THE SUBJECTIVE EXPERIENCE OF PSYCHIATRIC HOSPITALIZATION: A CASE STUDY APPROACH

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Supervisor

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"My hospital stays were not what I expected. They were unpleasant, in that being in a psychiatric ward is almost like being in jail. You are not free to come and go and the windows all have tough screens or even bars on them. You are not allowed to do anything not approved by your doctor or ward staff. Visitors can only visit two hours a day and, even then, only a pre-approved list of people. You are not allowed any rest during the day, as activities are planned all the time. In short, I can't recommend it as a vacation destination. However my stay was pleasant in that I didn't experience any of the expected 'horror stories" such as *One Flew Over The Cuckoo's Nest.* The ward staff was pleasant (but firm, very firm) everyone did their best to make a bad situation as comfortable as possible."

Anonymous (Healthyplace.com. April 2005)

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I would like to express my appreciation towards the following people:

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- The participants in the study without whose inputs this article would not be possible

SUMMARY

THE SUBJECTIVE EXPERIENCE OF PSYCHIATRIC HOSPITALISATION: A CASE STUDY APPROACH.

KEY WORDS: Psychiatric hospitalisation, subjective experience, self-management behaviour, stress

The aim of the research was to explore the subjective experience of patients admitted to a psychiatric hospital. Sub-aims were to explore how these experiences relate to self management, stress and psychological well-being. This study was motivated by research literature that documents a wide variety of negative experiences by patients. A recent psychiatric patient survey conducted in England and Wales (Mind, 2004) found that more than 50% of respondents indicated that hospital surroundings had not helped their recovery. In fact, close to a third of those thought that it had a detrimental effect on their health. Wood and Pistrang (2004) found that psychiatric patients often represent a lower status, marginalized group in society and thus their views are often not taken into account in mainstream research. These results, however, were overwhelmingly based on research conducted in an American or European context. The South African context is unique in the sense of our political, economic and social issues that influence people's perceptions. In relation to other developing and developed nations little research has been done. The research was conducted at a large Psychiatric hospital in Pretoria South Africa. An availability sample of five adults from the hospital was used. A qualitative case study method design was used. Data were obtained through interviews and analysed using Interpretive Phenomenological Analysis (IPA) (Smith, 1996; Smith et al., 1997, 1999) Using the IPA method the data was analysed to extract significant or relevant points related to the research topic. These themes were then collated with themes that occur in other accounts and from there tested against the hypothesised outcomes of the investigation. Positive experiences and negative experiences were identified as the main themes; these were each divided into subthemes. The negative experiences related primarily to interaction with hospital staff and –environment, while positive experiences primarily related to effective treatment. Implications of results are that patient

experiences and perceptions may be more influential for long term psychological well-being than has been acknowledged by care givers within larger mental healthcare facilities. It was concluded that many if not all of the results of previous studies were confirmed. Additionally this study recognised that singular positive experiences may to a greater degree influence patients recovery and maintenance than a combination of negative experiences. Recommendations following from the findings include further studies to assess enhanced interpersonal skills training for nursing staff, and greater community based care facilities.

OPSOMMING

DIE SUBJEKTIEWE BELEWENIS VAN PSIGIATRIESE HOSPITALISASIE: 'N GEVALLESTUDIE BENADERING

SLEUTEL WOORDE: Psigiatriese Hospitalisasie, subjektiewe belewenis, selfbestuur, stres.

Die doel van die navorsing was om die subjektiewe belewenisse van pasiënte wat in 'n psigiatriese hospitaal opgeneem is, te evalueer. Onlangse navorsing in Engeland en Wallis met psigiatriese pasiente (Mind, 2004), het bevind dat 50% van respondente aandui dat hulle hospitaal omgewing nie hulle genesing bevorder het nie. In teendeel het nagenoeg 'n derde van die groep gevoel dat dit hulle psigiatriese gesondheid benadeel het. Wood en Pistrang (2004) het gevind dat psigiatriese pasiënte dikwels van uit laer status, gemargimaliseerde groepe in die samelewing verteenwoordig is en as sulks word hulle ondervinding nie in die navorsing weerspieël nie. Subdoelwitte was om te ondersoek hoe hierdie belewenisse verband hou met die pasiënte se selfbestuur, stres en psigologiese welstand. Die studie is gemotiveer deur literatuur waarin navorsers 'n wye verskeidenheid van negatiewe ervarings van pasiënte dokumenteer. Die resultate is egter oorwegend gebaseer op navorsing wat binne 'n Amerikaans of Europese konteks uitgevoer is. Die Suid Afrikaanse konteks is uniek in terme van ons politiese-, ekonomiese- en sosiale realiteite. In vergelyking met ander ontwikkelende en ontwikkelde lande is min navorsing hieroor in Suid-Afrika gedoen. Die navorsing is uitgevoer in 'n psigiatriese hospitaal, in Pretoria, Suid-Afrika. 'n Doelgerigte, beskikbaarheidsteekproef van vyf volwasse pasiënte is gebruik. 'n Kwalitatiewe, gevallestudiemetode-navorsingsontwerp is gebruik. Die data is ontleed deur gebruik te maak van Interpretatiewe Fenomenologiese Analise (IFA). (Smith, 1996; Smith et al., 1997, 1999). Kwalitatiewe data is verkry deur onderhoude wat op band opgeneem en getranskribeer is. Die data is met behulp van die IFA-metode geanaliseer om betekenisvolle en relevante temas wat verband hou met die navorsingstema te identifiseer. Hierdie temas is vergelyk met temas wat voorkom in ander studies en getoets teen die gehipotetiseerde uitkomste van die ondersoek. Negatiewe en positiewe

