't think it helped me **(laughs)** much **(laughs)** in the long run really" (5, 217-219).

"I didn't feel as bad about it as I did the first time around, not that I, I don't remember much about the first time around but when I was sectioned the second time I felt a bit more easy, easy about it, do you know what I mean. A bit more relaxed about it 'cause I knew that they were there and they were trying to help me. And I was trying to help myself, but it wasn't happening all the time, but, but I'm, I'm... in a way I'm glad I was sectioned because otherwise I'd probably have gone off the rails you know, which I have done on **(laughs)** quite a lot of" (5, 227-233).

"While I was in there, a lot of the time it was like "I'm feeling so alone" and all that sort of thing even though there's loads of people around me and I thought that being sectioned seemed to have...made me feel worse" (8, 361-363).

"There's no way I'd like to go back in there anyway but you know, umm.....it was.....umm.....hard times" (9, 415-416).

"I think the *best* time was the one that I was saying about them actually talking to me and me talking to them and kinda worked things out, without b.....,without harming anything, anybody. Me included, you know (13,609-611)

Appendix J: Paper trail for the analysis of narrative genre

Identifying narrative genre: Analysis of the escape narratives.

Key features of the plot of all escape narratives:

1. The individual being imprisoned.
2. The individual believing that the imprisonment is wrongful.
3. The individual formulating a plan to escape.
4. The individual escaping.

However particular to the narratives found in this study were other features listed below:

Key features specific to the plot in the participants escape narratives:

1. The individual being imprisoned in hospital.
2. The individual believing that the imprisonment is wrongful.
3. Anger and/or frustration at being sectioned and involuntary treatment.
4. Hostility/critical attitude to staff and treatment.
5. The individual formulating a plan to escape. The plan in these narratives is to "play the game" which involves accepting the medication and/or telling staff what they want to hear.
6. The individual escaping being sectioned in hospital.

Why not a different genre?

This genre of escape was chosen because the other genres of rescue, enlightenment and endurance do not capture the essence of the narrative. Although the endurance genre shared some of the criticisms of psychiatric care, in the escape genre angry or protesting voices dominate the escape narrative. Whereas in the endurance narrative the participant's narrative sounds less angry and is more accepting of the involuntary treatment in a more disengaged and passive way. The escape narratives share similarities with the escape narratives found in Thornhill et al.'s (2004) research where the participants describe wanting to escape from psychiatric care and hospitals which they viewed as un-therapeutic.

Interview 2-Daniel

The analysis of genre will now be illustrated with quotes from Daniel's narrative, which highlight the key features that make it an escape narrative:

The individual getting imprisoned in hospital.

"I didn't like being in this enclosed area where you're not allowed to go outside and you have to stay in" (1, 91-92).

"I'd never experienced anything like it really. Never been locked away for months on end, I mean it was, I wouldn't say it was like prison, 'cause I've never been to prison but, if felt like restricting on myself and I've never felt like that before" (8, 392-394).

The individual believing that the imprisonment is wrongful

"Yeah I was just, four walls were all a bit....I just kept going through scenarios in my mind that like I was gonna get...like umm that I was just gonna go and turn around and they'd say "ahh you have to be here anymore" and it was just coming to the realisation that that wasn't gonna to happen really"(3, 115-117).

"My behaviour wasn't too good, but it wasn't as bad as some, I mean, some people were knocking the doors of the hinges and stuff while I was in there and I was thinking I don't behave like that so why are they saying that I'm so mentally ill because they said that I was quite ill when I got sectioned and I didn't believe that but obviously the doctors and the staff thought I was mentally ill" (2, 96-100).

"I wish I'd done a few things a bit differently, but I still probably would have ended up going in a mental hospital at some point because they said I was really unwell, but I didn't feel really unwell in myself I just felt like I'd been put in all these situations by some person that decided that I was mentally ill and umm..I wasn't but, that wasn't the case" (4, 178-181).

"Why am I here? You know I've just been sitting around not having, smashing doors of hinges or getting really angry at people. I've been trying to sit here calmly, get on with it, I go to the OT, I go to the dinners and I eat all the time, so what's the problem?"(6,263-266).

Anger and/or frustration at being sectioned and involuntary treatment

"I felt anger towards it really I didn't really like it" (1, 91).

"I was really really annoyed by that, I kept looking back and thinking what have I one to get in here then?"(2, 92-94).

"I got really angry, I got angry about having to take medication, I didn't want to take the strange drugs that I didn't understand" (3, 124-125).

"I got *really* angry getting told that I had to go on a section three" (3, 128-19).

"Just really angry really, just not really wanting to umm admit that I was mentally ill. Just trying to get on with people around me to a degree where ahh they'd just think "ahh he's ok now" but they didn't. I was just trying to be calm about everything but, I wasn't".

"I was really angry about getting sectioned over my mum and when they put a section three on me I got really, really angry about it. I was really angry about it, it was like "I don't want to be here anymore really" (6, 261-263).

"I just really did not like getting section three put on me to be honest" (8, 268-269).

"I just, when I felt I was getting angry about things I just relaxed really and just tried to relax. It's frustrating sitting in an enclosed area but umm I just tried to relax and not get frustrated about stuff. I was really restless as well, kept punching the air and stuff like" (6,289-291).

"Just wanna...get of there really. But it wasn't like that inside, when you're on a section you can't just get out of there, you have to sit down and just stew it out, take your medication" (10, 469-471).

