A Qualitative Analysis of Experiences of Detention within Mental Health Services

A thesis submitted to The University of Manchester for the degree of Doctor of Clinical Psychology in the Faculty of Medical and Human Sciences

2014

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School of Psychological Sciences
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Abstract

This thesis set out to explore the experiences of being detained and admitted to an inpatient unit. It is comprised of three papers. Paper one and paper two have been prepared according to the guidelines of the journal they will be submitted to. Paper one is a systematic review of the qualitative literature which has explored participants’ experiences of involuntary detention. This paper provides an update to a review previously carried out and attempts to answer some questions that the previous review were unable to answer. Databases were searched and studies were screened for their relevance. Fifteen studies were located and the results were synthesised using a standardised metasynthesis methodology. Seven overarching themes emerged, illustrating positive and negative experiences of involuntary detention and factors which impact on these experiences. The synthesis resulted in clear recommendations for clinical practice and future research.

Paper two is a qualitative study which sought to explore the experiences of detention under the Mental Health Act for anorexia nervosa. Four participants were inpatients and under the Mental Health Act at the time of interview and eight participants had been discharged. A grounded theory analysis revealed four overarching themes which capture their experiences over time and how these experiences impact on a person’s recovery. The findings have been incorporated into a framework and are discussed in relation to existing literature. The paper outlines recommendations for clinical practice and future research.

Paper three is a critical appraisal of the overall research process. It draws on the researcher’s reflective journal to highlight the theoretical, methodological, personal challenges and learning outcomes which the researcher encountered. It discusses the clinical implications in relation to the researcher’s future career as a clinical psychologist within the NHS, as well as the wider implication for the profession as a whole.
Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.
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Acknowledgements

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A special thank you to Dr Saeideh Saeidi for supporting recruitment at Yorkshire Centre for Eating Disorders and a special thank you to BEAT, both of which were enthusiastic and willing to help in any way they could and truly valued supporting this project. I would like to thank Tracey Hepburn for transcribing some of my interviews. She was skilled and efficient and besides that, she has also been a reassuring voice throughout the course.

A very big thank you to all my family and friends. I appreciate those who listened to my anxieties and all those who helped me keep everything in perspective. Thank you for looking after my little boy Theodore during particularly stressful times. My mother has stuck by me throughout this process and I appreciate all her guidance and wisdom. Lastly, thank you baby Theodore for staying away from the office and for giving me such a wonderful distraction!
The Experience of Involuntary Detention in Acute Psychiatric Care.
A Meta-Synthesis of Qualitative Studies

Paper 1 has been prepared for submission to International Journal of Nursing Studies in accordance with the guidelines for contributors (Appendix 1)

Word Count (excluding tables, figures and references): 7435
Abstract

Objective: To replicate and build on a previous review and develop an updated understanding of how participants experience involuntary detention for their mental health difficulties.

Design: This systematic review is a qualitative meta-synthesis and follows the methodological guidelines outlined by Noblitt and Hare.

Data sources: Using pre-defined search terms, the following databases were searched covering the period 2006 to March 2014: Psychinfo, Medline, MedlineIn-Process and Embase, and in addition to the previous review: Web of Knowledge, Scopus, Science Direct, British Nursing Index and Cinahl Plus. Three journals were electronically hand-searched.

Review methods: The search resulted in the retrieval of 6230 records which were screened by title. Relevant studies were then screened by abstract and further articles were read for full text. References of articles read for full text were screened using an inclusion and exclusion criteria. A total of fifteen studies were identified and a quality evaluation tool was applied to each study. All fifteen studies were integrated and analysed using a standardised metasynthesis methodology.

Results: Seven overarching themes emerged. ‘Sanctuary’, ‘loss’, ‘I felt terrified’ and ‘fluctuating emotions’ illustrate the experiences of involuntary detention, and the remaining themes reflect the factors that mediate these experiences: ‘a continuum of person-centred practice’, ‘you’re disempowering me’ and ‘intra-psychic coping’.
**Conclusions:** Participants varied in how they experienced involuntary detention. Some people experienced a sense of sanctuary, whereas others experienced loss, fear and trauma. Participants’ experiences were mediated by the degree of actual or perceived person-centred and empowering care, which also had an impact on their coping style. Development of a ‘therapeutic bond’ with clinicians was a key factor which mediated positive experiences of involuntary detention. The implications of the findings are discussed with reference to existing literature and recommendations are made for clinical practice. Ideas for future research have been identified.

**What is already known about the topic?**

- Internationally, rates of involuntary detention are high. Many people are unable to sustain recovery and can often be re-detained.

- A qualitative review was carried out in 2006 which located five studies which explored experiences of involuntary detention. A thematic analysis highlighted positive and negative experiences of involuntary detention; however, the authors could not ascertain how positive and negative experiences were linked to each other.

**What this paper adds**

- There has been a resurgence of interest, debate and research into the experience of being involuntary detained and this paper provides an updated understanding of participants’ experiences.
• The meta-synthesis methodology provides a theoretical understanding of participants’ experiences of involuntary detention and factors which impact on these experiences.

• This paper recommends that services are reconstructed so that recovery and person-centred approaches are firmly embedded in services.

**Keywords:** Adolescent, Adult, Coercion, Detention, Experiences, Hospital, Involuntary, Meta-synthesis, Recovery, Review, Section.
Introduction

People in the acute stages of a mental illness can be a risk to themselves or others and can be involuntarily detained against their will. Across Europe, rates range from a mere six annual compulsory admissions per 100,000 of the population in Portugal, to 218 in Finland (Salize & Dressing, 2004). During the 1990’s, analysis of compulsory admission quotas (percentages of all psychiatric admissions) remained relatively stable in most countries. However, reliability and validity of the data were compromised due to non-standardised definitions of concepts, invalid recording methods and availability of data. To our knowledge, current data on the international practice of involuntary detention (ID) are absent from the literature. In England, The Health and Social Care Information Centre (2012) reported that the number of people detained under the Mental Health Act (1983/2007) was rising. The concern is given Kallert, Glockner and Schutzwohl’s (2008) findings, that length of stay, re-admission risk and risk of involuntary re-admission are at least equal, if not greater for involuntary service users. It could be that ID influences the threshold for further legal measures or these people are more distressed and at more risk. Factors that contribute to this finding are unclear. However, there is a link between admission status and outcome and a clearer understanding of people’s experiences of ID to improve care and outcomes is essential.

Research exploring participants’ experiences of inpatient treatment (regardless of legal status) highlight both positive and negative aspects. This has added to debates around the ethical, legal and best practice of ID (Cleary, Hunt, Walter & Robertson, 2009). Criticism has been raised by patients and political bodies such as the Council of Europe (Working Party on Psychiatry and Human Rights, 2000). Katsakou and Priebe (2007) reviewed
qualitative studies on the experiences of involuntarily admission up until 2006; it was unclear between which dates the authors searched although five studies were identified. They found positive aspects of ID including: respect and autonomy, being cared for and treated like ‘a human being, like other people’, in addition to negative aspects: restrictions of autonomy/no participation in decisions for treatment, feeling uncared for, emotional impact and feeling devalued. They reported that it was unclear how positive and negative experiences of involuntary treatment were linked to each other, i.e. they could not ascertain if it was different patient groups reporting positive and negative themes, or the same individuals reporting both positive and negative aspects.

**Rationale**

Since Katsakou and Priebe’s (2007) publication, there has been a growth of studies exploring experiences of ID in adult psychiatric care. There have been many contextual changes that may affect a person’s experiences of ID: the international policy drivers, which push for person-centred care and recovery approaches, the amended version of the MHA (Mental Health Act: 1983/2007) in England, increasing economic pressure on services generally, as well as the sheer numbers of people being detained internationally.

The aim of this paper is to update the review of Katsakou and Priebe (2007) by reviewing studies from 2006 to 2014 and extend it by using a meta-synthesis methodology which offers an additional level of interpretation to a thematic analysis. We will attempt to answer the questions they originally posed:
i) How do participants experience involuntary admission and treatment and what are their perceived outcomes of such interventions?

ii) Do participants report both positive and negative experiences and how are these linked?

iii) What are the differences between patient groups holding positive and negative views on this issue, in terms of their characteristics, thought processes and treatment experiences?

A greater understanding of patients’ experiences of ID could inform assessment and treatment practices. Improving their experiences could improve outcomes of treatment, potentially reducing the time spent in hospital or risk of relapse.

Method

Literature searching

The period July 2006 to March 2014 was searched across all the databases: Psychinfo, Medline, MedlineIn-Process and Embase, replicating Katsakou and Priebe’s (2007) method. The following additional databases were searched: Web of Knowledge, Scopus, Science Direct, British Nursing Index and Cinahl Plus. International Journal of Social Psychiatry, Journal of Mental Health and Journal of Psychiatric and Mental Health Nursing were electronically hand-searched because they located potentially relevant articles during an initial scoping exercise.
Search terms applied by Katsakou and Priebe (2007) did not locate all of the articles which were found during the initial scoping exercise. Search terms were broadened out and divided into four categories: 1) the topic under study (for example, compulsory or involuntary or coer* or forced or commitment or detention or refusal); 2) terms related to procedures of treatment (for example, admission or admitted or treatment or assessment or hospitali*); 3) terms which captured peoples experiences (attitude* or experience* or view* or perception* or perspective* or stories) and; 4) terms related to mental health (for example, mental* or psych*). The four categories were combined and limited to include only English language articles and to exclude book chapters, conference papers and unpublished theses. Studies were scanned by title and those deemed potentially relevant were collected. Abstracts of these studies were assessed for their relevance and studies considered appropriate were read for full text. References of these articles were searched. The second and third author agreed on the final 15 studies. Figure 1 presents the studies retrieved through each step of the search.
Figure 1. Flow chart illustrating the study selection procedure and results

<table>
<thead>
<tr>
<th>Database</th>
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<td>Medline In-Process</td>
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<tr>
<td>Medline</td>
<td>1087</td>
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<td>Psychinfo</td>
<td>1705</td>
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<td>Science Direct</td>
<td>988</td>
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<td>Embase</td>
<td>2285</td>
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<td>Scopus</td>
<td>2736</td>
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<tr>
<td>Web of Knowledge</td>
<td>2499</td>
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<tr>
<td>Cinahl Plus</td>
<td>943</td>
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<tr>
<td>British Nursing Index</td>
<td>52</td>
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<td>Scopus</td>
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<tr>
<td>Web of Knowledge</td>
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<td>Cinahl Plus</td>
<td>943</td>
</tr>
<tr>
<td>British Nursing Index</td>
<td>52</td>
</tr>
<tr>
<td>Handsearching of 3 journals</td>
<td>15</td>
</tr>
</tbody>
</table>

Duplicates removed n = 6172

Excluded on title n = 6109

Total excluded on abstract n = 83
Irrelevant n = 43
Quantitative n = 37
Not involuntary n = 3

Full text read against inclusion/exclusion criteria

Total included n = 14

Excluded on full text n = 24
Irrelevant n = 5
Quantitative n = 10
Involuntary n = 9

Hand searched reference list. Total identified n = 1

Total included and assessed for quality n = 15

Final number of studies included in the metasynthesis n = 15
Inclusion/exclusion criteria

The inclusion/exclusion criteria replicated that of Katsakou and Priebe (2007) and are outlined in table 1.

Table 1. Inclusion and exclusion criteria

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
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<tr>
<td>Assessed the experiences of involuntarily admitted patients using a qualitative methodology</td>
<td>Used mixed sample of involuntary and voluntary admitted patients with no separate qualitative analysis for the involuntarily admitted patients</td>
</tr>
<tr>
<td>Included patients who had been treated in acute general psychiatric wards.</td>
<td>Views of patients being treated involuntarily in the community rather than in a hospital setting</td>
</tr>
<tr>
<td>Published in English</td>
<td>Experiences of people being in forensic or drug addiction units</td>
</tr>
<tr>
<td></td>
<td>Experiences of specific treatment procedures such as medication and restraint, without looking at the overall experiences of assessment and treatment</td>
</tr>
<tr>
<td></td>
<td>Dissertation abstracts, books, editorials, review papers and commentaries were excluded.</td>
</tr>
</tbody>
</table>

The search located some studies with mixed samples of voluntary and involuntary patients; however, the exact numbers in each category had not been recorded. These authors were contacted and if they could not provide the exact numbers, the study was excluded (N =8). One study consisted of the majority of involuntary participants with 1 voluntary participant (Study 4). It was included because it was deemed that the results would be largely representative of ID. Studies with multiple perspectives were included if the patients’ experiences were reported independently.
Quality assessment

Eligible studies were examined for their quality to reduce the chance of compromising the quality of the meta-synthesis (Walsh & Downe, 2006). The Critical Appraisal Skills Programme (CASP, 2010; appendix 2) quality assessment tool was employed because it is standardised and widely used for assessing qualitative research. Following this, a more detailed appraisal tool by Walsh and Downe (2006; appendix 3) was applied and therefore these ratings are presented in Table 3. Quality grades ranged from A (few flaws) to D (significant flaws which are likely to affect the credibility, transferability and dependability of the study). The first author assessed all fifteen studies. The second and third author each selected seven or eight of the fifteen studies and independently carried out assessments. Eighty seven percent of the ratings were agreed upon. Ratings where there was a difference between raters were discussed and agreed upon.