belewenisse is as hooftemas geïdentifiseer, terwyl elk verder in subtemas verdeel is. Negatiewe belewenisse het primêr verband gehou met interaksie met die hospitaalpersoneel en –omgewing, terwyl positiewe belewenisse primêr verband gehou het met effektiewe behandeling. Die implikasies van die resultate is dat pasiënte se ervarings en persepsies meer invloed uitoefen op toekomstige psigologiese welstand as wat erken word deur hulpgewers van groot psigiatriese inrigtings. Die gevolgtrekking is gemaak dat die meeste, indien nie al die resultate van vorige studies, bevestig kon word. Bykomend het hierdie studie gevind dat afsonderlike positiewe ervarings tot 'n groter mate pasiënte se selfbestuur en herstel bevorder, as 'n kombinasie van negatiewe ervarings. Aanbevelings wat uit die studie volg is dat verdere studies geloods word om te evalueer watter bykomende interpersoonlike vaardighede aangeleer moet word deur verpleegpersoneel en die daarstelling van meer gemeenskapsgebaseerde fasiliteite.

Letter of consent

I hereby give consent that Mark Edward de la Rey may submit this manuscript for the purposes of a dissertation.

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Dr. Karel Botha

PsySSA

South African Journal of Psychology

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Manuscript

The subjective experience of psychiatric hospitalization: a case study approach

The subjective experience of psychiatric hospitalization: a case study approach

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The subjective experience of psychiatric hospitalization: a case study approach

ABSTRACT

The aim of this study was to explore the subjective experience of hospitalisation in a typical South African Psychiatric hospital. Sub-aims were to explore how these experiences relate to self-management, stress and psychological well-being. An availability sample of 5 patients were interviewed. Data was analysed using Interpretative Phenomenological Analysis. Results show that psychiatric hospitalisation consist of both positive and negative experiences. It was concluded that many if not all of the results of previous studies were confirmed. Additionally this study recognised that singular positive experiences may to a greater degree influence patients' recovery and maintenance than a combination of negative experiences. Recommendations following from the findings include further studies to assess enhanced interpersonal skills training for nursing staff, and greater community based care facilities.

INTRODUCTION

The focus of this study is the subjective experience of psychiatric patients of the hospitalisation process in a typically South African psychiatric hospital. Help seeking patterns of people with emotional disturbances or mental illness has long been a concern to researchers. Back in 1948 Ramsey and Seipp found that respondents would rather confide in a family member, friend or the family doctor before consulting a psychologist or psychiatrist. This was particularly in reaction to the perceived stigma attached to psychiatric treatment. This and related phenomena have persisted to recent research.

A recent psychiatric patient survey conducted in England and Wales (Mind, 2004) found that more than 50% of respondents indicated that hospital surroundings had not helped their recovery. In fact, close to a third of those thought that it had a detrimental effect on their health. Wood and Pistrang (2004) found that psychiatric patients often represent a lower status, marginalized group in society and thus their views are often not taken into account in mainstream research.

Accounts from mental health patients suggest that many aspects of hospitalisation and the subjective interpretation of events affect their experience of treatment. For example staff attitudes contribute to feelings of safety or not (Wood & Pistrang, 2004), being restrained in resting bonds result in feelings of helplessness, fear and humiliation, (Koivisto, Janhonen & Vaisanen, 2004), whilst a lack of participation in decisions about one's care, result in a loss of respect (Johansson & Lundman, 2002). Psychiatric hospitalisation may also impact on the patients' self-management behaviour. Self-management behaviour is defined as the myriad ways in which illness influences a person's actions in relation to social interaction, appropriate use of health care resources, and interpersonal relationships (Kellner, 1990). Non-adherence to psychiatric medication and resultant psychotic relapse is strongly influenced by attitudes towards treatment.

Experience of coercion during admission and low insight are strong indicators of a negative attitude towards treatment (Day et al., 2005).

Sing-Fai, Yee-Chiu, and Cap Siu-Ching (2000) indicate that long hospitalisation affect patients by reducing their ability to function outside of the hospital. This is in part due to the fact that hospital staff functions as decision makers for patients, making decisions about what is good for them and structuring their care accordingly (Lidz & Arnold, 1990). Conversely, Spence et al. (in Lidz and Arnold, 1990) found that although patients who were admitted involuntarily initially reported unfavourable attitudes towards their admission, they had opinions similar to voluntary patients after a period of several weeks or months. It suggests that researchers should take care when forming opinions about what patients may perceive as irrevocably punitive of their treatment during hospitalisations.

Furnham and Wardley (1990 & 1991) as well as Furnham, Wardley and Lille (1992) found strong evidence that the perceived social risk of receiving treatment in a psychiatric context adversely influenced patients' motivation and consequent prognosis. In terms of 'psychological experience' they found that people who had experienced psychotherapy or possessed professional knowledge of psychotherapy tended to be less optimistic regarding its benefits. Taking this into account, questions arise on how a patients experience might affect their help seeking behaviour with regard to mental illness and psychological distress in future.

Gardner et al. (1999) found that many patients, who initially judged that they did not need hospitalisation, revised their belief after discharge from hospital. However, patients' initial perceptions of coercion were stable from admission to follow up and consequently attitudes to hospitalisation per se did not become more positive.

Bentall (2004) observes that the unusual beliefs and experiences psychiatric patients sometimes have seem to reflect preoccupations with the position of the self in the social universe. If a psychiatric patient therefore experiences a sense of inferiority, loss of

control or coercion, it may indeed negatively impact on the patient's perception of the need for, and efficacy of, treatment. Docherty (1996) indicates that a significant number of schizophrenic patients' symptoms worsen when they are emotionally stressed. Often such patients will enter hospital when ill and be placed in a closed ward with other psychotic patients. This is a stressful situation that could amplify a patient's symptoms.