"It was *frustrating* really 'cause there wasn't a lot to do, all we had to do was watch TV or read or do something ..I started reading books 'cause there was just nothing else to do really" (10, 475-477).

"So umm to find somebody you can talk to about it and get a load off your chest about it really does help aswell, otherwise you just bottle it up and that just adds to the frustration. And adds to the anger of it really if you get angry about it. Some people don't, some people do, but I felt a lot of frustration at getting sectioned, whilst I was there" (10, 501-505).

Hostility/critical attitude to staff and treatment

"When they first said that I had to take medication I was like "no way, I don't want to take the medication". They said "you have to take it" and I was like "ahhh" and then I got angry and I threw somebody on the floor and stuff and they umm eventually had to restrain me because I got *really* angry getting told that I had to go on a section three" (3, 125-129).

"I mean I found it hard to talk to the doctors about what was going on with me really. I didn't relate to them enough to umm...all their questions, they just asked me the same sort of questions all the time and it was like "I've answered all these questions really, I don't really wanna tell you how I feel too much" (8, 350-353).

"I didn't really wanna talk to the staff though, I felt they're asking me questions, all kinds of questions, there I was like "no", like umm "what sort of drugs I'd taken?" and I was like "I don't really wanna talk about it to be honest". It's not through drugs that I'm here, and I was like you know... "I wasn't taking drugs at the time, if I hadn't got sectioned". And they're like "you know you've gotta talk to us, so we can understand how to help you" and I was like "ahh, you're not really helping me, at all really, I don't see why I need help". And that was what my emotion was really, I was like "well why do I need help, I don't see why I'm here" (4, 193-200).

"And they were like, "You're gonna have a section three" and they never really gave me much reason for it, apart from to say that, "ohh we feel you're really unwell" and I was like "That's not good enough" (6, 266-268).

"Yeah, the reasons why they put me on a sectioned three, they explained what a section three is, but they didn't explain why they thought I was someone to put on a section three, and I just thought that was a bit annoying really" (7,309-311).

The individual formulating a plan to escape. The plan in these narratives is to "play the game" which involves accepting the medication and/or telling staff what they want to hear.

"So they restrained me and injected me so uhh..that time, then I just said uhh, I just calmed down about it really and I just thought I don't want to be restrained again so I just calmed down about it and I managed to" (3,124-133).

"So I tried not to get angry at him...like moments where I was just getting angry at people and stuff" (4, 159-160).

"They said "Ohh you can go on voluntary, umm go out when you want, come back at a reasonable time". So I was like "Ahh, thank-you very much". Yeah, that was basically because I said "I accept the medication and umm I accept the fact I have to be treated" and he said "If that's the case then you can go on voluntary" (4, 155-159).

"Yeah, if you get sectioned, try not to be get, like go mental about it. Try and keep calm about it because it does help. At the end of the day when you get really wound up about it you end up just like going crazy really, which just makes it worse" (10, 481-483).

The individual escaping being sectioned in hospital.

"Moving out was really good. I just I was like "wow, that's something I don't want to have to go through again". I was really, really, really, happy to move away from mental health hospitals and umm come here in a relaxed atmosphere where I could just sit down and think about things really and like, all I could ever think about was you know "how come I managed to go through all of that?" (4, 174-178).

"I felt relieved. Its like 'yeah I'm out of their little system' and I was like that really, really did make me feel better about it really. It's like 'ohh that's all over now, let's start again'. And umm I just felt that it was a big weight being lifted off my shoulders coming out of that really. "Yeah. It was good getting out. I felt really relieved about it" (8, 362).

"It's just a big weight off your shoulders when you leave being sectioned" (9, 435-436).

Interview 5-Jacob

The analysis of genre will now be illustrated with quotes from Jacob's narrative, which highlight the key features that make it an escape narrative:

The individual getting imprisoned in hospital.

"Umm, my attitude towards being sectioned has changed over the years, at first I hated it with a vengeance, especially umm compulsory treatment, forced medication, you know being pinned down by 6 members of staff and being injected against my will when I didn't think I was doing, I hadn't committed any crime, you know and I didn't think it was necessary so I fought medication for many" (1, 23-27).

"I thought I was coping alright and then to suddenly find yourself in hospital and not allowed to leave" (3,114-115).

"The worst part about it was that I wasn't allowed to leave, I wasn't free to leave you know, and if I'd run away the police would have come and got me, which I did do on one occasion" (4,179-181).

"Making me stay in hospital and not allowing me to leave" (5, 253-254).

The individual believing that the imprisonment is wrongful

"I still don't really think that it was, part of me doesn't feel it was necessary for me to have to go into hospital. But uhh, they thought it was necessary. And that's, that's the same on every, on every time, all the four times I've been sectioned I've never really agreed that it's been necessary" (4,182-185).

"So...if ever I was threatened with...touch wood it will never happen, but if ever I was threatened with umm being sectioned again I would fight it" (7,300-302).

Anger and/or frustration at being sectioned and involuntary treatment

"'Cause hospital to me is the worst place I've ever experienced, you know, and I hate it" (2, 94-95).

"Yeah, there's no point in being angry, first of all, anger is the first reaction for being sectioned and then its sort of acceptance really" (4, 199-200).

"I had a real problem with people telling me I was ill I didn't...agree with them that I was ill and uhh...so uhh it got my back up you know, and I got defensive when I was told I was ill **(coughs)** and I wouldn't have agreed to any sort of treatment" (5, 245-247).