Synthesis of findings

This meta-synthesis followed methodology developed by Noblit and Hare (1988) because it is considered to be the most effective review of qualitative research (Walsh & Downe, 2004). The structured approach ensures rigour, it has been applied across diverse areas of healthcare and it is considered to be the most frequently cited in meta-synthesis publications (Bondas & Hall, 2007). Key metaphors, themes, ideas, concepts or phrases in each study were identified and documented using a ‘data extraction form’ (appendix 4). This involved extracting the quotations used in the individual studies alongside extracting second-order interpretations made by the authors. The second stage involved determining if the quotations, themes, ideas, concepts or phrases were in opposition to each other, directly comparable, or if when collapsed together they took a ‘line of
argument’ (Noblit & Hare, 1988). This involved the studies being collated and
synthesised in order to create overarching themes which captured the participants’
experiences. These overarching themes were then compared to each other to determine if
they could be encompassed into other themes. The first author carried out the initial
synthesis and discussions with the research team and an independent qualitative
researcher allowed further insight and refinement of themes, improving the validity of the
synthesis.

Results

Overview of search results

Details of the fifteen studies are included in table 2. The overall quality of the studies
(table 3) ranged from a B to C. Many of the studies were rated poorly on their reflexivity.
The lack of reflexivity makes it difficult to understand how the researcher shaped the
study and interpreted the findings. In some of the studies, there was a lack of detail and
transparency in the design and analytical procedure. None of the studies were rated with
an A on the analysis; many studies did not retain the context of the findings which made
interpretation difficult and in some studies, quotations were limited. In study two, a
notebook was used to record the interviews, potentially affecting the quality of the study.
The relevance and transferability of the research was rated highly in studies eight and
thirteen; however, other studies failed to integrate the findings with previous research and
there was limited applicability of the findings. None were rated a D, therefore all fifteen
were included.
To document the experiences of a service user through a mental health crisis and the experience of detention under Section 136 of the MHA, admission to hospital and eventual recovery.

To explore the impact of involuntary hospital admission and illuminate the lived experience of involuntary admission.

To explore the experiences of participants who have been held involuntarily under the local mental health act and who had absconded.

To evaluate the implementation of the Mental Health (Care and Treatment) (Scotland) Act by exploring the experiences and views of participants treated under the Act.

To explore how patients and staff act and how they describe their experiences in the context of involuntary commitment in a locked psychiatric ward.

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<th>Aim</th>
<th>Data collection</th>
<th>Time point</th>
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<td>To document the experiences of a service user through a mental health crisis and the experience of detention under Section 136 of the MHA, admission to hospital and eventual recovery.</td>
<td>Personal narrative</td>
<td>Retrospective</td>
</tr>
<tr>
<td>Interpretative phenomenological analysis</td>
<td>To explore the impact of involuntary hospital admission and illuminate the lived experience of involuntary admission.</td>
<td>Semi-structured interviews</td>
<td>Retrospective</td>
</tr>
<tr>
<td>Thematic analysis</td>
<td>To explore the experiences of participants who have been held involuntarily under the local mental health act and who had absconded.</td>
<td>Semi-structured interviews</td>
<td>Retrospective</td>
</tr>
<tr>
<td>Thematic analysis</td>
<td>To evaluate the implementation of the Mental Health (Care and Treatment) (Scotland) Act by exploring the experiences and views of participants treated under the Act.</td>
<td>Semi-structured interviews</td>
<td>Retrospective</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Sample</th>
<th>Discipline</th>
<th>Time point</th>
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<tbody>
<tr>
<td>1 service user with experience of being detained under Section 136 of the Mental Health Act with a diagnosis of psychosis.</td>
<td>Service user with Social Work background</td>
<td>Retrospective</td>
</tr>
<tr>
<td>6 participants under detention in a Irish mental health centre. (Ages 22-49). Diagnoses: 5 bipolar or psychosis, 1 participant 1st admission</td>
<td>Nursing</td>
<td>Either under detention or awaiting discharge</td>
</tr>
<tr>
<td>12 participants (4 men, 8 women). Aged 18 and over.</td>
<td>Nursing</td>
<td>Retrospective</td>
</tr>
<tr>
<td>49 self-selecting service users with experience of being treated under the Mental Health Care and Treatment (Scotland) Act, 2003. Ages 21-63, 33 Males, 15 females Recruited from 4 sites across Scotland.</td>
<td>Social Work</td>
<td>Retrospective</td>
</tr>
<tr>
<td>4 involuntarily participants on a locked psychiatric ward with dual diagnoses.</td>
<td>Nursing</td>
<td>Detained</td>
</tr>
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</table>

Table 2. Characteristics of included studies
<table>
<thead>
<tr>
<th>Detained</th>
<th>Interviews</th>
<th>Phenomenographic approach</th>
<th>Grounded theory</th>
<th>Components of grounded theory and thematic analysis</th>
<th>Grounded theory</th>
<th>Components of grounded theory and thematic analysis</th>
<th>Grounded theory</th>
<th>Components of grounded theory and thematic analysis</th>
</tr>
</thead>
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<td>Detained</td>
<td>Semi-structured interviews</td>
<td>Semi-structured interviews</td>
<td>Semi-structured interviews</td>
<td>Semi-structured interviews</td>
<td>Semi-structured interviews</td>
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<tr>
<td>Nursing</td>
<td>Nursing</td>
<td>Nursing</td>
<td>Nursing</td>
<td>Nursing</td>
<td>Nursing</td>
<td>Nursing</td>
<td>Nursing</td>
<td>Nursing</td>
</tr>
<tr>
<td>12 compulsory admitted participants (5 women, 7 men aged 18-65) who had been admitted to two units for psychotic disorders. Relationship status: single.</td>
<td>12 participants (8 women, 4 men) who had been admitted involuntarily onto a secure 16-bed unit within a specialist psychiatric hospital. A total of 52 diagnosis.</td>
<td>59 involuntary admitted participants from inpatient acute wards across 22 hospitals. Diagnosis: Schizophrenia (22), Affective disorder (20), other (8). Ethnicity: White (37), Black (14), Asian (6), Other (2).</td>
<td>16 participants with a history of compulsory detention (8 men, 8 women) and a history of psychosis. Age range: 38-62. Ethnicity: all white. Length of illness: between 5 and 41 years.</td>
<td>18 detainees who had a history of being detained under Section 136 of the Mental Health Act</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To describe participants’ experiences of care and treatment during compulsory admission during an acute psychotic phase. To examine how participants experience the specialist treatment and which elements of the treatment they perceived to be essential. To explore the involuntary patients’ retrospective views on whether their perceived hospitalisation was right or wrong. To investigate the experiences and attitudes of patients with psychosis in relation to trust, choice and power. To elicit the views and experiences of individuals being detained under Section 136 of the MHA</td>
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<td>12 compulsory admitted participants (5 women, 7 men aged 18-65) who had been admitted to two units for psychotic disorders. Relationship status: single.</td>
<td>12 participants (8 women, 4 men) who had been admitted involuntarily onto a secure 16-bed unit within a specialist psychiatric hospital. A total of 52 diagnosis.</td>
<td>59 involuntary admitted participants from inpatient acute wards across 22 hospitals. Diagnosis: Schizophrenia (22), Affective disorder (20), other (8). Ethnicity: White (37), Black (14), Asian (6), Other (2).</td>
<td>16 participants with a history of compulsory detention (8 men, 8 women) and a history of psychosis. Age range: 38-62. Ethnicity: all white. Length of illness: between 5 and 41 years.</td>
<td>18 detainees who had a history of being detained under Section 136 of the Mental Health Act</td>
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Sibitz et al (2011) Vienna  | Psychiatry  | 15 participants (7 men, 8 women) using mental health services and with a history of involuntary detention. Aged 32-66 with either a psychotic or mood disorder diagnosis. | Retrospective: Average duration since last ID was 3.8 years. | Semi-structured interviews | Modified grounded theory; pragmatism and Chicago-style interactionism | To establish a typology of coercion perspectives and styles of integration into life stories.

Gault (2009) UK  | Nursing  | 19 participants with a history of repeatedly being involuntarily detained ‘some time ago’ and have been non-compliant with medication. Ten males, 9 females, 20-89. European (7), Afro-Caribbean (11), Asian (1) | Retrospective | Semi-structured interviews | Adaptation of Grounded Theory to fully include context. | To explore participants’ understanding and perceptions as a result of their experience of non-compliance with medication and compulsory treatment.

Hughes et al (2009) UK  | Clinical Psychology  | 12 participants with a history of involuntary inpatient treatment (5 Males, 7 Females) 19-62 mean 39. Bipolar affective disorder (6), Borderline personality disorder (2), schizophrenia (2), depression (2). | Retrospective: 2.2 years average time since last admission and a range of diagnosis. | Semi-structured interviews | Thematic analysis | To provide a detailed consumer perspective of involuntary inpatient care and how this is perceived to have impacted the self, relationships and recovery.

Lilja & Hellzen (2008) Sweden  | Nursing  | 10 former patients (3 men, 7 women) who had experience of involuntary psychiatric hospitalisation within the previous 5 years. Mood disorder (1)Psychosis/schizophrenia (5) personality disorder (2) aspergers (2).Age range 32-64 | Retrospective | Semi-structured interviews | Content analysis | To extend understanding of former inpatients’ experience of psychiatric care.

Mc Nally et al (2007) UK  | Psychology  | 7 participants with mild learning disability detained under the mental health act (5 men, 2 women) for deterioration in mental state. English speaking and white. | Under detention | Semi-structured interviews | Interpretative phenomenological analysis | To examine the experience of compulsory detention under the MHA (1983) for participants with
Table 3. Results of Walsh & Downe (2006) quality assessment

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Synthesis results

Synthesis and translation of the findings resulted in seven overarching themes. Four themes reflect participants’ responses to ID: ‘sanctuary’, ‘loss’, ‘I felt terrified’ and ‘fluctuating emotions’. Three themes reflect factors which impact on their experiences: ‘a continuum of person-centred practice’ and ‘you’re disempowering me’ are external factors and ‘intra-psychic coping’ is an internal factor and includes ‘fighting back’,
‘acceptance’, ‘developing a model patient role’ and ‘avoidance’ as subthemes. A thematic map (figure 2) represents the data. This illustrates that participants experienced a mix of positive and negative emotions to being involuntarily detained. Experiences of positive emotions were linked to experiences of sanctuary from being detained, and negative emotions were linked to participants experiencing a degree of loss. Factors which had an impact on these experiences are represented centrally within the circle. Participants who perceived clinical practice to be person-centred and empowering experienced more positive emotions than participants who perceived clinical practice to be less person-centred and disempowering. The circle illustrates that experiences fluctuate and change over time. The coping strategies participants adopted influenced their overall experiences. More unhelpful strategies exacerbated an overall more negative experience, and more helpful strategies lead to a perceived quicker discharge. Links between the themes and subthemes are detailed in the text. Extracts represent the essence of the themes. Appendix five illustrates the studies that discussed each theme.
Figure 2. Diagram of results

Involuntary detention

Responses to ID and staff practice

Perceptions of clinical practices

Sanctuary: staying safe and restoration to normality

Relief

Loss of normality, independence and identity

Anger

I felt terrified

Disempowered

Person-centred practice

Lack of person-centred practice

Intra-psychic coping

Acceptance, Exemplary patient

Fighting back, Sick patient role, Avoidance

Discharge
Experiences, feelings and responses to ID

1) Sanctuary

All participants believed ID was unnecessary upon admission. Over time, their beliefs changed as some participants experienced a feeling of sanctuary, which incorporates two subthemes ‘staying safe’, and ‘restoration to normality’.

Staying safe

Some participants recognised that they were destructive before admission and ID was necessary to maintain the safety of themselves or others:

‘I tried to stab someone, I was self-harming… it was necessary for me to be put in hospital because I was getting very out of control’ (Study 8).

Participants who had co-morbid drug and alcohol problems looked back and were relieved detention was imposed on them. They recognised their safety in the community was threatened due to drug related crime. Participants with ambivalent views about the necessity of ID recognised that it stopped him/her from ‘getting into any more trouble’. However, it was perceived as unnecessary because they also experienced a sense of loss and believed there were ‘much better ways of dealing with it than hospitalisation’ (Study 12), such as outpatient intervention (Study 8).

Restoration to normality

Some participants recognised that they were chaotic and mentally unwell prior to admission and that the choice being taken away from them was necessary for them to be
able to stabilise their mental state. Being detained was experienced as restorative, a place to ‘take a break away from the difficulties of life’ and the ‘only possibility to bring (them) back to normality’:

‘It gave me the rest that I needed. I hadn’t slept properly for 2 weeks…I quickly settled down and felt better’ (Study 8).

One participant started to realise that ID helped her ‘gradually with medication and various things’ be ‘built up’. These participants felt contained by rules, routines and clear consequences to behaviour (Study 4). Activities interrupted rumination as they experienced ‘little breaks to do something else’ (Study 3). Some participants described a sense of belonging when detained (Study 11) and saw it as a way to recover back to their former identity:

‘I am prouder of myself… I am becoming me again; I am more accepting of myself’ (Study 4).

2) Loss

Contrary to the above, some participants described pervasive experiences of ‘loss of normality and perceived independence’ and ‘loss of identity’, contributing to ambivalent beliefs about the necessary of ID.

**Loss of normality and perceived independence**

Participants perceived ID as a disruption to their lives. These perceptions increased their anxiety and preoccupation with their ‘normal lives outside of the ward’, making it difficult to settle:
‘I certainly didn’t need to be sectioned. I was very anxious to get home, to find out where my dog was and to get my business running and get myself back on my feet…I lost all the trade’ (Study 8).

These participants perceived it as a ‘waste of (their) lives’. Participants described a loss of independence and felt monitored by family and friends, which led to a ‘life on probation’:

‘…I can’t do anything, I can’t go anywhere, can’t show any kind of personality, the first thing that happens is that I have to go to a psychiatric clinic’ (Study 14).

Friendships were lost as ‘life fell apart’. The long-term legal consequences of detention were a concern (Study 14) and participants believed that a history of detention was a threat to their independence because ‘once under the surgeon’s knife’ they were ‘always under the surgeon’s knife’. They described being a ‘victim’ of the stigma and believed there was nothing they could do to change it. Over time, participants experienced ID as something which took control over their lives.