Hynan (1990) suggests that discomfort with services and situational constraints are important factors in premature termination of treatment by patients, resulting in repeated hospitalisations, some of which may be involuntary and additionally traumatizing. Howard et al. (in Hynan, 1990) indicate that the concept of situational constraints may be expanded to include the limited number of psychiatric or psychological sessions that are available to patients in large and 'full' institutions. The authors' clinical experience suggests that an adequate number of sessions increase the chances of the patient having a positive experience. Within the context of understaffed psychiatric institutions, in relation to volume of patients, the possibility that a patient may not receive an adequate number of consultations becomes more significant. Luborsky (in Hynan, 1990) indicates that the therapeutic alliance, including the patient's perceptions of the therapist's respect and warmth, will influence the duration of the therapy. This alliance may be influenced by the therapist's ability to maintain an empathic relationship with all patients in such overcrowded situations.

Roth et al. (in Causey, 1998) state that patient's understanding of psychiatric hospitalisation has important implications for how they respond to treatment. According to Rosenbaum, Elizur and Wijsenbeek (1976) patients often enter the hospital environment expecting to be treated as a sick person, highly dependent on staff for all their needs and not responsible for their own actions. This places a pre-existing burden on staff members at all levels to perform accordingly and may, from the patient's point of reference, cause interventions to appear ineffectual or inadequate. It cannot, however, detract from the overwhelming number of studies (Kahn et al., 1970; Rosenbaum et al., 1976; Liberman et al., 1998; and Olusina, Ohaeri & Olatawura, 2002) that indicate that patients feel victimised when the hospital is seen as a place that is penal and restrictive.

This could lead to an opposition to psychological goals as well as a generally hostile and complaining attitude

The fact that patients may experience the admittance process as traumatic, irrespective of their particular diagnosis, should be seen as significant with regard to their attitude towards treatment (Causey, 1998; Goldberg, 1990; Piersma, 1987; Stevens, 1986). Cusack et al. (2003) suggests that events surrounding, involuntary admission, which in certain cases may include arrest, restraint, sedation and injury, may constitute traumatic events. Fifty percent of respondents in the study by Bonner et al. (2002) indicated that such incidents reactivated distressing memories of earlier traumatic events. In the psychiatric context this may lead to patients with less severe initial diagnoses to develop co-morbidity with other somatic illnesses that are linked with post-traumatic stress disorder (PTSD) like symptoms. Research indicates that some patients may indeed experience symptoms similar to PTSD due to this process and its antecedent experiences (Shaw, McFarlane & Bookless, 1997). Rosenberg et al. (2002) in a study investigating trauma exposure and PTSD in people with severe mental illness, shows that there is some evidence to indicate that psychotic illness in itself can have the impact of a DSM-IV-TR (2001) defined traumatic event. Chandler (2002) indicates that the experience of traumatic events has been associated with dramatic increases in healthcare utilization. The initial manner in which a patient is dealt with may thus have an enduring effect on compliance with outpatient protocols and recovery time (Olofsson & Jacobson, 2001).

The experience of patients during the post-admittance period, when they begin to stabilize and medication begins to take effect, is also significant. Patients are often placed in a situation where there are other patients at various stages of recovery. This situational stress in itself, most especially for the first time patient, can be an additional traumatizing event (Causey, 1998).

Living conditions in hospitals may also affect psychological well-being and future compliance with treatment (Farnham & James, 2000). Olusina et al (2002) indicate in their study of Nigerian psychiatric hospitals that patients' dissatisfaction with provisions

for freedom within the hospital, can be seen as complementary to staff concerns regarding the inadequacy of physical facilities. An improvement in said facilities should empower staff to make life more 'homely' for patients and consequently improve their experience of hospitalisation. Within the context of a developing nation with limited facilities this may not be directly comparable or indeed possible.

Racial discrimination is another factor known to compound the stigma attached to mental illness (Rawaf & Bahl, 1998), whereas Secker and Harding (2002) report that patients' perceptions of racism also contributes to a lack of trust within a psychiatric setting. Within a South African context some consideration needs to be given to the possibility that white patients may regard the mostly black nursing staff, and black patients the mostly white psychiatrists and psychologists, as prejudicial in their encounters with one another. In addition to this, earlier research has indicated that the majority of African people preferred to consult traditional healers, however whether this is still the case in 2006 would need to be verified. Holdstock (in Stones, 1996) states that the practice of psychology mostly concerned itself with pathologies of the white middle class in the past and, as such, held little relevance for the African working class.

In 1994 the South African government put forward a new national health plan (ANC, 1994). Within this plan provision was made to discharge as many long term mental health patients to their families as possible. Families were not prepared for this financially and logistically and many patients may as a result have experienced relapse. (Du Plessis, Greef, & Koen, 2004).

In this regard it may be incorrect to conclude that longer stays in psychiatric hospital settings would be more beneficial, but rather that more community based assistance should be made available to these families. Van der Merwe, Allan and Allan (1999) in a study conducted in the Western Cape on psychiatric patients discharged within 7 days of involuntary admission, concluded that these admissions were unnecessary and could have been taken care of at a general hospital. Moosa and Jeenah (2002) in their research on rapid turnover of psychiatric patients at Helen Joseph Hospital in Johannesburg, also

conclude that inadequate management of short stay patients is unjustified. In this regard the living conditions within South African psychiatric hospitals may not be a significant factor in the majority of new cases, and may only be relevant as a major criterion for long-term psychiatric hospitalisations.

Although previous research has focused mainly on the negative side of psychiatric hospitalisation, it is possible that patients may also have positive experiences that could contribute to their health and overall well-being. Bredel et al. (2004) found a significant positive correlation between the success of psychiatric treatment and the experience and satisfaction with treatment when viewed from the patients' perspective. Coursey, Farrell and Zahniser (1991) report on patients who found traditional interventions like individual and group psychotherapy helpful and who had good relationships with their therapists. These findings suggest that all interventions cannot be viewed as negative; however caution is needed not to generalize these findings.