"There's nothing to do, you just have to sit there and... stew in your own juices sort of thing" (6, 299-300).

"Well first of all I was angry that I had been sectioned" (6, 274).

"I had worked it out in my head how I wanted the conversation to go, and uhh...I rushed it a bit and I didn't give him a chance to answer me and each time I said something, well I got my point across and he said, and then my parents came in and he said I think " _____**(name)** is very angry". Which was the impression I wanted to give, I don't think I was angry, but then I'm not very good at uhh... expressing my anger, so it built up and built up" (9,408-413).

Hostility/critical attitude to staff and treatment

"But at the time I'm against the nurses and you know people think psychiatric nurses are caring, compassionate people but **(coughs)** if the psychiatrist says "Pin him down and inject him" they'll do just that. So I was, I had a thing about the staff, but in the end you know, you can't go anywhere, they're not going to let you out until you toe the line, so in the end I give up and just agree to take medication and...do everything they want me to do and with a view to getting out of hospital as soon as possible" (4, 186-191).

"The reason that I stopped talking is they ask you so many questions, they ask you question after question after question and you're answering these questions and they just fire another one at you and in the end it breaks down your... will" (5, 227-229).

"It's a bit isolating, you know, you're sat in, in either in the smoking room or the lounge with nothing to do and yet they're observing you and writing up reports about you to the psychiatrist" (6,293-295).

"How you can possibly do well in a hospital I don't understand, you know, because to me it's not a restful or a therapeutic place, its, it can be a dangerous place, you know I've been assaulted on a couple of times when I've been in hospital, you know so you've got to be wary of the other patients" (6, 296-299).

"I thought about going to the advocacy service they offer, but it usually takes a month anyway for them to come around and by that time, you know you either want to be let out straight away or if you're going to be there a month you might aswell just go a long with them till they let you out, you know. So that's one issue that don't like about the, the length of time it takes for your case to be independently assessed" (7, 302-307).

"Umm, whether it's because they're busy or not but the staff don't talk to you enough in hospital, they observe you and they make comments about your behaviour, but your behaviour is in a completely artificial situation, you know. Like the doctor complained once that I went to bed at 4.30, well I'd been up since 8 in the morning sat in an armchair in a...in a.., with nothing to do and you know if I felt like going to bed at 4... he seemed to think that was a sign of illness, I disagreed with him but and uhh..I think if the staff did talk to you more that would be helpful. But uhh....for one reason or another they don't" (11, 521-527).

"I don't like the thought of compulsory treatment and on two occasions I've been pinned down by six members, members of staff even though I wasn't resisting **(coughs)**. And uhh injected, had my trousers pulled down and injected, and what good it did, I don't know...really" (11, 533-536).

"I came into the ward review one week and I said "Why are you torturing me?" and he said "I didn't know I was torturing you" and I said "By keeping me in hospital unnecessarily" and I said "I want to be discharged" (9,405-407).

The individual formulating a plan to escape. The plan in these narratives is to "play the game" which involves accepting the medication and/or telling staff what they want to hear.

"So I'd do anything to get out of hospital and the way to get out of hospital is to take medication, so I've always agreed to take it" (2, 95-96)

"I had a thing about the staff, but in the end you know, you can't go anywhere, they're not going to let you out until you toe the line, so in the end I give up and just agree to take medication and...do everything they want me to do and with a view to getting out of hospital as soon as possible" (4,188-191).

"The only way to get out was to take the medication" (6,254-255).

"I won't stop taking the medication because I couldn't cope with another admission into hospital, I thought the third time would be the last time so the fourth time was a real disappointment" (6,264-266).

"I only take the medication, not because... not for what it does to me, but for what it, it keeps me out of hospital. Which is the main thing for me" (7,322-324).

"Well I knew I had to do something because I kept ending up back in hospital you know against my will and although I didn't feel it was necessary...it did dawn on me that umm...this not talking was wrong and umm...I suppose just getting caught up in my own thoughts you think, you think you're in control and you're being rational when you realise your behaviour and, is not rational, you know and I s'pose I thought umm...to stop getting sectioned all the time would have to take the medication and umm...that's what I've done" (7,392-397).

The individual escaping being sectioned in hospital.

"In the end it was just relief to get out of hospital **(coughs)**. They didn't cure me or anything you know, but they did get me on the medication which is....it's their one defining thing, you must take the medication you know that's how they, that's what they, that's what they want you to do" (6, 274-276).

"No, I couldn't umm..cope, I don't know what would happen if I ever ended up in there again. I'd probably run away or something" (10, 462-463).

Interview 6-Graham

The analysis of genre will now be illustrated with quotes from Graham's narrative, which highlight the key features that make it an escape narrative:

The individual getting imprisoned in hospital.

"I was feeling really emotional, nervous, anxious. You know I didn't know what the hell was going on, then the doctor come 'cause he needed umm his signature as well for me to be umm sectioned and I was smoking and the doctor come around and he said "Oh cigarette, cigarette." And I thought "you know", so that put me right off straight away. He didn't say nothing, he agreed with the social worker without speaking to me, he signed the form, then the social worker asked me to sign the form and I thought, I just signed the form, just get it over and done with" (2, 51-57).

"I said "I've committed no crime" and I refused to go" (2, 79-80).