**Loss of identity**

Across many studies, participants described a loss of identity. A diagnosis contributed to a perceived permanent loss of their former healthy self and their future self was seen as being defined by their diagnosis:

‘I had a psychotic episode and when I had it they labelled me and my health status . . . they labelled me as a paranoid schizo . . . the problem is that the diagnosis is there even when the disease is gone, so to speak’. (Study 1)
Participants described ‘becoming a patient’ as a process whereby their identity transforms from being individualistic to one of a collective which is based on their behaviour (Study 7). This omits other aspects of the self (beliefs, values, emotions, history) resulting in their views not being taken seriously. Participants worried what ‘people think on the outside’ after ‘being labelled as a feckin psycho’ (Study 10). One participant described ‘not knowing what (she) was like before’ and not knowing ‘what you’re going to be like’ (Study 7), demonstrating an uncertainty about her future identity. External factors such as the use of coercive interventions created a loss of identity and self-worth:

'It leads to an absolute inferiority complex, I have the feeling that I am not worth talking to other people, already thinking that I am not worth it, well, we can say destroying my personality’. (Study 14)

3) ‘I felt terrified’

In contrast to experiences of sanctuary, being detained against someone’s will was described as ‘going to hell’ (Study 12). Many participants experienced ‘fear’ when in contact with the police and they believed that they were going to inflict harm or kill them. In study six, the ‘unprofessional demeanour’ of the police worsened their paranoid beliefs and distress. Being in a prison and mixed wards contributed to distress. Interventions such as restraint and forced medication were terrifying for some:

‘I used to plead with them and plead with them (tearful), please don’t give me that …and of course that used to make me more crazy, because I didn’t know where to turn, I didn’t know what to do (crying)…the more bad I was, the more I knew I was going to be medicated, so the more crazy I got, because I was terrified’ (Study 7).
Side effects of medication were perceived as ‘life threatening’ (Study 7). Detention activated pre-existing feelings of vulnerability and powerlessness from abuse (Study 11) as it ‘took (them) back to (their)… childhood’ (Study 7). These emotive experiences are a result of their perceptions of harm and punishment (discussed later).

4) Fluctuating emotions

The emotional experience of ID varied between participants and across time. Most participants experienced powerful negative affect upon detention:

‘Well, anger, I was angry, I was angry. I was just f*** angry’ (Study 10).

These feelings remained for those who described a lack of person-centred and disempowering practice. Over time, arousal reduced as it ‘changed from paranoia to acceptance, from acceptance to relief, from relief to normality’ (Study 10). This change in emotion was mediated by practices which created a feeling of ‘sanctuary’. Some participants felt anxious when admitted, which changed to relief, and a resurgence of negative affect if they believed their length of stay was unnecessarily long.

Factors mediating experiences

Factors which mediate the above experiences are external to the person and are discussed under the themes of, ‘a continuum of person-centred practice’ and ‘you’re disempowering me’ and factors internal to a person are discussed under ‘intra-psychic coping’. Person-centred practice fostered experiences of ‘sanctuary’, which created trust in professionals, providing the foundations of a ‘therapeutic bond’ which enabled
‘acceptance’ and compliance and contributed to a more positive experience of ID. Opposite experiences contributed to experiences of ‘loss’, had a detrimental impact on the therapeutic bond, reduced compliance and contributed to an overall negative experience of ID.

5) A continuum of person-centred practice

Aspects of care fell along a continuum and within this, the following subthemes were derived from the data:

Working with me versus “steamrolling”

In five studies, there was evidence of collaborative working. This was largely orientated around medication changes. One participant explained that because he/she had a long history of being mentally ill he/she believed staff thought he/she ‘had enough knowledge and experience to input’ (Study 9). However, most of the participants experienced a lack of collaboration. Studies highlighted an unmet need for an advocate and participants did not even know what a care plan entailed (Study 12). Teams rarely informed participants about the reasons for detention (Study 6), participants were routinely excluded from ward rounds and decision-making and participants believed staff withheld information about the side effects of medication. These practices left participants ‘voiceless’.

Connecting and disconnecting practices

Across five studies, participants described caring characteristics of clinicians which initiated trust. Clinicians ‘being there’, ‘showing interest’ and clinicians who ‘took the time to listen’, had ‘one-to-ones’ (Study 4) and those who had a ‘good understanding of people’, were ‘enthusiastic and responded flexibly to individual circumstances’, ‘created
a good atmosphere’, talked in a ‘soft voice’, ‘look (you) in the face’, ‘want to help’, ‘do not just say that it is your own responsibility’ and followed through with promises helped to foster a trusting relationship (Study 9).

On the contrary, participants experienced clinicians as different due to their knowledge and professional expertise because ‘they would never know what it is like to be at the bottom of the heap’:

‘They’re intellectuals who are theorizing well you know, out of touch with reality or normal reality because you know middle class or whatever, they don’t know what ordinary people, my sort of level and their (patients) sort of level, are like’ (Study 9).

Participants experienced some clinicians as ‘detached’ because they ‘consider things from a scientific basis too much’ (Study 9) which restricted their understanding of the personal experience of mental illness. Clinicians failed to talk to participants, ‘explore where (his/her) fears came from’ which increased agitation and participants were then ‘instantly put on drugs’ (Study 14) or restrained. Some staff were seen as ‘just doing their job’ and more concerned with following procedures than ‘what the individual really needs’ (Study 7). A team was seen as ‘authoritative’ and ‘indifferent’ which evoked feelings of loneliness for participants (Study 4). Some participants described being abandoned by staff, left alone and ‘kept in storage’ which was perceived to be an active attempt by staff to make them passive (Study 1).

I am a ‘person’ versus I am an ‘illness’

The following subtheme goes beyond the previous. Participants experienced being treated ‘normally’, as an equal, with an identity as somebody other than ‘a patient’, with an ‘illness’. Clinicians being in communal areas and doing joint activities (Study 4) and staff
having ‘normal conversations’ over ‘normal activities’ and ‘having a laugh’ were a
distraction from their mental distress (Study 3). Part of being treated ‘not just as a patient’
involved an element of self-disclosure on the part of clinicians whilst also portraying a
sense of being ‘mentally healthy’ themselves (Study 14), which entailed the suppression
of difficult emotions (Study 6). In contrast, there was evidence across the studies that
participants when involuntarily detained were not treated as a ‘human being’ but rather as
an ‘illness’ and therefore they were not taken ‘seriously’ (Study 3). When participants
tried to resist treatments that were being imposed on them, they were put in seclusion and
one participant described being treated as an object:

‘Doctors were in and out, checking on you, not even paying you a second notice’ (Study
10).

Some participants felt clinicians infantilised them because they ‘treat (them) like a child
first of all and then they treat (them) as if (they’re) totally mad in the head’ (Study 10).
Participants described a lack of normal conversations and one participant described how a
staff member failed to acknowledge them outside of the hospital setting. This was
experienced as a rejection, making participants feel ‘sad’, reminding them of their
‘subordinate position’ as a patient (Study 3). The experience of being treated in this way
compounded a loss of their identity.

6) You’re disempowering me

Many studies described practices where professionals were perceived to exploit their
power (Study 3) which invoked the emotional response ‘I felt terrified’. Participants
believed they were being punished when arrested by the police (Study 13) and there was a general lack of communication and participants were felt forced into having medication.

‘I eh refused to take it at first . . . and then they came round with their heavies to try and inject me and then I stuck out my hand and took it’ (Study 10).

Some participants believed they were being raped (Study 7) and others that they were going to die (Study 8). These practices went beyond a lack of collaboration to being perceived as punitive. Participants described personal boundaries being violated (e.g. ‘dragged into the shower’) and felt pressured to comply with the rules of the ward which participants believed were enforced in order to create a power difference between participants and staff (Study 1). The rules were interpreted as rigid and inflexible and communicated in a commanding way. They were perceived as a threat to their liberty and freedom of choice and a way of creating behaviour change and compliance but neglected aspects of the participant’s emotional world (Study 1). Participants had to wait for basic things, such as going for a walk (Study 3) and the removal of furniture, for safety purposes, left them feeling punished (Study 7). The strict rules and routines created a ‘power struggle’ with staff (Study 4) and some participants responded by ‘fighting back’.

7) **Intra-psychic coping**

Participants’ coped with ID in various ways which are captured under the following subthemes. These responses mediated their relationship with clinicians, their experience of ID and influenced the perceived speed of discharge and recovery.
**Fighting back**

Some participants described ‘fighting the system’ when acutely unwell, when they believed ID was unnecessary and when they perceived a lack of person-centred and disempowering practices. Participants attempted to gain power by ‘complaining to get out’, ‘causing trouble to the staff’ (Study 10), ‘objecting to the care given’ (Study 1), not going ‘with the flow’ and ‘putting up a barrier’ to being helped by being aggressive:

‘I was very aggressive, I was very abusive. That was probably in this environment that I was in [...] I did say to them, if you treat me like an animal, then I’ll act like an animal. Why are you doing this, to me? You know, because I was acting, totally out of character’ (Study 7).

**Acceptance**

Some participants accepted ID which led to an experience of sanctuary. These participants characteristically perceived staff as ‘experts’ and were happy for doctors to take control and make decisions, on their behalf (Study 9). They embraced activities on the ward and some re-established goals to ‘live (their) own life’ (Study 4). This resulted in an intrinsic change and ‘drove’ participants to ‘stick by the rules’, which resulted in an acceptance of personal responsibility over their behaviour. The presence and attitudes of friends and family who ‘convinced (him/her) that (they) needed help’ (Study 7) mediated acceptance.

**Developing a ‘model patient’ role**

Some participants ‘cooperated and played the game’ by becoming an ‘exemplary patient’ which is a coping strategy that is learned over time and of being admitted:
'I had little plans to work my way through the day . . . I used to clean my room, and make my bed and try to occupy myself with activities, that were per se, done by everybody else in the community in their normal lives’. (Study 7)

This participant believed that this strategy enabled him to be discharged quicker. One participant remarked that being a ‘good patient’ led to less direct coercion from the staff and led to ‘getting (his) freedom back’ (Study 5). In contrast, participants who had been on the ward for a significant length of time adopted an ‘ill patient role’. They portrayed themselves as ‘sick and helpless when staff were present’, however, they were ‘lively and happy when they were absent’ as one person explained, ‘some of them had opinions about everything’.

**Avoidance**

Some participants coped by using avoidant strategies. One common avoidance strategy was to sleep most of the day to pass the time (Study 1). Some participants who had been discharged from a section actively tried to repress their experiences:

‘I don’t want to talk about or remember it, and when I realise in a dialogue that the other person is affected as well and might find it burdensome, then it is even worse. Usually I don’t think about it anymore because I don’t want to remember, same with regular psychiatric hospitalisations’ (Study 14).

This strategy was an attempt to avoid painful reminders, memories and emotions of the negative and coercive experiences. Some participants did not want to incorporate the experience into their sense of self. This was described in one study as a ‘sealing over’ style (Study 10). Some participants kept ‘quiet about it’ (Study 14) in an attempt to avoid further rejection by friends.
Discussion

This paper set out to build on a previous review and explore participants’ experiences of ID, whilst also investigating how factors such as participant’s characteristics, thought processes and treatment experiences mediate differences in participant’s experiences. Seven overarching themes emerged from the synthesis of fifteen studies illustrating positive experiences and negative experiences, and factors which mediate these experiences. Each of the participant’s experiences varied, and their thought processes and emotions changed over time; therefore, to capture the complexity of the findings, the questions are answered collectively below.

All participants reported not wanting to be detained and feeling angry upon admission. However, some participants began to experience detention as a sanctuary to recover from everyday life, which is a theme that has been found in a mixed sample of voluntary and involuntary admitted participants (Johnannson, 2009). Participants who believed detention was necessary, were participants who felt under threat in their home environment. Other participants recognised they were self-destructive and were happy for professionals to take control. They believed that structure and routine helped create a sense of sanctuary which is a finding supported by previous research (Moses, 2011). Humane aspects of care was a theme similar to those which emerged in Katsakou and Priebe’s (2007) review, and include factors which promote a more positive experience of detention. Psychodynamic theory may be applicable here. These practices have arguably resulted in participants having their emotional communications received and attended to by an “attuned” staff member (a term introduced by Stern, 1985) leaving people feeling ‘contained’ (Bion, 1962), reducing arousal. The attunement and how staff interacted with
a person may map onto the ‘nonspecific’ or ‘relationship factors’ which enables the
formation of what Orlinsky, Grawe and Parks (1994) termed the ‘therapeutic bond’
between a patient and a clinician. This review found, and in accordance with Bordin’s
(1994) view, that ‘attuned’ relationships increased compliance and in this review the
relationship enabled toleration of medication and mediated acceptance of their situation.
The importance of the therapeutic relationship in providing a safe and therapeutic milieu
for patients has been documented elsewhere (Gilburt, Rose & Slade, 2008).

To answer question two, some participants were ambivalent about their experiences of
ID. These participants retrospectively recognised how self-destructive and acutely unwell
they were, and they believed that ID was necessary to maintain their safety and enabled
them to be ‘restored back to normality’. Simultaneously, they experienced a loss, both of
their perceived independence (because they worried about the impact on their business,
stigma and employment) and of their identity. These participants believed that the length
of their ID was unnecessary which resulted in a resurgence of negative effect.