The works of Lazare et al. (1972) and Lazare, Eisenthal and Wasserman (1975) have contributed significantly to the fact that patients are now increasingly being regarded as 'consumers' of mental health services. Mental health service providers are increasingly taking cognisance of patient's views and opinions as valid contributions to the mental health care knowledge base. Researchers are thus obligated to take cognisance of this fact. This implies that the gathering of data from an insider perspective (Chadwick, 1997) is necessary to enhance knowledge of consumers and their needs. No related research findings about psychiatric patients' experience of the hospitalisation process in the South African context could be found.

From such an insider's perspective, the following questions emerge: What is the subjective experience of a group of psychiatric patients of the hospitalisation process in a typical South African psychiatric hospital? To what extent does this influence their perceived levels of stress, psychological well-being and self-management behaviour?

RESEARCH AIMS AND OBJECTIVES

The aims of this study were to

- explore the subjective experience of psychiatric patients of the hospitalization process in a typical South African psychiatric hospital;
- explore what emerges from these experiences that specifically relate to psychiatric patients' perceived levels of stress, psychological well-being and self-management behavior.

4. METHOD OF INVESTIGATION

4.1 DESIGN

A qualitative case study approach was applied. Qualitative methods have been found to be effective when the intention is to obtain a deeper understanding of experience (Greenwood et al., 1999; Olofsson & Jacobson 2001) and to give voice to the diversity of their experiences (Avis, 1997). This study follows a phenomenological approach, in that it is the patient's experience that is the most essential component. In this context it is the patient's experience that is used to explore the impact of the hospitalisation process, both negative and positive. This may serve to cast an enquiring light on the 'culture' within this psychiatric hospital system.

4.2 PARTICIPANTS

An availability sample of five adult patients from a large psychiatric hospital was used. All consented to their participation in the study. The participants are divergent in terms of race, gender, age and number of admissions. All participants except one spoke English. This interview was conducted in Afrikaans and translated into English to maintain continuity in the text. Exclusion criteria were demented patients or patients who, at the time of the interview, experienced a psychotic episode (e.g. hallucinations or delusions) usually associated with schizophrenia, schizoaffective disorder, or brief schizophrenic disorder. The participants were: (pseudonyms have been used throughout)

Gordon is a divorced white male patient aged 47. He was diagnosed 27 years ago with Bipolar I Disorder and more recently co-morbid with poly-substance abuse and Post Traumatic Stress Disorder.

Coline is a white female aged 30. She also a qualified nursing sister, but was not employed at the time of her interview. She was diagnosed at the age of 20 with Major Depressive Disorder. She was studying at the time towards her qualification as a nursing sister. Five years ago she was also diagnosed with Borderline Personality Disorder.

Nafeesa is an Indian female aged 27. Her first contact with psychiatric care was after her elder brother committed suicide when she was aged 16. After school she began working and studying part-time but at the age of 23 became a chronic psychiatric patient with repeated, extended hospitalizations. She was diagnosed with Bipolar I Disorder with psychotic features and Co-morbidly Poly-substance abuse. At the time of her interview she was judged to be a-psychotic by the attending psychiatrist.

Farouk is an Indian male aged 30. He was 23 years old when he experienced a major depressive episode that caused him to withdraw to the extent that he had to give up his university studies. When he recovered he did not return to his studies but now works as a personnel consultant. After his most recent admission his diagnosis was changed to Bipolar II Disorder.

Shanti is a Black female aged 25. After witnessing the death of a close military colleague during a rescue operation she became depressed and attempted suicide. She was diagnosed with Major Depressive Disorder.

All the participants in this sample had mood disorder subtypes and in some cases additional disorders. These co-morbid diagnoses were either present at the time of their first admission or developed over a period of time and subsequently added during repeated admissions. All the participants, with the exception of Shanti are at the time of

completion of this document out of hospital and functioning in the community. They follow up with psychotherapy, occupational therapy (OT) and medication at the hospital on a regular basis.

4.3 DATA GENERATION

Patients' experiences were explored through semi-structured interviews. The initial question asked to participants was:" I want you to share as fully as possible your own experience of the hospitalization process. I want you to explain in your own words, beginning at your first psychiatric hospitalization and ending at your most recent, what you experienced as a patient." The interviews, which lasted between 45min and 120min, were tape-recorded and transcribed. The semi-structured approach allowed the participants to discuss issues of primary concern to them within the context of their hospitalization experience. The questions were thus purposefully open ended to provide cues to the participants with the minimum of constraint or interference by the interviewer.

4.4 DATA ANALYSIS

Data was analyzed using Interpretive Phenomenological Analysis (IPA) (Smith, 1996; Smith et al., 1997, 1999). IPA focuses on the development of a perspective as true as possible to the participants' experience, concentrating on the meaning they attach to their experiences. To achieve this, a detailed analysis of small samples of individual accounts of their experiences is required. Analysis involved detailed examination of each account to extract significant or relevant points related to the research topic. During this process it was important to ensure that these 'emergent' themes remain based on the participants accounts by "checking for evidence" (Osborn et al., 2002) in their transcripts to support these themes. These emergent themes were then collated with themes that occur in other accounts, and from there tested against the hypothesized outcomes of the investigation.

The IPA methodology recognizes the fact that research conducted will be influenced by the researchers interpretive framework (Osborn et al., 2002). According to Thorn et al.

(2004) the intended products of interpretive description would constitute not a new truth, but a sort of "tentative truth claim" about what is common within a clinical phenomenon. This study attempts in this way, to illuminate what may be common within the experience of psychiatric hospitalization for the patient.