The individual believing that the imprisonment is wrongful

"Why did they take me there in the first place if there wasn't a bed? So that made me even worse and when they eventually came out and said we've found you a bed" (3,114-116).

"No 12 and a half weeks to finally get the help and support I think I needed and got. It took too long" (4,171-172).

Anger and/or frustration at being sectioned and involuntary treatment

"Well he said we'll take you straight to _____**(local hospital name)** so there must have been a bed there for me, it was on _____ward and when I got there was a complete wreck, anxious, nervous, emotional and I was told to sit outside the office in a corridor for 60 minutes which I did and all the nurse kept on coming out of the office and saying "Oh, we're trying to find you a bed" (3, 110-114).

"Sometimes umm...when you're in the ward and umm...another patient just kicks off and you're, the nurse comes in they lock you in the lounge. Now that makes everybody frustrated and so everybody's kicking off, yet all their attention is on this one patient who's kicking off, though by locking you in one room, with saying its too dangerous to get out and you cant do this, couldn't they just take a patient away from the, this situation and away all the people, so the other people wouldn't get so frustrated and anxious and wound up" (6 & 7, 299-304).

Hostility/critical attitude to staff and treatment

"You were sitting there and there was a semi-circle in front of you of psychiatrists, SHO's, is it ?, trainee doctor, couple of CPN's, couple of students.....And all staring at me, I found it totally intimidating" (3, 118-124).

"I just wanted to get out of the situation because I felt so intimidated and I thought would it be better if they had a two way mirror or a CCTV you know, something like that, so they could observe outside instead of so many people being in there" (3, 119-129).

"Well he suggested I take ECT treatment, which I did, I took 8-10 treatments and that kept on bringing me up on a high, but my memory was shot to pieces I couldn't remember a thing. I'm still having trouble nowadays trying to remember things" (3, 137-139).

"'Cause all you was doing in the day was sitting in the lounge smoking cigarettes and then and again I was offered OT making collages again" (4,172-173).

"I, I felt like, when I was being taken there, when you first arrive to be left in the corridor outside the office is...well that's completely wrong. Surely I could have been taken to a quiet room with a nurse, meeting a nurse there, you know and just... give me reassurance I 'spose, instead of you're just another number sir, a statistic, you know, not being left in the corridor and seeing all the other patients coming down just staring at you all the time, you know, which was making me feel even worse. All I want to do is, I know I've arrived but I just want to try and relax and stop feeling anxious" (6, 251-257).

"It taught me to umm...share my opinion and views on the way I was treated instead of keeping it inside me. Tell these professionals how I really feel, instead of going through the motions. And it's taught me never to have ECT treatment again, because of the umm...memory loss. I'm still suffering from it" (6,277-280).

The individual formulating a plan to escape. The plan in these narratives is to "play the game" which involves accepting the medication and/or telling staff what they want to hear.

"I was just saying yes to any of the psychiatrist's questions just to get out of there. So it wasn't any good because umm...he wasn't getting the right things out of me," (3,124-126).

"I felt much better and by then I just agreed with everything the psychiatrist said, just to get out of there" (6, 233-234).

The individual escaping being sectioned in hospital.

"He suggested this place Rethink, he said "you're not going back to your old accommodation, 'cause I think its wrong" and he suggested this place and it's helped me to uhh recover properly" (3,140-143).

"But then, with the good support I've had from my new CPN after leaving _____**(local hospital name)** I've really recovered and I'm hoping to go onto full independence and back into employment" (6, 234-236).

APPENDIX J: Identifying narrative genre: Analysis of the rescue narratives.

Key features of the plot of all rescue narratives:

1. The individual facing danger.
2. The individual being rescued by somebody or something
3. The individual returning to a less dangerous lifestyle

However particular to the narratives found in this study were other features listed below:

Key features specific to the plot in the participants escape narratives:

1. The individual facing danger or getting involved in a chaotic lifestyle.
2. The individual's mental health deteriorating because of drink and drugs
3. The individual being rescued from drug/alcohol misuse and mental heath problems by hospitalisation.
4. Primarily positive attitude to care staff.
5. The individual returning to a more functional lifestyle.

Why not a different genre?

This genre of rescue was chosen because the other genres of escape, enlightenment and endurance do not capture the essence of the narratives. In the rescue genre, primarily positive comments were made regarding involuntary treatment. The rescue narratives share similarities with the rescue narratives found in literature and film, in particular in biblical stories for example, the story of Mary Magdalene being rescued from a deviant lifestyle as a prostitute by Christ.

Interview 1-John

The analysis of genre will now be illustrated with quotes from John's narrative, which highlight the key features that make it a rescue narrative:

The individual facing danger or getting involved in a chaotic lifestyle

"I smoked a lot of cannabis and drinking a lot and I sort of like sort of got a bit confused about my thoughts about I couldn't think very clearly about the situation and that, felt like the TV was giving me messages and stuff like that, and um got into a bit of trouble and ended up being in a cell all night and then going to _____**(first hospital)** at the beginning of 2003" (1,6-10).

"Then I was in a cell over night but I was quite delusional, I was having quite chronic hallucinations and stuff and umm, it just felt like I was smoking so much and drinking so much that it all built up, and that I wasn't very sober even if I wasn't doing it, and I woke up in the morning and I was still de-toxicated every day" (1, 38-41)

The individual's mental health deteriorating because of drink and drugs

"Like I started doing and saying some *funny* things cause I felt like I needed to say them to people, like sexual things and stuff so I was just being a bit strange and it got reported back to the doctors" (2, 60-63).