Negative experiences of ID were mediated by several factors. The lack of person-centred
practice reflect similar findings to Katsakou and Priebe's (2006) review. Participants also
reported practices which disempowered them and various forms are discussed in the
literature (see Laugharne and Priebe, 2006). These practices were distressing for some
participants, which fits with existing literature outlined in a review by Berry, Ford,
Jellicoe-Jones and Haddock (2007). The role of attribution and perceptions of punishment
mediated these experiences, and participants who had been arrested and/or detained on
several times experienced less distress. It makes sense why participants with a history of
abuse were most distressed as they may already hold pre-existing beliefs about harm and punishment. Many participants were diagnosed with a psychotic disorder so it could that the nature of their illness made them more vulnerable to these interpretations. In line with self-determination theory (Deci & Ryan, 2002), ‘fighting back’ may be an attempt to develop some autonomy – a basic psychological need; however, this response and the use of coercive interventions to control behaviour concurrently eroded the therapeutic bond, resulting in a negative impact on recovery and speed of discharge.

**Implications**

This study has many implications for clinical practice and research. The theme ‘a continuum of person-centred practice’ suggests at times services may be failing to operate in line with person-centred approaches which are advocated by policies such as Mental Health and Wellbeing in Europe: A Person-Centred Community Approach (2011) and Making Recovery a Reality (2008). This is a key mechanism for change and the work of Repper and Perkins (2003) illustrate how services can be reconstructed. The meta-synthesis suggests that services need to be ensuring participants are adequately informed about every aspect of their admission and treatment when detained, thus increasing perceived choice and control, which is important for recovery. Collaborative working is paramount as well as ensuring clinicians are relating to participants as a ‘person’ rather than an ‘illness’. The finding ‘connecting and disconnecting practices’ suggests that clinicians need to be developing and maintaining skills in the non-specifics of a therapeutic alliance: empathy, compassion and unconditional positive regard because these skills would help meet participants emotional needs, help them feel ‘contained’ when they are in acute mental distress and help to build a ‘therapeutic bond’. In line with
a person-centred recovery approach, services should seek to develop and maintain a person’s identity throughout the process of ID for example, introducing and promoting recovery activities to reduce the experiences of loss of normality and perceived independence which has been suggested to be a key process in recovery across a variety of mental illnesses (Young & Ensing, 1999). Future research could explore the impact on participants’ emotional experiences and outcomes of treatments.

The finding ‘you’re disempowering me’ and ‘I felt terrified’ together suggest coercive interventions such as restraint and forced medication need to be addressed. Police may need more training about how to engage and manage someone who is in acute distress who may hold beliefs that they are being punished and harmed. The finding that distress is mediated by factors such as a person’s history, attributions and coping style, suggests that further research into these mechanisms is recommended and such factors need to be assessed and considered when thinking about the use of coercive interventions. This could be done when developing care plans and through ‘advance statements’ (Rethink, 2010), in collaboration with a patient. Importantly, the synthesis does illustrate that such interventions need to be reduced. Borckardt, Madan, Grubaugh, Danielson, Pelic, Hardesty and Frueh (2011) described and evaluated an ‘engagement model’ which could be applied across settings. Future research would need to evaluate the impact on participants’ perceptions of hospitalisation and outcomes. Considering the evidence that distressing experiences in hospital reduces participants’ willingness to engage with treatment in the future (Grunbaugh, Frueh, Zinzow, Cusack & Wells, 2007), improving patient experiences is vital.
**Strengths and Limitations**

This review represents the views of 254 participants, from a variety of countries, across a wide range of ages, with a broad range of diagnoses and provides an explanation and interpretation of experiences of being detained. This broad sample allows for reliable, general application to other contexts. The studies were cross-sectional, thereby restricting our understanding of how participants’ views and experiences change over time and indicates an important area for future research. Some studies did not match the quotations with the participants making it difficult to identify people’s characteristics and interpret their views; therefore, it would be useful for research to explore this specifically. The findings also mirror literature on inpatient experiences in general, rather than people who specifically have been detained involuntarily. Qualitative research could be carried out in samples of voluntary and involuntary participants to compare similarities and differences between the two groups and these ideas for future research may have different treatment implications. Lastly, research for the studies would have been carried out earlier than the publication date, meaning that services could have changed.

**Conclusion**

This meta-synthesis set out to articulate a conceptual framework to improve our understanding of the experiences of ID. A person’s social circumstances, specific mental health practices and the clinician-patient relationship affects participant’s experiences. How participants reflect on their experiences and cope with being detained influences the treatment they receive and ultimately impacts on their overall experience. Improving person-centred care, introducing a recovery approach and developing interventions to
reduce the need for coercive interventions may all help to improve the participants’
experiences and outcome of treatment.
References


http://rethink.org/living-with-mental-illness/rights-restrictions/advance-statements-planning-for-the-future/legal-status


Experiences of Detention under the Mental Health Act for Adults with Anorexia Nervosa

This paper has been prepared for submission to European Eating Disorders Review and accords with the necessary guidelines (appendix 6)

Word Count (excluding tables, figures and references): 6237
Abstract

People with Anorexia Nervosa are often resistant to treatment and can be detained under the Mental Health Act. Detention can be distressing for some client groups; however, there is little research to explore how people with Anorexia Nervosa experience detention and how these experiences impact on recovery. This study utilised a qualitative methodology to develop a model for understanding how people perceive, experience and process detention under the Mental Health Act. Data from twelve participants were analysed using constructivist grounded theory. Four overarching categories conceptualise their experience over time: ‘the battle’, ‘the bubble’, ‘stepping out of the bubble’ and ‘the anorexic self’. Within each overarching category are further subordinate categories which represent the nuances of the data. The resultant model is discussed in relation to the literature whilst recommendations have been made to embed person-centred, recovery practice into inpatient services.

Keywords: detention, mental health act, qualitative, anorexia.
Introduction


There is limited published research exploring the experiences of detention for AN. Colton and Pistrang (2004) interviewed adolescents with AN and an interpretive phenomenological methodology revealed the following themes: feeling uncared for by staff, isolated by family and a lack of collaborative working. Participants resisted treatment when they felt restricted and punished and this was linked to the transtheoretical stages of change model (Prochaska & DiClemente, 1982). Studies exploring experiences of inpatient treatment, irrespective of their legal status, have revealed similar themes as well as: a lack of attention to emotional needs (Tierney, 2008) and individualised treatment (Tierney, 2008; Offord, Turner & Cooper, 2006), restrictive, punitive and controlling practices (Offord et al, 2006; Colton & Pistrang, 2004), a ‘suspension of real life’ (Offord et al, 2006) and difficulties in decision-making upon discharge (Offord et al, 2006; Colton & Pistrang, 2004). Conversely, safety and containment, holistic treatment (Offord et al, 2006) and collaborative working (Offord et al, 2006; Colton & Pistrang, 2004) have also been found. These themes reflect mixed experiences of actual, or perceived coercive and non-coercive practices.
The purpose, legal regulation, justification and best practice in the implementation of the MHA is a controversial legal, political and ethical issue. The MHA (1983/2007) is underpinned by the code of practice and is monitored (in England) by The Care Quality Commission. However, there is some evidence that detention is distressing and is associated with trauma symptoms in participants with psychosis (See Berry, Ford, Jellicoe-Jones and Haddock, 2013) which may parallel experiences for participants with AN when prevented from starving themselves.

**Rationale**

Often the voice of the service user (SUs) is lost in research and little is known about the impact of being detained on the individual or their AN. Service-users’ experiences are high on the government agenda (NICE, National Institute Clinical Excellence, 2011) and are pivotal to the improvement of services. Therefore, a qualitative approach was chosen to explore the experience of detention under the MHA for AN. Data were collected from participants under the care of, or discharged from the MHA to explore:

1. How does perceived care influence perceptions of recovery?
2. To what extent is perceived coercion experienced as traumatic and how does this influence participants perceptions of recovery?
3. To develop a theory/model for understanding how participants perceive, experience and process detention under the MHA.
Methods

Recruitment procedure

Ethical and Governance approval was obtained from the NHS and University committee (appendix 7). Purposive sampling was employed to recruit twelve participants who met the following inclusion criteria: aged 18 and over, who had been detained under a detention 2 or 3 of the MHA with a diagnosis of AN (according to the ICD-10 criteria) within the last 10 years, detained participants with a Body Mass Index (BMI) < 17.5, English speaking and judged to be both mentally and physically well enough to participate.

Recruitment spanned the period June 2013 to May 2014. Sites included one NHS inpatient service, one NHS outpatient service and one private inpatient unit, across the North of England. A nominated clinician identified and provided potential participants with an information sheet (appendix 8) and an advert was placed on an eating disorder charity website (BEAT) and in nominated inpatient wards (appendix 9). A demographic questionnaire (appendix 10), the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983) and the Eating Disorder Examination questionnaire (EDEQ; Fairburn & Beglin, 1994) were completed to locate the context of the sample (Charmaz, 2006) and pre- and post-interview consent forms were collected (appendix 11).

Interview schedule

A ‘semi-structured’ interview format was chosen to enable findings to be followed up. Topics were influenced by research literature, the stages of detention and psychological
theory. A schedule was piloted with a fellow trainee psychologist and the schedule was shortened. After interview 3, the schedule was altered to develop the properties of the categories, allowing for saturation of data. Table one illustrates example questions (see appendix 12 for the full interview schedule).

Table 1. Example questions

<table>
<thead>
<tr>
<th>Topic area</th>
<th>Example questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening and pre-admission</td>
<td>Can you describe what was going on in the lead up to your last compulsory detention?</td>
</tr>
<tr>
<td>Specific aspects to treatment</td>
<td>What thoughts were going through your mind? How did this make you feel? How did this impact on you at the time? And now?</td>
</tr>
<tr>
<td>restricted exercise</td>
<td></td>
</tr>
<tr>
<td>The discharge process</td>
<td>For some people, they have been detained involuntarily numerous times. What has that been like for you?</td>
</tr>
</tbody>
</table>

Participants

Twenty-one people contacted the research team. Twelve took part; three were recruited from the private inpatient unit, one from the NHS inpatient ward and the remaining through BEAT. Nine people expressed an interest in participation but declined when asked for a postal address. Two individuals returned their questionnaires but ceased further contact. Demographic information is presented in Table 2 using pseudonyms to protect confidentiality. Some participants chose not to disclose all information.

Participants reported high levels of anxiety compared to depression with the exception of Sarah and Grace who had been discharged for a long time. Grace had the lowest EDEQ score demonstrating a sustained recovery and is the only participants who reported being detained on one occasions. The remaining participants reported being detained on numerous occasions (both voluntary and involuntary) and scored highly on the EDEQ.
(particularly Olivia, Silvia and Kathy and the inpatients) illustrating AN symptoms. None of the participants were employed full-time at the time of the interview demonstrating potential difficulty in functioning. The majority of the participants described themselves as single. One participant interviewed as an inpatient reported being married; however, she had a long history of lengthy periods of inpatient treatment spending significant amounts of time out of her family environment. Participants varied in age from 19-55 and therefore they were inevitable in various life stages across the life span with differencing expectations, responsibilities and psychological challenges. Many participants reported that their admission was triggered by concerns raised by a family member.
Table 2. Demographic information

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Relationship status</th>
<th>Employment status</th>
<th>Admissions</th>
<th>Time since last discharge</th>
<th>EDEQ score</th>
<th>HADS score</th>
<th>Body Mass Index (BMI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah</td>
<td>33</td>
<td>Partner; living separately</td>
<td>Home duties</td>
<td>Involuntary (6) Voluntary (6)</td>
<td>14 years</td>
<td>SC (4.5), WC (2.8), RC (3), EC (3.2) GLOBAL (3.38)</td>
<td>A (2), D (0)</td>
<td>18.4</td>
</tr>
<tr>
<td>Jane</td>
<td>23</td>
<td>Single</td>
<td>Unemployed</td>
<td>Involuntary (3) Voluntary (7)</td>
<td>&lt; 2 years</td>
<td>SC (4.63), WC (3.4), RC (0.8), EC (2.8) GLOBAL (2.9)</td>
<td>A (10)</td>
<td>17</td>
</tr>
<tr>
<td>Olivia</td>
<td>34</td>
<td>Single</td>
<td>Part-time, sporadic</td>
<td>Involuntary (1) Voluntary (4)</td>
<td>2 years</td>
<td>R (5), WC (6), SC (5.25), EC (6) GLOBAL (5.56)</td>
<td>A (19), D (5)</td>
<td>15.5</td>
</tr>
<tr>
<td>Silvia</td>
<td>43</td>
<td>Single</td>
<td>Part-time</td>
<td>Involuntary (1) Voluntary (1)</td>
<td>2 years</td>
<td>SC (5.8, WC (5.8) RC (5.8), EC (5.8) GLOBAL (5.8)</td>
<td>A (16), D (16)</td>
<td>20</td>
</tr>
<tr>
<td>Sophie</td>
<td>33</td>
<td>Single</td>
<td>Home duties</td>
<td>8</td>
<td>1 year</td>
<td>SC (4) WC (3.4) RC (4.2) EC (3.2) GLOBAL (2.7)</td>
<td>A (9), D (4)</td>
<td></td>
</tr>
<tr>
<td>Marie</td>
<td>19</td>
<td>Single</td>
<td>Part-time</td>
<td>Involuntary (4) Voluntary (4)</td>
<td>&lt; 6 months</td>
<td>SC (5.38), WC (5.4), RC (4.2), EC (2.6) GLOBAL (4.4)</td>
<td>A (15), D (13)</td>
<td>14.5</td>
</tr>
<tr>
<td>Grace</td>
<td>23</td>
<td>Long-term Relationship</td>
<td>Part-time</td>
<td>1</td>
<td>&lt; 5 years</td>
<td>SC (1), WC (2.8), RC (0.4), EC (0.2) GLOBAL (1.1)</td>
<td>A (9) D (4)</td>
<td>22.2</td>
</tr>
<tr>
<td>Kathy</td>
<td>20</td>
<td>Single</td>
<td>Unemployed</td>
<td>Involuntary (2) Voluntary (2)</td>
<td>&lt; 1 year</td>
<td>SC (6), WC (6), RC (6), EC (6) GLOBAL (6)</td>
<td>A (20), D (16)</td>
<td></td>
</tr>
<tr>
<td>Anna</td>
<td>55</td>
<td>Married</td>
<td>Unemployed</td>
<td>Long history. Last 4 years: Involuntary (2) Voluntary (2)</td>
<td>Inpatient</td>
<td>SC (5.75), WC (5.6), RC (4.8), EC (2) GLOBAL (4.54)</td>
<td>A (19), D (13)</td>
<td>16.4</td>
</tr>
<tr>
<td>Emma</td>
<td>18</td>
<td>Single</td>
<td>Unemployed</td>
<td>Involuntary (4) voluntary (1)</td>
<td>inpatient</td>
<td>SC (5.62), WC (5.6), RC (4.8), EC (4.2) GLOBAL 5.06</td>
<td>A (20), D (12)</td>
<td>&lt;15</td>
</tr>
<tr>
<td>Becky</td>
<td>27</td>
<td>Single</td>
<td>Unemployed</td>
<td>20</td>
<td>inpatient</td>
<td></td>
<td>A (16), D (13)</td>
<td>15.7</td>
</tr>
<tr>
<td>Michelle</td>
<td>32</td>
<td>Single</td>
<td>Part-time</td>
<td>Involuntary (1) Voluntary (4)</td>
<td>Inpatient</td>
<td>SC (5.38), WC (5.2), RC (4.4), EC (3.6), GLOBAL (4.65)</td>
<td>A (18), D (13)</td>
<td>15.1</td>
</tr>
</tbody>
</table>
Interview procedure