4.5 PROCEDURE AND ETHICAL ASPECTS

The researcher is employed as intern clinical psychologist at a large psychiatric hospital, where the study was done. Permission for the study to be conducted was obtained from the relevant authority at the hospital as well as the ethical committee of the North-West University where the researcher is enrolled for his master's degree in Clinical Psychology. Informed and written consent was also obtained from the participants.

To prevent the participants from experiencing unnecessary stress due to the interviews, a basic counseling style format, following the recommendation of Coyle (1998), was undertaken. The researcher provided post-interview counseling to each participant. Credibility of the study is enhanced through the position of the study leader, who is a registered clinical psychologist, as co-researcher. From this position, he was able to guide the research process to ensure that reflexivity and transferability was achieved (cf. Malterud, 2001).

RESULTS

The same themes consistently emerged; therefore, results are not presented in terms of 5 different case studies, but rather as one integrated case study. Two broad themes emerged, namely positive and negative experiences. Negative experiences were divided into six sub themes: fear; lack of understanding; mismatching of patients; poor communication; negative attitude; and restrictive environment. These in turn were reduced into different components within each sub theme. Positive experiences were divided into: positive relationships with individual staff members; professionalism of treatment; and appreciation of the multidisciplinary team approach.

THEME 1 - NEGATIVE EXPERIENCES

FEAR

Fear features most prominently throughout the experience of the participants. There were two components, namely fear of the unknown or unexpected and fear of the expected.

Fear of the unexpected or unknown is what may be described as a naturally elicited fear in human beings. People most often fear that which is unknown to them. Coline, for example expressed her fear as follows: "You feel afraid because you don't know what lies ahead for you, the unknown. You feel afraid because you don't know what 'they' are going to do to you!" Shanti said: "I was thinking that they were putting me in jail because it looked like a jail. It did not look like a mental institution." Nafeesa indicated: "It was like, unusual, because it was my first time being with people with mental illness...it was a little bit scary because some of them were very, very sick!" Gordon expresses being shocked: "I thought, for crying out, what kind of a place have I come to and I turned around and I tried the door, it was locked. I saw all these guys in their pajamas lying on the floor and I was really shocked! I thought that it was like, really chronic, I felt like I was in hell!" Gordon's description evoked in me accounts of middle ages psychiatric asylums. His distress was palpable while he explained what he had felt at this point.

Fear of the expected was in its initial form based on hearsay and information through various media. In its secondary form this fear was based on previous experiences of hospitalization, and was not necessarily a confirmation of the initial 'expected fear'. In terms of fear based on hearsay and media information, Coline recounted her experience: "You get a fright, a hollow feeling in your stomach, because you don't know what the hell you are going to get. I mean you know of this place through the perceptions of others!" Shanti expressed similar feelings: "It is very negative...because a person is misinformed, a person thinks there are a bunch of crazy people walking around here."

In terms of fear based on previous experiences, Shanti, during a repeat admission to hospital said: "Your perception before, that you were going in with these crazy people, as it were, made you afraid. Made you think that you would not get better." At this point she folded her arms around herself, almost as if to hug her-self. When Gordon tells about this experience he visibly pales as if his sympathetic nervous system is drawing blood from the extremities to prepare his body for flight: "They sent me here for the first time and I was a bit shocked, I mean you are used to ward 6 (lock-up ward) at Sterkfontein (hospital), and I was under the impression they are going to take me back to Sterkfontein. Suddenly I ended up here and I was fighting against this, I did not want to be here. I remembered what happened to me the first time I was in lock-up, so I made sure that I wouldn't go there again!" I could feel and see Gordon's fear as he said this. Coline said that after her experience in an acute ward, if she had to go back to that particular ward on readmission, she would not have returned to the hospital: "The last time was difficult for me, so that made it difficult for me now to return."

While listening to these patients describing their experiences I could not help but feel that I was in the presence of frightened children. The pitch of their voices changed and their facial expressions reflected real fear.

LACK OF UNDERSTANDING

Lack of understanding was experienced for different reasons by all of the participants. Some experienced this through the manner in which staff interacted with them, based on pre-conceived ideas of right and wrong and what it was to be a psychiatric patient. Others had a sense that staff members did not really understand their distress and so did not address it in a satisfactory manner.

Shanti upon readmission, following her second suicide attempt, felt angry and sad: "They will say, are you sorry because you have done this? The fact that they questioned me in such a way, made me angry. To me it was insensitive. I was in this state and then, I needed help, and then they were taking me back to my sorrows." My own feeling at this

point was that she had reached such a point of desperation and confusion in her life that suicide seemed to her the only option. Often people in such a situation are not capable of recognizing the fact that there are alternatives to their distress. She was not offered understanding, but rather made to feel guilty for what happened. Shanti went on to say: "The thing is when I tell them that I am having this and that, they will just say, it will be ok, and not attend to it. Then it seems to me that they do not care. They were just giving medication; they did not worry what that medication was doing to us. It was lack of empathy and sympathy. Because if they wanted to know, they will go to their senior and say, I have got this patient and she is experiencing this or that, how can I deal with it?"

Farouk related an experience where as a patient he has personal needs that may be totally unrelated to his psychiatric diagnosis. The lack of understanding in this case left him feeling hurt: "I wanted to charge my cell phone battery, they said to me; Listen, you have a problem. You are here because you are sick. You must understand you have a mental problem! I mean, that to me is very, very negative...personally I feel it is an attitude problem. From a patients perspective, I felt quite offended and hurt." Farouk's words puts into sharp focus the sense of misunderstanding that patients may experience. The resistance toward the staff members and the treatment they represent is put vividly into perspective.