"Then I stopped going to college when I should have been going to college and I was smoking quite a lot again last year 'cause I was with a lot of friends who were smoking quite a bit and um...Basically Doctor_____, I'm not sure if it was Doctor_____ or it was another Doctor who come round again and my GP came and seen me one day, with like a couple of others later and then he come with some police officers" (3, 113-117).

"It's only 'cause like, obviously cannabis is illegal and people worry about people get affected different and they reckon I get a bit active imagination and stuff sometimes, especially if I spend a lot of time on my own and that" (4, 151-153).

"I went away on this holiday I drunk lots of alcohol and then when I come back I started drinking and smoking and then I sort of started skipping college. I just felt like I was in contact with people like Henry the 8th and stuff, people who had died, famous figures and stuff and it sounds a bit bizarre but when it's going on in your mind you really do believe things are going on, so when I was in _____ **(first hospital)** I was a bit delusional about some of the people who were around me" (6,251-256).

The individual being rescued from drug/alcohol misuse and mental heath problems by hospitalisation

"Yeah they did that and then like, they let me go after a couple of weeks 'cause I was fine and had sort of sobered up and they could tell I was quite sensible and a normal sort of person" (1, 37-41).

"It's mainly just 'cause I was doing some odd things down _____**(supermarket name)** and stuff like that and somebody reported it, but the last time I went in there and sobered up and come out now and I just feel so much more normal" (2, 90-92).

"It was alright, it was just the first time I went there, it was so much more... like now I've been in there a few times, I don't quite like to say it, but if feels a bit more homely"(8, 383-384).

"They think I'm a bit of a character probably but hopefully they think of me as like not too insane, just sort of like 'cause I maybe smoked a lot and my history and stuff doesn't help me too much" (9, 416-418).

Primarily positive attitude to care staff.

"The staff are nice but they're basically there to do a job" (2, 70-71).

"I do like the staff, I get on really with them" (7, 336).

"We were allowed to order kebabs every weekend, that was good" (7, 338-339).

The individual returning to a more functional lifestyle

"I just seeing as I've been sober for a few weeks um months even"(6, 273).

"It closes you off and the more you smoke it, it makes you feel more normal anyway sort of thing. But I'm just really trying not to now" (6, 277-278).

"Hospital is definitely good to sober up and make you feel a bit more like what life is about" (12, 571-572).

Interview 4-Darren

The analysis of genre will now be illustrated with quotes from Darren's narrative, which highlight the key features that make it an escape narrative:

The individual facing danger or getting involved in a chaotic lifestyle

"Well... a few years back I started hearing voices and that getting really paranoid thoughts and everything and uhh I started to think people were trying to poison me and that and thought people were trying to kill me and that. And umm I at the time I was smoking quite a lot of dope **(laughs)** really like and did a few other things as well and uhh, I was like, I was thinking people were trying to kill me and everything for about eight months or so and umm I tried topping myself and then uhh I did it again about two weeks after, later after the first time" (1,13-19).

" I went to my Uncle's and that when I was mean like *really* depressed and messed up thinking people were trying to poison me and kill me and that so I did a **(clears throat)** I did a runner and I started, just caught the trains all the way around England and that just thinking like there's good people and bad people and the good people are trying to... guide me somewhere and I thought the bad people are trying to like corner me and like trying to kill me really, that's what I thought at the time" (1, 20-25).

"It was quite scary at first really, at the time. I thought uhh they caught me so they could protect me from people so I was really paranoid for quite a long while really" (1,31-31).

"At first I was really scared when I was in _____**(local hospital name)**, because like well I thought it was good and bad people trying to get hold of me really"(1, 39-40).

"I could have been like that for even a year, 'cause everybody was really....it seemed like I was hanging around with a bit of a dangerous lot of people. That's what I thought after a while and then I just started getting really scared and trying to find out what was going on like and I kept going to all these people's places and that and everything was getting really weird and scary and I thought people was doing stuff to me and spiking me and stuff" (6, 281-286).

The individual's mental health deteriorating because of drink and drugs

"'Cause I've always thought too much about stuff, that's all...I mean when I go out my mates and that back then I sit around thinking and that like **(laughs)**, smoking weed and just sitting there on my own thinking, getting paranoid"(2, 59-62).

"I was terrified really, I mean I went to someone's place and uhh... I did a....I did a bong but when I got there he went out and cleaned it out and that and then come back and then one person did it and he didn't breathe in all the smoke, he just puffed it all out straight away and another person did it and did the same and then another person did it and then I did it and I did it alright, and then about half an hour after that I started coming up off something and it wasn't being stoned it was something more like. So that made me think that maybe they

spiked it or something to try and like kill me or something, 'cause my heart was racing after that for ages, for about four days straight" (6,266-273).

The individual being rescued from drug/alcohol misuse and mental heath problems by hospitalisation

"I thought it was some sort of divine intervention sort of thing **(laughs)** like to get me away from drugs and drinking all the time and stuff like that. That's want I thought really. Haven't touched nothing since then though, it's done me quite good" (2, 95-97).

"Yeah it was terrifying at the time **(laughs)**. I didn't know what to do, but when I got to uhh_____**(local hospital name)**, it was like some sort of safe haven, sort of place. Somewhere to recover and get my thoughts back together again" (2, 57-59).