Participants were interviewed for between 35 and 75 minutes by the first author and the interviews were audio recorded. Interviews were transcribed verbatim. Six were transcribed by the author and the remaining six were transcribed by an independent transcriber however transcriptions were checked by the author for accuracy, improving methodological rigour. Identifiable details were omitted during transcription. Eight interviews were conducted over the telephone, the remaining were face-to-face and participants were asked if they were happy for the data to be used. The author’s reflections were recorded in a journal after each interview. A distress management protocol was devised; however, it was not needed (appendix 13).

Data analysis

Grounded theory was chosen because analysis and collection of data occurs simultaneously to follow ideas and explore concepts in depth. It offers a theoretical understanding of experiences of detention in AN, which is a useful addition to the literature. This we hope would generate further interest, which in turn will increase our understanding of this area. A social constructivist perspective was incorporated because it recognises the role of the researcher in the analysis and interpretation of the data and how theory and meaning are socially co-constructed (Charmaz, 2006).

The analysis followed a systematic set of procedures explicated by Charmaz (2006) -line by line coding categorised, summarised and accounted for each piece of data. The researcher remained attentive to similarities and differences in the codes and analytic and theoretical reflections were recorded as ‘memos’. The most theoretically significant codes
were selected, grouped into categories and given conceptual definitions (i.e. ‘focused coding’). Categories were built into conceptual models through ‘constant comparison’ and ‘continued questioning’. This explained the relationships between the categories and the conditions under which it operates and changes - ‘axial coding’. Memos were sorted and integrated to develop theoretical links between categories. See appendix fourteen for an example of coding.

Credibility
To ensure credibility, Elliott, Fischer and Rennie’s (1999) guidelines were followed. The research team met regularly to discuss the data analysis and two researchers cross-checked the coding on two transcripts. No significant discrepancies were noted: codes were refined and memos were elaborated.

Reflexivity
In line with constructivist grounded theory and Elliott et al’s (1999) guidelines, the researchers’ backgrounds have been made explicit for readers to assess any influence on the study. The primary author carried out the research as part of her clinical psychology doctorate training. She is interested in complexity and attachment theory. Social constructionist, cognitive behavioural and systemic approaches inform her thinking. Authors JF and KB have extensive experience in working with complex mental health problems and they have years of research experience.

Results
Prior to being detained, some participants were withdrawn whilst others were actively focused on pursuing other goals (for example, PhD, working). All participants described
struggling emotionally with the stress of day-to-day and described a strong anorexic identity. Some described conflict over service provision and feeling ‘passed around’ like a ‘bag of luggage’ resulting in inappropriate service provision (for example, treatment on a general ward). The analysis revealed four overarching categories conceptualising the experience of being detained over time: ‘the battle’, ‘the bubble’ and ‘stepping out of the bubble’. ‘The anorexic self’ is pertinent across time. Each ‘overarching category’ has further ‘categories’ and some ‘subordinate categories’. Quotations illustrate the findings and a diagrammatical illustration is presented in figure 1. The processes linking the categories are explained in the main body of the text.
Figure 1. Diagrammatical illustration of the findings

Re-emergence of anorexic symptom, deterioration and increased risk of relapse

THE BATTLE (between ‘us and them’ i.e. participants and staff)
- I don’t feel like a person
- Opposites, catch 22 and conflict
- I am powerless
- Not ready for change
- Digging my heels in

Turning points: cognitive realisations and compliance

THE BUBBLE (Safety, attachment and dependence on the inpatient unit)

STEPPING OUT OF THE BUBBLE (challenges and outcomes of discharge)
- Spiralling downwards
- Getting my life back on track
- Sustained recovery

THE ANOREXIC SELF (how the anorexic identity is experienced across time)

Detained under The MHA

TIME

Sustained recovery

62
THE BATTLE

‘The battle’ is as an overarching category which incorporates five categories: ‘opposites, catch 22 and conflict’, ‘digging my heels in’, ‘I am powerless’ and ‘I don’t feel like a person.’ These represent factors which disrupt the therapeutic alliance, resulting in a battle between ‘us and them’.

Opposites, catch 22 and conflict

Upon admission participants experienced ‘opposite’ and internally conflicting thoughts and feelings about being detained leaving them in a ‘catch 22’. Many realised they were ill only when their body had failed them (for example, organ failure) because they ‘trusted (their) body rather than (their) head’. Participants felt ‘saved’, perceiving services as taking control, removing responsibility and granting ‘permission’ to recuperate. Concurrently, everyone felt angry upon detention, particularly when they believed they had been re-detained more readily due to past history of detention. If they were physically functioning, they were ‘in shock’ the MHA had been implemented and believed it was unnecessary, perceiving themselves as not ‘ill enough’. Ambivalence resembles the precontemplative stage in the transtheoretical model of change (Prochaska & DiClemente, 1982), resulting in processes such as cognitive dissonance (Festinger, 1957) and anxiety. Upon admission (and throughout treatment), most of the participants described being in conflict with the service (for example, regarding target weights/goal setting, beliefs about AN and inconsistent practice). Conflict resulted in internal distress exacerbated by cognitively distorted and inflexible thought processes and confusion due to low BMI. This conflict fuelled participants’ frustration and they responded by ‘digging their heels in’.

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Digging my heels in

Participants responded to the conflict by rebelling. This discourse was particularly prominent from inpatient interviewees who were tube feeding. Participants ‘stood (their) ground’, went ‘crazy’, would ‘hide the medication or purge it’ (Kathy), ‘hide... to like try and avoid’ staff and wait for the ‘opportunity to run away’. Becky described ‘ripping (her) NG tube out 11 times’. They described subtle ways of trying not to get ‘found out’ for example, hiding food. Kathy refused to engage with groups to ‘get back at the team’ and would tell staff she was regurgitating feeds or secretly exercising because she was ‘proud’. Services responded by implementing increasingly restrictive interventions (i.e. tube feeding, restraint and forced medication), alongside disempowering and less person-centred practices (discussed below), thereby creating a dichotomy between ‘us and them’, similar to in-group/out-groups processes in social identity theory (Tajfel, 1982), reinforcing the rebellion.

‘I am powerless’

This category illustrates how perceived treatment practices disempower participants and comprises of three subordinate categories: ‘just a puppet’, ‘I feel punished’ and ‘fear’:

- ‘Just a puppet’

Across the interviews, participants felt they were passive recipients of the MHA. Services failed to inform and be transparent about the process and implications of detention:

Grace: ‘I just thought it was something that ... I was kind of being made to do. So I didn’t realise up until they spoke about being detained that I was there voluntary’.
There were many examples of non-collaborative working. Grace illustrated that ‘there was never like a discussion about how (she) felt about going to (hospital) and whether (she) wanted to or not...and when (she) was there they told (her) they were gonnadetain (her)’. Kathy described how she ‘wouldn’t have a say in what medication (she would) be willing to try’. Decisions were perceived as unchangeable (Sophie). These experiences were perceived to be more apparent when participants were under the MHA compared to times when they were not under the MHA, and had a negative impact on self-esteem (Kathy).

- ‘I feel punished’

Participants believed that when they were under the MHA, the decision to impose restrictive interventions was made easier than when they were not under the MHA. They experienced feeling ‘guilty unless proven innocent all the time’ (Marie). One participant described building a relationship with staff and then in ward rounds, finding out they had accumulated evidence which she felt was then used against her. Participants experienced feeling ‘dictated to’, ‘told off’, ‘like a child’ and ‘watched like a hawk’ when on a section (Emma). Rules were seen as rigid and unable to be maintained in the ‘real world’. One-to-one experiences were experienced as punitive when undertaken by staff who they ‘never felt cared’.

Many participants felt ‘blackmailed’, even though for some they knew it was not the reality. When voluntarily treated, participants reported that the MHA was used as a threat to increase compliance. Marie felt blamed when on a detention. Jane worried about having a ‘slip up’ because she predicted she would be punished. One male staff member who worked nights was experienced as ‘cruel’ and on a ‘power trip’:
Marie: ‘if you couldn’t sleep, they might refuse that (medication)... ’you should have asked before, I’m not going to give it to you now’.

This staff member would ignore Marie when she knocked on the staff door. Grace described how a staff member tried to ‘physically...force this drink down (her) neck’ and reported ‘you wouldn’t treat an animal like that’. Participants described feeling like a ‘second class citizen’ and a ‘nobody’.

- Fear

Specific interventions such as restraint, force-feeding and forced medication were perceived as punishment and were terrifying because it was ‘forced upon’ them. It was particularly terrifying the first time they were implemented. Emma said that she did not ‘have the words to explain’:

‘...the first two times that I got one put in it was really, really traumatic...and as well it was quite...traumatic again, you know like ... having the feeds because it was like being force fed’.

When forcibly medicated Sarah felt ‘scared, and a real, real, real, terror,’ she recalled ‘not feeling anything, being numb, and then waking up and feeling really frightened and angry’. The fear increased resistance to such interventions. For some participants these perceived experiences re-affirmed pre-existing negative beliefs about being ‘a failure’, ‘bad’ and ‘deserving the punishment’.

‘I don’t feel like a person’

Subsumed under this category were two subcategories: ‘you never felt they cared’ and ‘reductionist attitudes’; factors which took away the participants’ personhood,
disempowered participants and had a negative impact on the therapeutic alliance. These perceived practices mediated the extent to which individuals ‘dug their heels in’, reinforcing the ‘anorexic self’.

- ‘you never felt they cared’

Participants described characteristics of some staff and their practices which neglected their emotional needs and left them feeling uncared for. Staff failed to follow through with promises and ‘asked quick questions about how (they were) feeling, ...It was like they had it on their sheet and they had to ask it’ (Sarah). Ward rounds were intimidating and likened to ‘being in an exam’. Care plans felt depersonalised ‘technical and impersonal’ about ‘how they can restrain you’ (Sophie). Marie illustrated how she had been actively dismissed by staff:

‘you’d be knocking on like the staff door, erm, .. and they’d sometimes just say, oh it’s you, it’s you, go away... or they’d just ignore you’.

Sarah explained that staff did not encourage her during mealtimes making her feel ‘like a freak a, nothing freak. Like under inspection’. Non-permanent staff were experienced as particularly uncaring and disinterested in their lives.

- Reductionist attitudes

Most participants described clinicians as attributing participants’ feelings and behaviours to having a ‘mental illness’. Grace described her identity being reduced to an illness ‘like someone who was just a person with anorexia’. When under the MHA, normal requests were pathologised as a symptom of illness (for example, not wanting to watch the same communal programme and preferring to spend time in their bedrooms was viewed as withdrawal). Emotions were pathologised:
'If you lost your temper or got upset, you were a risk then, like that was your, well you know you’ve blown it now because you know you wouldn’t be allowed out now anyway, not in that state’. (Marie)

This quotation illustrates that potentially time out was restricted because of their emotional behaviour. This could conflict with NICE (2004) guidelines which outline that behavioural regimes should not be used in the treatment of AN. The memos illustrate that being under the MHA in itself, and the more times they had been detained, the more their difficulties were medicalised and the more staff based their decision making on the participant’s past behaviour, providing evidence of the depersonalisation of participants (Prosser, Johnson, Kuipers, Dunn, Szmukler, Reid, Bebbington&Thornicroft, 1999)

THE BUBBLE

‘The bubble’ alludes to relief participants feel when detained and their attachment to the inpatient unit and other participants who were described ‘like a family’. This was more apparent for participants with repeated experiences of being detained and emerges over time. Factors which create this experience of attachment are captured under: ‘turning points’ which illustrate the cognitive changes that mediate compliance, ‘I feel cared for’ and ‘loss’.