MISMATCHING OF PATIENTS

This refers to the experience of the participants where they, as patients with varying levels of functioning and different diagnostic categories, are placed together in a situation that is either dangerous to them physically, or where their proximity to each other is counter-productive to recovery

Farouk for example, stated: "It was terrible, it is pathetic, everybody is mismatched. There is chaos, there is mayhem – it's being held together by a thread. I think it can help a lot if you group patients correctly. You should have wards for depression, for different psychotic patients. The mere fact that people can interact and socialize with others like

them will in itself be a healing and learning experience in my personal opinion". Gordon reiterated in his experiences what was mentioned by Farouk: "I understand that they have to have different rules; I think they should have a ward like that (refers to a woman's ward) for the guys because guys suffering from normal depression would never come right in a ward like this." In this regard Shanti felt that: "The thing that traumatized me was being admitted with people who were very ill...then that really traumatized me, because it was my first time in hospital. I could not sleep at night, things like that." I could empathize with Shanti, from my own experience of working in acute and lock-up wards. To try and sleep in such a situation could be a traumatic experience, as you never know what might happen next.

Gordon explained his perceptions of another patient, to further illustrate his point about mismatching: "There is a guy that is very, very ill. They cannot put him in a lockup ward because there the guys will kill him, you know, the guys are aggressive. He is sick, he spits and makes noises and all sorts of things, they cannot put him anywhere but with reasonably high functioning patients that sort of tolerate him."

Coline explains how this mismatching of patients may influence a number of factors simultaneously: "It drag's you down, so even though you may have become relatively better, it is as if its all for nothing. Even if you don't go down immediately, within a few days you will as a result of your fellow patients. It affects your hope for the future, because there is no hope in that ward. It sometimes affects the therapy and the medication. Because you don't know anymore, you feel as if you are not coming right, who is doing something wrong now! Is it the medication; is it the ward, what is going on? It affects the way you see yourself, how you evaluate and look at yourself." At this point Coline points to her head and rotates her finger, to show the spinning confusion and doubts that occur.

POOR COMMUNICATION.

This theme relates to miss communication, or lack of communication between patients and those providing treatment and care. Participants variously experienced this as being left out of their own therapy process, being used as a guineapig, and not being listened to.

Shanti explained that she felt as if she was being experimented with: "I felt I was being treated like a guineapig. I did not know that being on a conference[1] is very important for a patient. I felt as if they were making me their guineapig." When I asked Shanti that if the team had explained to her in a clearer manner what the reason was that she was at the conference, whether that would have made a difference to her, she replied: "Then a person would have felt less as if you are a guineapig and more as if people are actually trying to help you because you understand what they are doing." Her reaction to this experience was to sabotage her treatment, for example by not attending psychotherapy sessions.

Farouk felt staff didn't listen. He explained how he believed communication should work and what the consequences of poor communication were: "Look, in my opinion people are not prepared to listen. I think a very important part of therapy or treatment is the communication. That needs to take place between the people giving the treatment and the people receiving it. Information is not being transferred to the patients, and there are patients that are being treated for anxiety but they are being given anxiety, you know!" He went on to talk about the information that was relayed to the psychiatrists and psychologists: "There once again the feedback that they are receiving from the psychiatric nurses is distorting the treatment. Can you understand it is a communication problem? Nothing works without proper communication."

[1] The meeting of the entire multi-disciplinary team together with the patient to discuss their case and treatment.

NEGATIVE ATTITUDE

This theme relates to participants' perceived attitude of the staff towards them as patients and how they consequently treat them as people. It also includes their perception of the staff members' attitude towards their own tasks.

Farouk expressed his disappointment here: "You know I was absolutely disappointed by the treatment. I think it is more of an attitude problem with the staff. Staff too is individual people with different perspectives; different experiences in life... but some off them are, I think, very unsuited to the positions they are in. That is to the detriment of patients and treatments as a whole. Unfortunately I have to say these things. You know it is the manner in which the hospital is manifesting its authority over the patients". Farouk pushed down on his lap to emphasise this manifestation of authority. I can feel his frustration at the hospital and the way in which the staff treat him. Farouk continued to elaborate on his perception of the staff's negative attitude towards their own tasks: "The other thing that seems to come across, a lot of the people that are here (staff), are just here on a basis of look, I have to do my time, I have to serve the public for this period of time. I am an intern doctor, or an intern this. So don't give me shit, I have got to do, what I have to do. Once again attitude, attitude you see is a problem."

Coline spoke about the staff's perception of all patients being somehow mentally impaired due to the fact that they are in a psychiatric hospital: "They will rather scream at you, but that is because there are people functioning on different levels. They talk to you as if you are low functioning, as if you don't have a brain-cell in your head". She taped with a finger on her temple for emphasis. Shanti commented on two different aspects. Firstly, she related to the negative attitude described by Coline: "No, no, if they will just treat me like a human being, I will behave in a normal way. Some were treating me like a very, very sick person who does not have a brain or something!" Secondly, Shanti related that the staff's negative attitude caused her to feel as if she were malingering and just 'in the way', when she said: "Or they will start saying, you people are not really sick. That

made me feel like I was a burden to them." I could feel the rejection she experienced, from her perception, 'at the hands of the people that she has come to for help.

RESTRICTIVE ENVIRONMENT

Participants referred to their physical environment as being restrictive and oppressive. This was because of the lack of privacy, personal space and an environment with regulations that may be intimidating, even frightening to patients in a compromised psychiatric and emotional state.

Coline sketched a picture of personal space and patience that is needed to survive in that space: "There is no such thing as a room. Your personal space is very small. There are many people around you, so you become easily irritated. You need to be 'extra' patient. The line for medication is long; the line for food is long because there are a lot of patients." Coline additionally indicated that living in such a physically restrictive environment exposes one to others who do not share, or cannot through their illness, share one's own views on personal cleanliness: " There are small things, but the hygiene is a big thing... hygiene is very bad... that is not right for me." She finished off by saying. "In this ward people just get sicker, and it is actually the truth. The psychotic patients make me anxious, when you are ill it affects your sleep."