"I was like safe and scared" (3,101)

"It felt like a safety net sort of thing actually. With the support and people around me if I got a bit weird you can go and talk to people and that. So yeah, it was like a safety net really" (3,116-118).

Primarily positive attitude to care staff.

"My social worker he helped me out quite a lot" (41-42).

"Well there's loads of people trying to help, you know genuinely trying to help me and that was really nice of them. Well I just liked it, well it was good the way like the system worked like. 'Cause they get, they first uhh, they found out what was going on in my head and then uhh....they wanted to try to get me to try talk a bit more about my past and everything" (9,421-424)

The individual returning to a functional lifestyle

"They just got me talking really 'cause I was quiet, I was really quiet for, umm...I've always been really quiet. Like 'cause I've always thought people didn't like me, I mean always, like, even before I was ill. But then umm...I dunno I just sort of was just living with it and then I went all paranoid, severe paranoia was happening. Yeah but the doctors and that, yeah they helped me, they helped me quite a lot" (9,427-431).

"Yeah, like taking to people that was a big change, getting comfortable with people around me and stuff and umm...umm...got me to think bit more positive and it gave me time to get myself together and to get away from doing drugs and that. 'Cause **(clears throat)** the last time I touched something was a couple of days before I got put into _____ **(local hospital name)** and uhh...I've left it completely now" (9,444-448).

APPENDIX J: Identifying narrative genre: Analysis of the *enlightenment* narrative.

Key features of the plot of all enlightenment narratives:

1. The individual faces difficult times that personally challenge them.
2. The individual gradually gains understanding and spiritual growth through these difficulties.
3. This understanding helps them to grow stronger and understand life better.

However particular to the narrative found in this study were other features listed below:

Key features specific to the plot in this participant's enlightenment narratives:

1. The individual faces difficult times that personally challenge them.
2. The individual's mental health deteriorates.
3. The individual gradually gains understanding and spiritual growth through these difficulties.
4. Thoughtful rather than critical attitude to treatment perceived as negative.
5. This understanding helps them to grow stronger and understand life better.

Why not a different genre?

The genre of enlightenment was chosen because the other genres of escape, rescue and endurance do not capture the essence of this narrative. Although Vincent's narrative has similar elements to the escape narratives because he describes running away on his first admission, it does not share the same angry or critical tone as the escape narratives. In this narrative, the tone of his narrative was thoughtful throughout as he considered what he learnt emotionally and spiritually from his mental health difficulties and difficult treatment experiences. The narrative shares similarities with the enlightenment narratives found in Thornhill et al.'s (2004) research, which found that individuals gained spiritual and emotional enlightenment from their mental health difficulties. The narrative is also similar to the quest (Frank, 1995) and conversion/growth narratives (Crossley, 1999) which portray illness as a journey with difficulties from which the individual gains an increasing awareness.

Interview 3-Vincent

The analysis of genre will now be illustrated with quotes from Vincent's narrative, which highlight the key features that make it an enlightenment narrative:

The individual faces difficult times that personally challenge them

"Had shock.. my first lot of shock treatment there and just put in a cell and sort of.... you were in this...cell and really it was like the worst part, the worst hospital I've been in actually" (2,72-74)

"It was a very wrong a very horrible environment to be in I know that, that time now, I wish I wasn't...I didn't really enjoy being there at all, although I know I s'pose nobody could want to be in hospital really"(6,260-262).

"I think the first time was the worst time, and that was when I had the most uhh, the worst experiences to happen to me and I think they used to put things in you or to in, in.... your coffee and things like that and I think that time, in the 60's uhh the _____**(northern city hospital name)** maybe wasn't a very good hospital I don't know it might have changed now but umm, all sorts of things were happening on the ward, which I think back and think, that shouldn't have happened, you know people were.....they didn't treat you, I mean, some people were, I s'pose you just, the attitude of people were "Oh they're mental, they're not really human", sort of people you know, but uhh...which... were just one of many who were... but I s'pose I wasn't like treated as bad as some were. But I was put in a cell one day and night and I banged at the door and then this chap came in and threw me to the ground **(laughs)** and twisted my arm around my back and I didn't.....there was no bed I think, I can't remember any toilet facilities so, I just, did it work? Uhh, you know, uhh so, it was a horrific experience" (10, 473-484).

The individual's mental health deteriorates

"I thought it was the end of the world, I thought I was left behind, I had all these strange dreams, I underlined in the bible, all these things about souls in your hand, Leviticus???, about souls, if you had a soul in your hand its unclean, I had the, I had my I had a decision, I was made a decision for Christ in 1967, I had this and he had lots of it for some reason, for me and I thought "Oh I've been blotted out of the book of life" (2, 90-94)

"I stayed with my brother for two nights and he uhh tried to sort of calm me down, went for long walks with me and I was, I was acting a bit funny and apparently that night I came out one night and tried to get out of the house and _____**(brother)** saw me and I smashed this window like to get out the house, and anyway he had to call the police and the police had to sort of....calmly sort of put an injection in me to calm me...and I ended up being on a drip because I wouldn't eat, I wouldn't eat or drink anything because I was I thought it was poisoned, I thought everything was poisoned and umm I ended up by being on a drip"(4,173-180).

"I was going around _____**(northern city name**) and saying "Come to know the Lord" and I was, I was rushing at people and people thought I was trying to rape them or something, I said "I want you to know about the Lord" and I was sort of so...It often happens

that there's a time of real encouragement, it's just before that time when you feel, really feel up with, with God or something but and then it seems to lower and you seem to go right down"(10, 458-463).