Turning points

Across all the interviews, participants described ‘wake up calls’ which stopped the cycle of ‘the battle’. They realised how ‘trapped’ they were, in a ‘black hole when there is nothing you can do or say to get out of it’. Kathy realised ‘they had all the control’ and some with repeated experiences of being detained were ‘too tired to fight’, which led to
hopelessness and resentment. Similarly, Becky started to feel depressed and others with no discharge date lost hope. They gave up resisting, illustrating a process of learned helplessness (Maiser & Seligman, 1976). Participants also realised that digging their heels in was ineffective in getting their needs met. Michelle who was on a ‘risk reduction programme’ realised that staff were working alongside her and she felt they understood how difficult it was, setting goals perceived as achievable. Turning points were unique to the individual and mediated compliance. Participants aimed to ‘eat their way out’ and described several ways they put on a ‘false face’. Participants like Marie learned to ‘hide (their) feelings all the time’, ‘just pretend to be alright’, ate, took medication and presented as articulate in ward rounds. Others made a choice to ‘get on with it’, ‘pick (themselves) back up’ (Becky) and ‘turn it around’ recognising that AN did not control them. This conflicted with many of the participants who said that anorexia ‘is not a choice’. Many like Becky started thinking about the things she missed out on from being detained and renegotiated her life goals. It is hypothesised in the memos that these participants had reached the perceived bottom line (discussed later). Regardless of the motivation, compliance meant that everyone started recovering both physically, as their weight increased and cognitively, because they felt ‘different in (their) heads’ as thinking became more rational.

**I feel cared for**

In contrast with examples under the categories ‘I am powerless’ and ‘you never felt they cared’, some participants felt cared for by some staff because they listened, were empathic, treated participants equally and were non-judgemental. Michelle felt particularly cared for and understood by all staff when under detention. Participants felt
‘protected’ and ‘less alone’ with these staff (Sarah). In contrast to ‘reductionist attitudes’, some participants felt that staff saw their personality, interacted with them ‘normally’ and shared details of their personal lives. The memos illustrate that this helped participants keep in touch with those aspects of the self that had been lost by being detained and anorexic. These practices fostered trust and a therapeutic alliance which instilled motivation towards recovery.

Loss

Loss of former friends, a normal life, life skills (due to AN, but also due to duration and number of detentions) contributed to a dependence on the ward. Many participants had been detained at a crucial time, which meant they could not continue with education. Participants felt ‘left behind’ from peers and the memos left the researcher sensing they were frozen in a particular life stage and dependent on the friendships inside the units. This had a broader impact on their trajectories, making it harder to ‘let go’ of their anorexic self. Being detained meant that participants were removed from their families and less contact meant an avoidance of guilt, maintaining their resistance to the implications of the MHA.

THE ANOREXIC SELF

Prominent across all of the interviews was ‘the anorexic self’, which captures how this was experienced throughout detention. Prior to admission, some participants described being consumed in the AN identity and cut off from other activities. Others described diverse domains of self i.e. student/professional/sporty and recognised they were driven, perfectionistic and felt special. All participants demonstrated an uncertainty in their sense
of self, making upward (negative) comparisons to others throughout the stages of
treatment, a process defined by Festinger (1954) as ‘social-comparison’, triggering
shame. It is hypothesised that the MHA, alongside participants’ responses to being
detained (‘digging their heels’) and subsequent increased coercive service responses,
which reflected ‘not knowing what to do with (them),’ were factors for some participants
which reinforcing the anorexic self:

Grace: ‘You’re gonna have to go onto these wards, and have this tube again and you’re
gonna be really unwell, so then when it was kind of put to me like that, I started to feel
like ... this sense of like achievement again... and because people were worrying and they
couldn’t control and I was getting really sick...I really felt quite proud about it’.

Their strong anorexic identity reinforced the participants’ rebellion as an attempt to hold
onto being a ‘good anorexic’ and ‘not a text book case’. This was particularly prominent
for the subgroup of participants who competed to be the ‘most ill’ and who were less
ready for change (for example, some participants would actively attempt to find out how
to be under the MHA), in comparison to the recovery-orientated subgroup who despite
resisting, aimed to recover. Upon discharge, participants like Marie found it a challenge
not to ‘lose herself’ to the anorexia but conversely did not want to ‘let it go’- a factor
found to hinder recovery (Espindola & Blay, 2009).

**STEPPING OUT OF THE BUBBLE**

Compliance resulted in physical recovery and more balanced thought processes, resulting
in discharge. ‘Getting my life back on track’ illustrates the positive outcomes of being
detained and discharged, whilst ‘spiralling downwards’ illustrates the challenges and
potential negative outcomes. Recovery was dependent on the experience of treatment and perceptions of the ‘anorexic self.’ Many individuals discussed both positive and negative experiences. The interplay of these factors were pivotal in mediating recovery or relapse.

**Getting my life back on track**

There were many examples of factors which helped participants sustain recovery. A graded and planned discharge helped integration ‘*back to normal life*’. Some participants wanted and chose to take responsibility for their actions for example, Jane ‘*put (herself) on house arrest and ate*’. Participants expressed relief and appreciated their autonomy in having the ‘*chains taken off*’ and believed the MHA was necessary in removing personal responsibility. Some participants described ‘*more understanding*’ and used their experiences to plan for their future career (Grace, Becky) and started to think about constructing an alternative identity similar to the process of ‘finding me’ in Weaver, Wuest and Ciliskas’ self-development model of recovery (2005). Jane talked about having more compassion for herself because, ‘*there are some days where it’s say raining, and you really don’t want to move, and that’s ok*’ as she started ‘*trusting that it is going to be ok*’. This provides evidence of the process of self-care in recovery (Weiner et al, 2005). Some described an awareness of their own mortality reflecting a spiritual process of change.

**Spiralling downwards**

Many factors made ‘stepping out of the bubble’ challenging. Jane described how the bubble ‘*becomes the norm*’, reducing motivation to change. Some participants experienced being ‘*scared by the change*’of ‘*having to ... see people and just get back to normal life*’(Kathy) which is a known barrier to recovery (Espindola & Blay,
Having the section removed was a relief for some but upon discharge, some participants described feeling ‘dropped’ with little support. Jane talked about being inaccurately judged based on her physical appearance and that because she ‘looks fine, she is fine’. Participants like Becky described remaining beliefs that felt compelled to act on their thoughts and others described being ‘trapped in (their) own mind’ with remaining symptoms and compulsions to get ‘back in control’ to find an arbitrary ‘bottom line’:

Marie: ‘I thought that maybe...I’d get through it, you know I’d come, I'd come through the illness,...you know there was something there that I, that was tangible and I felt, I could actually get better, allow, be allowed to get better, but it wasn’t true’.

Becky re-lapsed because she felt unable to meet the expectations of life and ‘being ‘ill’ was (her) only justification for her delay’. Participants feared and felt overwhelmed by responsibility. Marie ‘didn’t want to compete’ on an ‘even playing field’. Some participants described not feeling ‘special’, difficulty indecision-making and as Becky illustrated, fear that no one would care. Some participants experienced an emergence of depression, anxiety, shame and lack of self-worth because of the loss of their ‘anorexic self’ and worried that they had let their family down and worried about the impact of the MHA on future prospects.

Discussion

This study aimed to understand the impact of detention using a grounded theory methodology. It found four overarching categories, which conceptualise participants’ experiences over time: ‘the battle’, ‘the bubble’ and ‘stepping out of the bubble’. A key
longitudinal code was the relationship between the self and the anorexia nervosa, named the ‘anorexic self’. Many of the overarching themes are paralleled in the broader literature exploring experiences of detention. However, the prominence of the ‘anorexic self’ and ‘the bubble’ was qualitatively more pertinent for this group of participants with anorexia nervosa, especially given the interaction with their anorexic identity. Findings are discussed around the overarching categories and in relation to existing literature.

The finding that ambivalence about detention triggered resistance supports the evidence that motivation is a key factor for recovery in AN (Espindola & Blay, 2009). Services would often meet resistance by the patient with increasingly restrictive practices. This appeared to be linked to carers and teams’ anxiety about low BMI, thereby forcing the team to act as ‘experts’ in order to ‘cure’ the person. Mason’s (1993) model of ‘safe uncertainty’ is useful here. The use of the MHA and treatment implications lends itself to the use of more medical interventions as these are perceived to be ‘certain’ to ensure the ‘safety’ of the SU, in that they are not going to starve to death. However, the patient does not respond favourably to these ‘certain’ practices. Consequently, services are destabilised because the perceived expertise status of services is challenged, moving them to a position of ‘unsafe uncertainty’, which may lead to increasingly restrictive practices, as the team search of a ‘certain’ solution. Deci and Ryan (1985) have found evidence that autonomy is important for good psychological health. The memos illustrate that in line with self-determination theory (Deci & Ryan, 1985), participants continued to ‘dig their heels in’ to regain autonomy, reduce dissonance and avoid being understood, in order to maintain integrity of their ‘anorexic self’.
As the above process continues, some participants experienced ‘I don’t feel like a person’ – i.e. a loss of personhood which is discordant with the NICE (2011) guidelines and reinforces treatment resistance. Staff may be less person-centred because they feel hopeless and burnt out when managing a challenging client group. The ‘loss of personhood’ finding is similar to experiences of clinicians when managing challenging behaviour in learning disabilities (Hastings, Reed & Watts, 1997). Weiner’s (1986) empirically supported model of ‘helping behaviour’ would speculate that if staff believe that a client is in control of their resistance, staff may feel angry and withdraw from helping that particular individual when resistant. There may be similarities in staff responses to AN which would warrant further exploration.

The finding that participants experienced distress during specific interventions replicates people’s experiences of detention in other psychiatric disorders (Berry et al, 2013). These perceptions and feelings increased mistrust in professionals, meaning participants were likely to conceal their symptoms and cut off from services after discharge from the MHA which is likely to have a detrimental impact on future therapeutic alliances, thereby reducing the chance of sustaining recovery.

The finding ‘turning points’ illustrate that in line with motivational theories of change and self-determination theory (Deci & Ryan, 1985), the MHA externally regulated individuals’ behaviour, thereby limiting their investment in change and making recovery difficult to sustain. For others, compliance was intrinsically motivated, a factor well documented as important for recovery (Federici & Kaplan, 2008). However, discharge
from the MHA and from the ward was difficult, particularly for those with long histories. This was partly a result of the ‘loss’ of normality which is a prominent finding in the literature (Offord et al, 2006; Colton & Pistrang, 2004) and a dependence on the ward, culture and system which echoes key features of institutionalism or institutionalisation (see Chow and Priebe 2013 for a review). Participants described a difficulty taking responsibility, which accords with Gowers, Weetman, Shore, Hossain and Elvins’ (2000) view that detention can reinforce personal ineffectiveness and maintain a ‘sick role’ (Gruenberg, 1967). The re-emergence of emotional difficulties upon discharge supports the evidence that AN is an attempt to manage other emotions (Fox & Power, 2009). The emergence of shame upon discharge perhaps results from participants’ awareness of being unable to meet ‘perfectionistic’ ideals, particularly as they had fallen behind peers. Their high expectations created stress and activated key negative self-beliefs. Individuals tended to compensate by endeavouring to be the ‘perfect’ anorexic, subsequently leading to relapse. This fits with a process Cockell, Gellar and Linden (2002) termed a ‘functional avoidance’ of life. Furthermore, the finding that being anorexic and detained elicited care, suggests that being ‘ill’ has a reinforcing function.

The overarching category of the ‘anorexic self’ supports literature that people with AN struggle to establish diverse domains of self (Bruch, 1982). The self-regulation model of illness perceptions developed by Leventhal, Brissette and Leventhal (2003) sheds light on how factors such as being detained, coercive interventions and ‘reductionist attitudes’ inadvertently reinforce illness perceptions of anorexia as: a strong ‘anorexic self’, that it is perceived to be caused by a ‘illness’, which is chronic and outside of their control. For
some participants, in line with social determination theory (Deci & Ryan, 1985), these factors reinforced a sense of achievement.

**Implications**

Data suggests several implications for clinical practice. Firstly, the finding ‘internal conflict’ suggests the need for the transtheoretical model of change framework (Prochaska & DiClemente, 1983) and motivational interviewing (Miller & Rollnick, 2002) to be embedded within services.

Secondly, the finding ‘I don’t feel like a person’ suggests the need to develop person-centred facilitative conditions (empathy, warmth, congruence) in staff to develop the therapeutic alliance (Lambert & Barley, 2001). In light of Robert Francis’s report (2013), services need to be reconstructed to make them more person-centred. Individualised biopsychosocial formulations would address the context, function and motivation of a person’s behaviour (i.e. are they intrinsically motivated or eating their way out?) particularly with respect to the treatment process. Building on this would be the implementation of a longer-term recovery approach as advocated by Perkins (2012) and Slade, Amering, Farkas, Hamilton, O’Hagan, Panther and Whitley (2014) suggest initiatives which works towards developing other aspects of a service-user’s identity. Goals should focus on quality of life so participants can hold onto parts of their ‘anorexic self’ in a safe way and Weaver et al’s (2005) model of recovery may be used to help SU’s and staff understand the process of recovery. The finding ‘spiralling downwards’ suggests that discharge should be formulated and planned for from the beginning of an admission. It should be graded and set up with a continuation of psychological support to
address negative emotions. This should be individually and idiosyncratically formulated and planned for from the beginning of an admission and positioned within a relational context, with a recovery orientated focus. Advance directives may be useful to promote choice and control in the event of a further episode of detention.

Lastly, the finding that services impose restrictions on a SU when they resist treatment suggests that we need to understand and manage the pressure to be ‘experts’. Hastings et al.’s (1997) framework could be applied with staff teams to explore staff attributions, feelings and responses to the SU, within the culture of the working environment (for example, stress), and within a wider societal context which would look at altering service, team and individual staff responses to the SU for example, positive risk taking and reducing coercion. This shared narrative would challenge ‘reductionist attitudes’ and may help staff reach a position of ‘safe-uncertainty’ (Mason, 1993).