Shanti described her perceptions of the rules about dress in the hospital environment: "When I came in, we went to central admissions and then I saw people wearing this uniform. Then I asked myself am I going to wear the same uniform? It was very strange to me, so I was like afraid."

In summary, negative experiences include the following themes: fear, lack of understanding, mismatching of patients, poor communication, negative attitude and restrictive environment. The respondent's reactions too these themes varied in intensity for each but each experienced them on an almost universal basis.

THEME 2
POSITIVE EXPERIENCES

The second theme that emerged during the interviews was positive experiences. Positive experiences were divided into the following sub themes, namely: Positive relationships with individual staff members, Professionalism of treatment and Appreciation of multi-disciplinary team approach.

POSITIVE RELATIONSHIPS WITH STAFF MEMBERS

This theme refers to instances where individual staff members have made a positive contribution, either to a patient's psychological well-being, or to their overall positive regard towards psychiatric hospitalization.

Shanti for example told of a nursing sister that comforted her: "There was this one sister, she was my favorite, let me say that! When she sees me, like sitting alone and stuff like that, she would call me and say, let us play a game. She taught me rumicub, so it was very interesting. Then we would sit and play and then I will forget about everything that is bugging me." Shanti continues by saying: "Like I used to have nightmares at night. I will wake up and then they will come and hold me, stuff like that when I cried... it was soothing. The nurses were very welcoming and I could feel the warmth in ward 26 and the environment and the ward as it is, is very calming" Her face is relaxed and almost serene as she relates this part of her story. Shanti finally adds to this: "With the new doctor everything is fine, I feel safe here, I really, really trust her with my life." This was told after an initially negative experience with her first psychiatrist at the hospital.

Gordon speaks with emotion about the nursing sister that attended to him: "Sister Marie, she saw I was bad, I was just crying all the time. There was a spare single room open and usually patients have to do their own beds and everything, and she came and she made my bed, and she gave me a globe for my nightlight, which other hospitals don't even have in the wards. She was really sympathetic and all that."

Coline said that: "The occupational therapist was nice, the programme and all was nice." She later relates that the occupational therapist was one of the most significant motivating factors for her return to hospital. Coline then added a second dimension, not related to individual staff, but rather to staff within a particular ward: "If ward 26 ever didn't exist anymore, it would be a big reason not to come back. Ward 26 is like a haven to us women." I could concur with her on this as I had heard similar sentiments from both male and female patients that this ward and its staff had a nurturing approach. It would appear that staff working under particular ward managers might react differently to patients and their treatment.

PROFESSIONALISM OF TREATMENT

A second sub-theme was positive experiences of medical and psychiatric treatment. This relates to specific treatments not relating to staff attitude or good-will but rather based on the professionalism of the service provided.

Gordon enthused about the quality of occupational therapy (OT): "The OT is so organized and I got involved with OT in the morning and afternoon, and ja, I found that pretty good. The treatment here in this hospital is a lot better. "Gordon then went on to say about medical treatment: "I was stung by a bee, I am allergic to bees, the treatment was immediate when I complained, that was very good. I do not think that I would have had that in a private hospital and I was really impressed."

Coline talked about the use of medication in the hospital, saying: "I mean they are a bit more discriminating regarding sleep and anxiety medication. At private hospitals it feels to me that they put you on too much medication. It's as if they want you to be in a 'trance'." This is a feeling also expressed by the other respondents but to a lesser degree. Finally, Nafeesa valued the professional service she got from a psychologist when she said "It is the first time that I feel I am having real psychotherapy."

APPRECIATION OF MULTI-DISCIPLINARY TEAM APPROACH

This theme refers to the patients' positive experience of the team approach as employed in state hospitals. Patients view it as more effective, than the individual approach to diagnosis and treatment some of them received in the private sector. The 'team' here refers to the Psychiatrist, Psychologist, Doctor, Occupational Therapist and Social Worker assigned to individual cases. The members of the team individually assess each patient that is admitted. They then sit in a conference to jointly decide on the most effective treatment plan for the patient.

Coline relates her feelings regarding the team: "It feels as if here, the team is definitely larger and everyone delivers their contribution as they experienced you, the patient. It seems to me the bigger the team the better the choice that is made. It is in that sense that I think the diagnosis is more correct in here." Finally, Shanti after her initially negative feelings toward the conference admitted that the team's attention as a whole gave a greater sense of validity to her treatment.

In summary, positive experiences were elicited by positive relationships with individual staff, professionalism of psychiatric/medical treatment within the hospital and the multi-disciplinary team approach. These positive experiences appear to have a significantly palliative effect.

DISCUSSION

The themes that emerge from the patient's experiences concur well with information from studies related to psychiatric hospitalization. First among the findings that this study has replicated is fear. Koivisto et al. (2004) found that patients valued especially the feeling of safety. All the patients in the current study indicated that at one point or another they experienced fear, ranging from fear of physical harm, and finally to fear of not fully recovering. Causey (1998) construes fear from a hospital-related stressor perspective. He found a significant association between depressed mood and stress specifically related to fear experienced within an inpatient unit.

The perception of mismatching induced additional levels of stress and fear in the participants. This in various ways affected their recovery and indeed attitude towards medication, therapy and staff in general. This is in part due to physical and psychological re-traumatization or the effect of experiencing first hand, other patients' observable signs of psychosis and depression. This experience in many instances may affect's the patient's well-being and self-image.

Poor communication in psychiatric hospitals is one of the themes that support findings from previous studies. Johansson and Lundman (2002) state that patient's related experiences of distress when receiving treatment and care without information or participation in the decisions, whereas Koivisito, Janhonen and Vaisanen (2004) reported that feelings of confusion and worthlessness were experienced when the patient's need for information was not met. Also noted was the fact that distress was relieved by accurate, meaningful information. Elements of these experiences were also encountered in the current study.