The individual gradually gains understanding and spiritual growth through these difficulties.

"I have benefited from a Christian upbringing which I think has helped me in my, in my mental illness to uhh get better really, because people have been praying for me over the years and especially when I was ill and I'm sure I'm as well really because of god's goodness and grace that I've uhh been able to get better" (1, 13-16).

"I'm sure God kept me through the time but it was, I mean there's, quite a different characters there which uhh, I know all hospitals I've been in there's been difficult people to cope with, people maybe worse off than you are and you know, you've had to cope with them" (6,265-268).

"I was in great danger there because of the environment I was in was not very... suited to a umm... a Christian life at all, but the Lord protected me I'm sure with..at that time" (6,273-274).

"I was on a drip 'cause and wasn't taking in fluids or anything. But umm, you know I just..it just thing is, I accept, I didn't object to it I just felt that maybe that's God's part of like, he's put me for a reason, I don't quite know why I've been ill but its probably best for me to be here and although I didn't like it, I you know I didn't particularly" (6, 294-298).

"I don't think I actually complained about being sectioned, I probably just chatted about ordinary things, about my faith I suppose and...I didn't....I didn't as I say I don't think I objected as such, at being where I was I just felt it as God's plan for me at that time, that I,I should be there to get well. They're trying to help me so, I've got to be where God has put me there for a reason, so you know. even if it is to uhh....make me more like him, in some ways, make me more understanding of what other people go through when they're in that situation" (13, 630-636).

Thoughtful attitude to treatment perceived as negative

"But I s'pose I wasn't like treated as bad as some were. But I was put in a cell one day and night and I banged at the door and then this chap came in and threw me to the ground **(laughs)** and twisted my arm around my back and I didn't.....there was no bed I think, I can't remember any toilet facilities so, I just, did it work?" (1, 480-484).

"It was a very wrong a very horrible environment to be in I know that, that time now, I wish I wasn't...I didn't really enjoy being there at all, although I know I s'pose nobody could want to be in hospital really"(6,260-262).

"Its been a uhh gradual process of growing through bad experiences and I think sometimes difficult experiences help you to mature and grow and if you had things easy all the time, things would probably...you'd be a very weak person, but because you've had trouble and difficulties these builds you up" (8, 379-382).

"I mean you get your, there were nurses who were not as nice, and not as umm pleasant but I think umm on the whole, you were treated, I was treated all right there, you know, I mean not that I liked some of the things that happened" (11,511-513).

This understanding helps the individual to grow stronger and understand life better.

"Oh relieved that I sort of umm, you know got there and hopefully I never want to go back there again if I can...if I happen to be, not like that again and although at the times, even now when I feel very down and sort of feel I'm having to cope with life, you know, but uhh on the whole the Lord has helped me, he's... each day comes as a challenge and you know it's a day at a time, to live every day at a time, you know if you take one day at a time and don't expect to worry about the extra. You know, its not happened yet, we can face it when we come and God gives us the grace to face each day, not a week in advance but each day" (14, 676-682).

APPENDIX J: Identifying narrative genre: Analysis of the endurance narrative.

Key features of the plot of all endurance narratives:

1. Individual experiences several difficult life events.
2. Individual's acceptance of life as a struggle.
3. Individual sees mental health problems as an illness.
4. The medical model holds an important but sometimes conflictual position for the individual.

However particular to the narrative found in this study were other features listed below:

Key features specific to the plot in this participant's endurance narratives:

1. Individual experiences several difficult life events.
2. Individual's acceptance of life as a struggle that they gradually try to overcome.
3. Individual sees mental health problems as an illness.
4. The medical model holds an important but sometimes conflictual position for the individual.
5. Primary acceptance of need for involuntary treatment due to illness.

Why not a different genre?

This genre of endurance was chosen because the other genres of escape, rescue and enlightenment do not capture the essence of this narrative. Although Alice's narrative has similar elements to the escape narratives because she describes running away from hospital on one admission, it does not share the same angry or critical tone as the escape narratives. In this narrative, the tone of her narrative was thoughtful throughout as she considered what she had endured through life and what had led up to her hospitalisations. The narrative shares similarities with the accommodation narratives found in Bell's (1999) research, which found that individuals conformed to the biomedical conceptualisation of their problems.

Interview 7-Alice

The analysis of genre will now be illustrated with quotes from Alice's narrative, which highlight the key features that make it an endurance narrative:

Individual experiences several difficult life events

"Started getting very depressed and....after after I'd finished college, umm I thought "Oh I'm better now" so I went away to university in _____**(town name)** but umm.... while I was there my...my illness progressed and umm..I had some bad stuff happen up there uhh.. I got raped while I was up there so and that didn't help me at all, you know so umm...and I ju...I haven't self harmed for eight months now but I used to self harm every day because of

that I had a lot of things going on in my head... but umm... because of that I was unable to finish my course so I had to come back and I think I was 19 then and that was the first time I went into hospital under a section"(1,30-37).
"And other times I used to drink a lot, I *mean* a lot and I used to mix..mix it with my pills and I used to be on a lot of drugs and I thought "Ohh, you know If I'm ill then, you know there isn't much I can do about it" so I thought I just...I turned to drugs most of the time but...umm and that didn't help and then when I was in hospital I was doing a lot of drugs as well. Which isn't too good" (5, 212-216).