**Limitations**

Potential limitations are as follows. The homogeneous sample of participants (ethnicity, socio-demographics and gender) may have affected the data; however, participants were recruited from all over the UK, which may have negated this effect. ‘Selection characteristics’ could be a source of bias which is unavoidable in research. The apt sample size suggests saturation may have been achieved and in line with Dey’s (1999) view, the researcher believes the length and depth of the data was sufficient to develop a theoretically ‘grounded’ model. It is a limitation that only four participants participated who were under the MHA at the time of the interview. Participants receiving treatment may have been too unwell to contemplate taking part, or as indicated by the results,
potential participants could have perceived the researcher as another professional to resist. Future research could carry out consecutive interviews with inpatients over time to build trust and facilitate openness. The low number recruited from NHS services may be due to staff prioritising clinical need rather than supporting recruitment. Nevertheless, the data was rich which provided valuable insights into their experiences at the time.

There are several potential influences on the study. Firstly, the inherent power dynamic in the research-participant relationship may have influenced how participants articulated their experience. The researcher’s clinical skills helped participants feel as comfortable as possible and telephone interviews took away participants’ social anxieties. Secondly, the researcher noticed that her therapeutic and clinical experiences had started to shape her interpretation of the data, which was in line with a cognitive behavioural model (for example, thoughts, feelings and behaviours were distinguished). Her clinical experiences and beliefs about the dominant ‘ill identity’ meant that the researcher found herself tuning into the ‘illness’ narrative, which could have closed off other interpretations. However, discussion with the research team and the reflective journal, alongside strict adherence to the methodology ensured the findings were grounded in the data. Instead, it can be argued that her experience and skills have added depth to the interpretation that otherwise may not have been achieved.
References


Paper 3

A Critical Review of the Process of Exploring Experiences of Involuntary detention

Word count: 9784
Abstract

This paper is a reflective account and critical appraisal of the overall research process. It will reflect on the questions that the researcher was fraught by, the challenges she encountered, and the learning outcomes of conducting a literature review, as well as carrying out empirical research. Some areas of this paper may refer to both spheres. The researcher has concluded with some reflections on the personal and professional implications, in terms of her future career as a clinical psychologist.

Literature review (paper 1)

- Should I do a quantitative or a qualitative review and what is my question?

The initial task of deciding on the research question and the methodological approach was a thought provoking process. The researcher and her supervisor agreed that a review of qualitative research would compliment the qualitative empirical study (which had already been decided upon), and together they thought broadly about interesting topics that may be of interest. The research enabled the researcher to become more knowledgeable about the amount and content of data available. One other qualitative systematic review in the area of interest (Katsakou & Priebe, 2007) which had been carried out in 2006 and published in 2007, reviewed the qualitative literature on the experiences of involuntary detention and was closely related to the aims of the researcher’s empirical paper. It specifically aimed to explore if participants report both negative and positive experiences of involuntary detention and investigate how these experiences were linked. Furthermore, it intended to discover the differences between patient groups holding negative and positive views, in terms of their characteristics, thought processes and treatment experiences. However, the authors reported that they were unable to ascertain how positive and negative experiences were linked to each other, and they were unable to understand why participants held different views of their experiences. This was because there was no information on who mentioned these themes, i.e. the same participants could have talked about having both positive and negative
experiences, whereas these themes could have been mentioned by different patient groups. Therefore, in paper one, the researcher’s first aim was to address two of the questions that Katsakou and Priebe (2007) reported that they were unable to answer. Additionally, the researcher noticed that there had been a proliferation of studies published since 2007, which had explored experiences of being detained promulgating a second aim - to provide an updated understanding of service-users experiences of involuntary detention.

The researcher had concerns that her review would not add much to the literature and she sought to see how she could make her review distinct from the previous one. She noticed that Katsakou and Priebe (2007) had carried out a qualitative, systemic review and a thematic analysis was the chosen methodology for synthesis. Through becoming familiar with the literature, the researcher learned that there were many different ways of reviewing qualitative data. The researcher decided to build on the previous review by employing a metasynthesis methodology. Paterson, Thorne, Canam, and Jillings (2001) point out that a metasynthesis methodology enables studies implemented in different areas and in different contexts, to be brought together, analysed and the data synthesised like other synthesis methodologies; however, it does this in order to generate new theoretical models. The researcher believed that the generation of a theoretical model would have a great deal of clinical utility. This fits with the researcher’s ethical values that research is used to change practice which is in the best interests of service-users.

The researcher was still left with some uncertainty about her review. She became quite stuck in the debates surrounding the use of quantitative and qualitative methodologies. The underlying paradigms of scientific methods and positivism are at odds with the qualitative and interpretive paradigm. The researcher often felt polarised and pulled to accept one paradigm having more value than another. The researcher’s academic teaching and clinical experience has led her to the understanding that the scientific method of attempting to quantify social phenomena and assess statistical relationships, is much more valued in scientific communities. Therefore, it makes sense that the major focus of systematic reviews has been on studies employing a quantitative methodology. Qualitative studies have been isolated in the literature and their limited impact on
evidence-based practice is perhaps because of their historical exclusion from reviews (Bondas & Hall, 2007a). These issues added to the researcher’s uncertainty about the usefulness and credibility of a qualitative synthesis.

On the other hand, she was drawn to the literature which suggests that the role and contribution of qualitative research is increasingly being recognised (Bondas & Hall, 2007a). Ring, Ritchie, Mandava and Jepson (2010) brought her attention to the fact that attitudes to qualitative research are changing. Qualitative research does demonstrate a substantial body of knowledge. It focuses on ‘meaning in context’ (Noblitt & Hare, 1988), which the researcher believes is essential when studying human psychology. It captures uniqueness and depth, whilst seeking for an explanation for phenomena based on the perspectives of the lived experiences of people, which arguably more deductive quantitative methods cannot obtain. It is fundamental in centralising the service-user’s needs and preferences. This echoes the policy drivers which push for person-centred care and service user involvement (NICE, 2011), which is becoming pivotal to treatments and service design. The Cochrane Collaboration Qualitative Methods Groups have also identified how qualitative research can contribute to systematic reviews of effectiveness (see Ring et al. 2010 for more detail). Taking this into account, it makes sense that bringing together qualitative research in a review is gradually becoming an important source of evidence. It could be argued that it is now highly likely to influence policy and change clinical practice because it puts the views of service-users central to the process. The researcher came to an understanding that qualitative research does have an important role in the understanding of psychological and social experiences and therefore a qualitative synthesis was an important addition to the literature.

Which synthesise methodology should I use?

The research team was tasked with deciding which methodological approach would be most suitable to synthesis qualitative research. She was initially struck by the amount of emerging literature that addresses this issue and the interest and attention in developing methods of synthesis (Barnett-Page & Thomas, 2009). There are two umbrella methodologies which fall into either a framework analysis (with the associated variants (for example, the ‘best fit framework’) or another, very different approach, which
incorporates a thematic synthesis, critical interpretive synthesis or a meta-ethnography. The former, and specifically the ‘best fit framework’, has become increasingly popular especially in areas of healthcare. It is appealing to practitioners and policymakers when they need knowledge and answers quickly (Dixon-Woods, Bonas, Booth, Jones, Miller, Sutton, et al, 2006). This approach is augmentative and deductive, because, by locating an existing model or framework in the literature, it builds on this by using it as a coding framework. In other words, qualitative results of studies are then fitted into this framework. The framework is therefore modified in response to the evidence reported in the studies. The researcher was able to see the value in this approach; however, to the researcher’s knowledge there is no published model that has conceptualised people’s experiences of being involuntarily detained. With an increased understanding of different methodologies, it was therefore decided that an inductive approach would be most appropriate.

When deciding which inductive approach to take, a metasynthesis in line with Noblit and Hare’s (1988) method is considered to be the most effective review of qualitative research (Walsh & Downe, 2004). It has also been applied across diverse areas of healthcare (See Bondas and Hall, 2007b for a review). Therefore, a metasynthesis was the chosen methodology.

- Can you synthesis qualitative research?

The researcher became immersed in the debate surrounding the meaningfulness of synthesising qualitative data. She sought to have an opinion in relation to the debate and in doing so, she thought through the following points which are helpfully summarised by Ring and colleagues (2010). Some argue that the synthesis of qualitative research is meaningless; indeed, the researcher does believe (and it certainly reflects her experience) that the finer contextual details can be lost in a metasynthesis, which may fail to do justice to individual studies. Additionally, it can be argued that synthesis of qualitative studies involves the reviewer (or reviewers), providing their interpretation of the original author’s (or authors) interpretations, of their participants’ views and experiences. As such, qualitative synthesis is a ‘third order’ of findings, i.e. an interpretation of an
interpretation of an interpretation (Noblit & Hare, 1988). The researcher can see the argument that analysis is potentially a leap away from valid and credible research.

The additional problem in synthesising qualitative studies is that qualitative interpretation and reporting of results is informed by different philosophical positions. Therefore, the interpretation and presentation of data across several individual studies may be very different, even if the participants’ articulation of their views and experiences are essentially the expression of the same or similar things. The researcher certainly can understand from her current metasynthesis how this can happen; for example, many of the practices that have been described as ‘person-centred’ and captured under the overarching theme ‘a continuum or humane care’ in her review have been ordered, categorised and labelled in other studies differently. Even when comparing Kataskou and Priebe's (2007) review with the researcher’s metasynthesis, differences in interpretations were found. The following quotation taken from Kataskou and Priebe's review (2007) may illustrate this point:

“I felt so extremely bad and wanted someone to talk to, it was at night I recall but he said I can’t help you and he just went away, he could at least just sit by my side or talk to me about anything then, I don’t expect him to do miracles but just being there would have been enough” (Kataskou & Priebe, 2007, p 176, 2002).

Although this quotation clearly illustrates what Kataskou and Priebe’s (2007) categorise as feeling ‘uncared for’. In the metasynthesis, this is a quote which may be categorised under the subtheme ‘connecting and disconnecting practices’. However, it may also be interpreted as evidence that the patient feels lonely or hopeless; or it could be evidence that the clinical staff feel hopeless, that nothing they do can help. It could reflect that a person feels abandoned or that their emotional needs are being neglected. Some may argue that it could illustrate an abuse of power depending on the context. Although all of these can be true (and in fact there is no ‘universal truth’ in this epistemology), what this does illustrate is that interpretation can be complex. This is different to quantitative research whereby the results are presented in an objective way and less interpretation is required. The researcher learned that the range of approaches in the analysis of
individual study data, means that there is no easy way to extract and combine data on the themes from several studies and no easy way to interpret across studies.

In reviewing the literature, the researcher learned to come to her own understanding about the usefulness of synthesising qualitative research. She accords with Britten, Campbell, Pope, Donovan and Morgan’s (2002) view that individual qualitative studies will remain isolated and have less of an impact on service-providers, commissioners and the evidence base, unless brought together and synthesised into a bigger review of the literature. There is more chance that the views of service-users are acknowledged and listened to, when research is brought together. For the researcher, research that makes changes in the best interests of service-users is imperative, fundamental to good quality person-centred care, and is ethically important to her. She does not see the point in carrying out research, which is challenging and time-consuming when the results, interpretations, and recommendations are not fed back and used in a clinically meaningful way. However, the researcher has learned that it is absolutely vital to acknowledge the challenges and limitations in carrying out a qualitative synthesis and be aware of different philosophical stances and methodologies. It is also important to follow the methodological procedure in a systemic way when searching the literature, synthesising and interpreting the findings. Skilfully appraising the quality of individual studies is also important because it aids interpretation of the data. In sum, synthesising qualitative research is invaluable; however, ensuring it is carried out with quality and rigour is vital.

- How do I search the literature?

The task of carrying out a systematic literature search was a novel task to the researcher and she was struck by the difficulties in being able to search and locate relevant literature. As mentioned above, a major component of evidence-based practice is the systematic review, which has historically been centred on randomised controlled trials. It was difficult locating qualitative research using the methods and tools provided by electronic databases, possibly because they were much less developed that those for identifying randomised controlled trails (Ring et al, 2010). Therefore, many preliminary searches produced irrelevant results.
The researcher considered many ways to overcome this challenge and locate relevant results. She considered limiting the searches to include only qualitative studies; however, this would have excluded studies which used a mixed-methods approach and therefore could have excluded potentially valuable findings. After initially attempting to identify key studies by inputting key terms in the title of studies, it was still difficult locating qualitative studies. The descriptive and ostentatious titles of some qualitative papers (although reflect a rich description of the methodology and findings), actually made selection based on specific key terms a lot more difficult. The indexing of studies (which can be used to describe both the subject and the method of research publications) can be used in the identification of studies. However, the researcher found that this was difficult when looking for qualitative research. The indexes varied between databases and it was difficult to capture mixed-methods studies. The researcher did not want to risk missing potentially relevant studies, therefore it was decided that the search would be kept as broad as possible. Broad search terms consequently resulted in the retrieval of thousands of potentially irrelevant papers and the screening was a time-consuming process.

- Where is the bias?

There are several sources of bias which is worth acknowledging and reflecting upon. The search included only those written in the English language. This may have excluded potentially relevant and insightful studies from different countries and cultures. Additionally, only peer reviewed journals were included therefore excluding anything that may have been in ‘grey’ literature. This could result in a publication bias, because the full range of experiences is missed from the literature. The researcher could see the argument in including ‘grey’ literature, especially considering the lack of published qualitative studies more generally (compared to quantitative studies). However, she wanted to ensure that only credible studies were included, because, as Noblitt and Hare (1988) point out, the inclusion of flawed studies ultimately could discredit the metasynthesis.
In addition to potential bias in the searching process, it has been argued that bias is inherent in the metasynthesis methodology. Firstly, a metasynthesis involves a dependence on the quality of the primary research publications. The researcher as a reviewer has therefore not been involved in the research design and the initial data collection of the individual studies and has to take the authors written word as it is. The researcher carried out a quality appraisal for each of the studies to take these considerations into account.