Participants in the current study add a new dimension namely that poor communication may cause patients to actively resist or attempt to sabotage their own treatment. This indicates the possibility of poor self-management behavior to the point where patients' psychological well-being is further impaired. It cannot be underestimated that psychiatric

patients need to be informed and heard. Adma (1998) states that while patients may admit to doubts and fears of their own abilities, they felt underestimated or undervalued when professionals failed to hear them.

In contrast, when they were being informed about treatment, they experienced a greater sense of psychological well-being. This was due to the fact that they had a greater sense of being listened to and cared for effectively. The extrapolated effect of this is that their self-management behavior was enhanced. This included not only compliance with medication but improved motivation to attend groups, occupational therapy and psychotherapy sessions.

Other factors in the Johansson and Lundman (2002) study that were replicated here include lack of understanding and negative attitude. They indicate that patient' perceptions that some of the staff failed to see them as individuals and to respect them, resulted in a negative experience of treatment and care. When a patient believes that a staff member feels their task is a burden, this translates for the patient into them being the burden. In both cases this impacts on the quality and level of interaction between staff members and patients. Patients in the current study experienced lack of understanding and negative attitude as 'not caring' on the part of staff. This perception in effect made the patient's experience even greater levels of self-doubt, leading them to question staff competence and efficacy of the treatment they received. In some cases this caused them to consider premature termination of treatment. Experiences with staff's negative attitude and lack of understanding caused patients to consider not coming back to the hospital. This may be irrespective of the fact that they had received effective treatment in other area's during their hospitalization.

Within the theme of lack of understanding there is a perceived element of discrimination. Patients' requests for general assistance were often perceived as being reacted to by staff in a negative manner. The perception was that requests were being refused on the basis that the patient has a psychiatric diagnosis and not on the merits of the request itself. With regard to this, Knight, Wykes and Hayward (2000) found that schizophrenic

patients were precluded from basic or everyday privileges that had nothing to do with their psychiatric status. This is discrimination not on the basis of race or ethnicity, but rather on the basis of psychiatric diagnosis or hospitalization. What is relevant to this study however is that a lack of understanding was perceived more often with regards to the psychiatric nursing staff. Nursing staff in any hospital is the first line of contact for patients when hospitalized. Doctors, psychiatrists, psychologists and any other service provider within the hospital context are reliant on nursing staff, not only for information but also the continuation of prescribed treatment regimes for patients. Patients also perceive nursing staff, because of their close proximity and extended contact, as a direct reflection of the treating institution and the professionalism and efficacy of treatment that is provided.

The positive experiences of participants in the current study confirm findings by Bredel et al. (2004) and Coursey, Farrell and Zahniser (1991). Almost all respondents in the current study recount a situation where an individual staff member has had a positive impact on their perceptions of the hospital and their own treatment. A strong case can therefore be made for the input of individual staff in counteracting to a significant degree, the negative influences of other staff and environment. Positive experiences also caused a perception of reduced stress levels, allowing participants to tolerate better the restrictive environment and mismatching of patients. This increased their willingness to co-operate with treatment, as well as positively influencing the way in which they participated in their own treatment, leading to an improvement in self-management behavior and the enhancement of psychological well-being.

CONCLUSION

The aim of this study was to explore the subjective experience of a group of psychiatric patients in a typically South African psychiatric hospital. Sub-aims were to explore how these experiences relate to self management, stress and psychological well-being.

Two main themes emerged, namely negative and positive psychiatric hospitalization experiences. The participants' negative experiences related primarily to interaction with

staff and environment. This had the effect of raising stress levels, which in turn impaired self-management behavior and psychological well-being. This involved an overwhelming increase in the sense of self doubt and doubt in the efficacy of treatment. This in turn led to passive and active resistance to treatment as well as 'conditional' resistance to future treatment. The positives that were experienced by participants included a sense of validity of diagnosis and increased sense of effective treatment; in turn leading to greater self-management and psychological well-being. This was in their experience largely through the perceived efficacy of diagnosis and treatment by a multi-disciplinary team, and to a lesser extent to caring and professional treatment by individual staff members.

Overwhelmingly it seems that patients' perceptions indicate a possible lack of training in empathic and sensitive management of their psychological and psychiatric needs. This is emphasized by being treated in a manner that often appears to ignore basic human rights, and instead being treated under a blanket diagnosis of 'you have a mental problem.'

Possible limitation's of this study is the use of only 5 participants. Secondly staff member's experiences, ideas and needs were not taken into account and thirdly focus was directed at only one hospital. It is recommended that a follow-up study should be conducted to address these possible limitations.

Further recommendations should firstly be conceptualized by Sing-Fai Tam et al.'s (2000) argument that de-institutionalization is an important objective in helping patients to achieve a better quality of life. This for the most part would necessitate greater community participation or community based involvement. Kirkpatrick, Younger, Links and Saunders (in Sing-Fai Tam et al., 2000) say that the longer that patients live in the community the higher they rated their quality of life. This in the long term had a positive influence on relapse rates in these patients. In South Africa this is an essentially untried quantity when compared to North American and European based programs of community-based care. In this regard it may be difficult to implement initially, but as indicated this type of program has proven to be successful.

A final recommendation is that a study be conducted, to determine at which point nursing staff in training should receive instruction to address the shortcomings in knowledge and sensitivity towards patient's diagnoses as have been highlighted. Current nursing staff should be given effective training in empathic and sensitive management of psychiatric patient's needs. An effective oversight and evaluation structure should be put in place, to monitor progress and ongoing improvement in treatment involving these staff members. A CPD point program for nursing staff, similar to those employed in other medical disciplines to encourage continuous improvement of knowledge may further enhance service delivery.

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