"I was sexually assaulted *again*...And umm... I cut up his back with a razor blade and I accidentally let it slip that **(laughs)** I did that to my Psycholo.....Psychologist and he told the Psychiatrist and everything and... I was cutting up a lot as well and so that's.. that's why I was sectioned *again,* cause they thought "Oh god she's gonna do it to him, she could do it to anybody", you know and at the time I felt like doing it to anybody so"(6, 268-277).

"But you know, umm.....it was.....umm....hard times" (9,416).

Individual's acceptance of life as a struggle that they gradually try to overcome

"And other times I used to drink a lot, I *mean* a lot and I used to mix..mix it with my pills and I used to be on a lot of drugs and I thought "Ohh, you know If I'm ill then, you know there isn't much I can do about it" so I thought I just...I turned to drugs most of the time but...umm and that didn't help and then when I was in hospital I was doing a lot of drugs as well. Which isn't too good" (5, 212-216).

"Yeah and umm you know trying to enjoy myself without having to worrying about "Uh ohh and I'm not very well today" but I'd still try and get, get out and do something" (10, 464-465).

"And thought "Oh God, they're gonna kick me out because I'm in hospital and I'm unwell". I was unwell and I thought.....a lot of bad things, I thought "Oh no they're gonna kick me out" and..... But.....they didn't and I was very relieved" (11, 498-500).

Individual sees mental health problems as an illness

"While I was there my...my illness progressed" (1, 32).

"I was very ill at the time aswell I didn't realise what was going on" (1, 44-45).

"When I was in there I didn't think I was ill at the time" (3, 129-130).

"I don't remember very much about it because I was **(laughs)** very ill but...but she did say you know "You weren't very well at all" and I didn't manage to cope...cope very well because I was self-harming a lot" (4, 157-159).

"I don't remember much about it because I was really ill" (13,602).

The medical model holds an important but sometimes conflictual position for the individual

" Uhh medication..Umm, I stopped taking it because I didn't think I needed it. And umm... gradually after, after about a month...I was thinking "Yeah I feel really, really good" and I'm glad I come off them but it takes about a month or something to come out your system. So after a month I started going a bit downhill again" (4, 173-180)

Primary acceptance of need for involuntary treatment due to illness

"When I was sectioned the second time I felt a bit more easy, easy about it, do you know what I mean. A bit more relaxed about it 'cause I knew that they were there and they were trying to help me. And I was trying to help myself, but it wasn't happening all the time, but, but I'm, I'm... in a way I'm glad I was sectioned because otherwise I'd probably have gone off the rails you know, which I have done on **(laughs)** quite a lot of" (5, 228-233).

"I understood what...what they were trying to do and everything" (5, 238).

"Feeling like...cutting up and umm they'd be there to s.....hel.....to talk to me about it and say "Well why do you want to do this" and.....you know trying to talk me around it instead of me actually doing it" (9,429-431).

"Trying to help me.....yeah" (11,524)

"A lot of the time I was actually quite happy, but then there was the odd occasions where I wasn't at all happy" (11, 532-533).

"Them actually talking to me and me talking to them and kinda worked things out, without b.....,without harming anything, anybody. Me included, you know" (13, 608-610).

Appendix K: Summary of main points covered in reflective journal

The researcher kept a reflective journal throughout the research process and some of the key areas covered by the journal are listed below.

Reflection on how the researcher has wanted to research this area for the past eight years and how this made her feel both excited and nervous. This involved further reflection on her motivation to carry out the research and how she wanted to give service users a 'voice' in a system where historically they have been silenced.

Reflection upon trying to find a supervisor who appreciated the importance of understanding service users' experiences of being sectioned. This also involved reflecting on how her social and political beliefs had shaped her position as a psychologist and how she identified as a critical psychologist, and came from a different approach to her supervisors.

Reflection on conversations with other psychologists nationally (by telephone) who share similar critical psychology views. Feeling encouraged by their comments that the research is an important piece of work and she should try and get it published. Reflection on speaking to other narrative researchers (by telephone) and in person and feeling inspired by their work.

Reflection on the difficulty recruiting individuals locally through service user organisations.

Reflection on the feelings evoked by the interviews, in particular those who described traumatic life experiences and distressing sectioning experiences. Reflection on the impact of transcribing the interviews and how this made her feel even more motivated to get the participants' views across and get the research published.

Reflection on how having a family member who has been sectioned several times has shaped her view on the mental health system and given her a different perspective to other clinicians without this personal experience. Reflection on how her personal assumptions may have affected the research process and how helpful it was to use supervision to explore this.

Reflection on using qualitative methods for the first time and the difficulties of learning how to do use narrative analysis. In particular 'letting go' of trying to find narrative analysis described procedurally in the literature as this approach does not lend itself to his framework.

Reflections on writing up the study and the effects of her commitment to the topic and her desire to portray the participants' experiences accurately. For example, difficulties in choosing between quotes to illustrate the participants' views in the most powerful way. This also involved reflecting on how hard it was to get the thesis under the 20,000 word count due to her commitment to highlighting peoples' views of being sectioned. This was the first time the researcher had experienced this as she usually finds it easy to express herself concisely.

Refection on what she has gained from the interviews and feeling privileged that the participants felt comfortable sharing their experiences with her. Reflection on how helpful the participants' reported telling their stories was and how they appeared to find this beneficial even within a research context. This further strengthened her view on the clinical importance of sharing a narrative.