Secondly, the metasynthesis also involves an interpretative element when synthesising and translating the findings. Inherent in this is the possibility of researcher bias or biases in interpretation which was alluded to earlier. This seemed to play out in many ways which was highlighted in the researcher’s reflective journal and was a point of reflection in supervision. Concurrent to the synthesis the researcher was reviewing the literature for paper two. The information from these studies could have biased her interpretation of the data in the metasynthesis. For example, she came across literature pointing to the distress caused by being admitted. Berry, Ford, Jellicoe-Jones and Haddock (2013) carried out a systemic review looking at post-traumatic stress associated with psychosis and hospital experiences. The authors found evidence that hospital experiences were distressing particularly when aspects of treatment include seclusion, restraint and forced medication. They also found evidence that being isolated, not understanding reasons for admission and environmental factors such as noise levels and locked doors were distressing. The researcher was also aware of the findings of the Robert Francis’s report published in 2013 which details the lack of compassion, dignity and failings of the Mid Staffordshire Foundation Trust which occurred at many different levels of the system. The Care Quality Commission (CQC) report in 2012 also highlighted a lack of good enough care. Thirty-seven percent of care plans checked by the CQC did not involve participants’ views and forty five percent of the records showed no evidence of discussions around consent to treatment before the first administration of medication. There was a lack of evidence that participants were informed of their legal right to an Independent Mental Health Advocate and ‘blanket rules’ were being applied in order to control and contain people, rather than prioritise their recovery. Thankfully, the report recognised that services remain under increasing amounts of pressure (for example, difficulties in the
provision of transport to hospital, high bed occupancy, increased workloads) and services are trying to maintain quality of care in light of the financial cuts. These reports resonated with the researcher’s earlier experiences. Whilst working as a nursing assistant and support worker she witnessed and was uncomfortable with the lack of person-centred care when someone is acutely or chronically mentally unwell. She also has previous experience of working as an assistant psychologist as part of a newly established psychology team, which had been tasked to input a psychological approach to several acute units. At the time, she was struck by the lack of collaboration between participants and staff and the dominance of the medical model. These experiences have stayed with her, and it is possible her thoughts and frustrations could have potentially biased her interpretation of the findings if they were not discussed and reflected upon in supervision.

Concurrent to the metasynthesis, the researcher was also carrying out a grounded theory qualitative analysis of her data. She was struck by prominent themes in her data of inequality, powerlessness and a lack of person-centred practice. It was noted during supervision with the research team, that the findings of the empirical study were potentially starting to bias the findings of the metasynthesis (and vice versa). The researcher also learned to identify that her background orientation to cognitive and behavioural models, meant that the ideas, concepts, quotations and interpretations were synthesised into similar categories i.e. affect (for instance ‘I felt terrified’ and ‘transient emotions’) and behaviour (i.e. intrapsychic coping). The same process happened in the grounded theory analysis of paper two. Skills in reflection enabled the researcher to understand where potential biases originated from and helped her understand more of herself as a researcher.

These potential biases were managed in several ways. As has already been mentioned, the researcher made good use of her reflective journal to note down key thoughts and feelings which were triggered in her. These tended to occur spontaneously, even when the researcher was not working on her research. Also, discussion of the synthesis took place with two research supervisors who are experienced in qualitative research and metasynthesis. During research meetings, she learned to be transparent and reflect on
potential biases, and collaboration with members of the research ensured assumptions were challenged and interpretations were evident in the literature. Furthermore, the researcher’s awareness of potential biases meant that she strictly adhered to Noblitt and Hares’ (1988) guidelines to reduce the risk of bias. She also ensured that a clear and detailed methodology documented the process so readers could assess the dependability of the findings. However, the researcher would strongly argue that academic teaching alongside extensive reading, peer supervision and close research supervision from two experienced researchers ensured the credibility of the analysis. Thus, the methodology reduced the chance of bias. However, it is worthy of note that the interpretive component of a metasynthesis alongside a critical realist stance means that the results cannot be bias free, instead they are a constructed interpretation. The importance of the researcher being transparent about her ideas, experiences, beliefs and preconceptions, both in paper one and paper two are essential in maintaining the quality of interpretative research.

- **The challenges of doing the synthesis**

The researcher came across some challenges and learning points when carrying out the metasynthesis. During the synthesis, there were countless discussions between members of the research team regarding the themes, subthemes and quotations i.e. what they were, what they should be categorised as and how they linked together. Some of the quotations reflected more than one theme and it was a challenge to decipher the interpretive meaning and where it made sense within the analysis. For example, some of the quotations where participants had described being forcibly medicated also could have been placed under the theme ‘a continuum of person-centred practice’ (as an example of a lack of person-centred care). The themes ‘you’re disempowering me’ and ‘a continuum of person-centred practice’ were a point of debate. A lack of collaborative working which was subsumed under the theme of ‘a continuum of person-centred practice’ could have been subsumed under the theme ‘you’re disempowering me’. However, it was agreed with the research team that a lack of collaborative working may or may not induce powerlessness. This is why it was agreed to be separate from ‘you’re disempowering me’. An additional challenge was the bringing together of the themes and understanding the relationships between them. Once the similarities and differences had been identified, the researcher
went back to the original studies and quotes to understand the links, in other words, to understand what factors mediated participant’s experiences. This was a lengthy part of the analysis and it was difficult to manage the uncertainty at times, particularly given multiple extra demands and time pressures. Working in line with the methodological procedure, organisation, supervision and reflection were invaluable skills needed in this stage of the research.

The empirical study (Paper 2)

- Where do I start?

The researcher’s previous personal, clinical and research experiences influenced the area she was keen to research and the choice of methodology. The researcher has a keen interest in complex presentations, particularly eating disorders which are renowned to be the most difficult disorders to treat. Clinically, the researcher has been trained but also has a keen interest in using psychology formulations to make sense of a person’s presentation and direct interventions. She thinks systemically about how problems can develop and how they are maintained. Psychodynamic, social constructivism, attachment and cognitive behavioural perspectives inform her thinking. Therefore, researching the experience of detention for anorexia nervosa, using qualitative methodology, and in particular by using a social constructivism grounded theory approach (discussed more below), married to some extent, both research and clinical interests.

- What methodology should I use?

The decision centred on the most appropriate qualitative approach to take. Going back to the aims, the team wanted to move beyond a descriptive account in order to generate a theoretical understanding of the experiences and process of being detained. The researcher thought that the generation of a framework may have more clinical utility than a purely descriptive study. Additionally, the researcher was drawn to grounded theory because of the underlying positivistic principles and structured practices. Rigorous techniques such as the ‘constant comparison method’ and systematic guidelines have
meant that the methodology is increasing in credibility. This helped reassure the researcher that the study could be a creditable addition to the literature.

There are various approaches to grounded theory and further decisions were made in regards to the chosen approach and rationale. Extensive reading helped the researcher decide on a constructivist grounded theory approach (Charmaz, 2006) and it was chosen for several reasons. Firstly, this approach attends to the power that exists between researchers and participants. In an objectivist epistemology the researcher and participants are seen as separate and are represented hierarchically in which the participant is typically subordinate to the researcher. Conversely, constructivist grounded theory promotes a non-hierarchical structure and the dissolution of power which is important if you are interviewing disempowered patient groups. This sits ethically within the researcher’s personal and professional values and with her belief system. Secondly, unlike classic versions of grounded theory (Glaser & Strauss, 1967) where theory is ‘discovered’, theory is seen as a constructed process and is an interpretive understanding. People are seen as active agents and meanings therefore emerge through peoples’ interactions. Truth is seen as relativistic and provisional. This approach can go one step further than this. Due to the influence of the symbolic inter-actionist perspective, society, reality and the self are seen as constructed through language and communication. In other words, language constructs our experience of reality. Therefore, this approach fits with the researcher’s previous experience and personal beliefs about the origins of knowledge and nature of reality.

- How do I recruit all the participants I need?

Recruiting from NHS services was particularly difficult. Due to the ethical constraints of confidentiality, clinical staff, who were routinely involved in participants’ care were tasked to identify potential participants. This was a challenge for several reasons. Firstly, the researcher was an outsider member of staff coming into a service, which meant that it was difficult to form a professional relationship with services and with individual staff. The researcher was aware that if she had been part of their team, she may have received more support. Secondly, it became obvious that staff members have many competing demands placed on them and it is possible that recruitment can at times fall short of their
agenda. This was particularly pertinent for this client group, who are often of high risk and create a lot of anxiety and stress for individual professionals and across teams. Services were operating under capacity with limited staff and resources making it understandable that staff had to prioritise clinical need over research. This left the researcher thinking that her research requests were a hindrance to their workload. This made it difficult at times to be assertive and remain hopeful about recruitment. An excerpt from the researcher’s reflective journal illustrates this:

“Everyone is so stressed and I feel like people just wonder why I am here. They have their jobs and are so busy running around that they probably think what I am doing is pointless. It’s really hard trying to set people aside and place any extra demands on them. What difference is this research going to make with a client group who are so complex, very stuck and rarely change?”.

It was useful in peer supervision (which was set up and integral to the course) to reflect on the process of research. It brought her attention to the counter-transference from these encounters. The researcher was often feeling similar to how staff felt clinically with this client group – stuck and hopeless. This reflection enabled the researcher to understand why she lacked assertiveness with staff and helped her think about what she could do differently. She remained understanding to the needs of staff groups; however, she continued to remind staff and pursue potential contacts with services either over the phone, in person or over email.

There are other reasons recruitment may have been difficult. One reason could be due to the sensitive nature of the topic and the difficult experiences some participants have encountered. The second reason could be hypothesised to be a result of the nature of the topic under investigation. In light of the findings of this study, potential participants may have been concerned that disclosing their experiences could result in re-detention. Some may mistrust professionals who work within mental health services as a direct result of their experiences. Participants who did engage were at time reluctant to disclose their BMI and most were concerned that their GP or care coordinator would know about them taking part and this fits with this hypothesis. It has been recognised elsewhere that the
more sensitive or threatening the research topic, the more difficulty it is to recruit people (Renzetti & Lee, 1993). The third reason was possibly due to the initially restrictive inclusion criteria which was widened over the course of several ethical amendments. In the first amendment the time period after being discharged from a section was lengthened (up until five years) and then lengthened again in the third amendment (up until ten years). Amendment four consisted of including participants with anorexia nervosa who had been detained on general acute units as well as specialist eating disorder units. The widening of the inclusion criteria meant that the topic was broadened out and less specific or focused. However, it was necessary in order to aid recruitment and the study was still a novel area of investigation to the researcher’s knowledge. The researcher also noticed that participants who had been sectioned were people who have suffered with anorexia nervosa for a long time. This meant that many of their friends became the very people whom were also receiving treatment. The researcher amended her methodology to take a ‘snowballing’ approach. The method is renowned to help find and recruit ‘hidden populations’, that is, groups not easily accessible to researchers through other sampling strategies. This was proved to be highly successful in this study. The researcher also widened the inclusion criteria to include people who had been sectioned on a general ward as well as a specialist ward and to include people, who had been discharged for up to 10 years from a section; both of which helped recruitment substantially. The researcher has limited experience in research methods; therefore, to meet the aims of the study, in hindsight she should have made the study as broad and inclusive as possible, straight from the beginning. These are all learning experiences which she can draw upon in future research.

- How do I interview people?

The process of interviewing participants raised many reflections and important insights for the researcher. The researcher initially proposed to carry out interviews face-to-face, which is the typical method of data collection in qualitative research. However, on two occasions, the researcher made lengthy trips across the country and potential participants had forgotten about the interview even though the researcher reminded them the appointment. As the study evolved, people who expressed an interest in the study were predominantly recruited through a national charity, which meant that participants resided
all over the UK. The researcher was aware of her limited budget which did not allow for too many lengthy trips. She also struggled to juggle her commitments as a parent because it was difficult for her to be travelling outside of working hours. Moreover, she noticed that recruitment also came in spits and spurts and the researcher was keen to interview participants as soon as they had consented to avoid losing their interest. Therefore, it was agreed in supervision that the study should be amended so interviews could be carried out over the telephone, if participants wished.

The researcher thinks it is important to reflect on her experiences of conducting interviews over the telephone. Telephone interviews did pose some challenges for the researcher. At times, the non-verbal nuances participants communicated were missed which made it difficult to know when to continue with questioning, and when to remain silent. For example, there were moments when the researcher was unsure if participants needed more time to think or if they had finished answering the question. Despite these small challenges, the researcher noticed that participants talked in length and in depth about their experiences over the telephone and all the participants fed back that they felt relaxed, comfortable and enjoyed talking about their experiences. In contrast, participants who were interviewed face-to-face talked much less about their experiences and seemed pre-occupied with the length of the interview. Indeed, this could be because the two participants interviewed face-to-face were inpatients and therefore were more unwell. The cognitive impact of starvation and the preoccupation with restricting could have influenced how able they were to concentrate and reflect on their experiences. However, it was also clear that trust in professionals, social anxiety and participants self-conscious worries were triggered, which seemed to be less important when interviews were carried out over the telephone. For example, one participant who was being interviewed face-to-face remarked that she felt anxious being interviewed, apologised and progressed to explain that “she has never been good in social situations”. The anonymity of a telephone interview seemed to allow a feeling of ease, which was reflected in their accounts. Therefore, telephone interviews were a highly valued amendment to the study and a good way of engaging harder to reach populations which is a view also reiterated by Holt (2010) and Stephens (2007).
Over the course of the interviews, the researcher noticed a change in her interviewing style. Initially, she felt grateful for participants’ time and consequently was cautious in asking too many direct questions that may affect their engagement. She felt guilty exploring a sensitive topic whilst not being able to interact therapeutically with the participants, which is a common experience for researchers (Dickson-Swift, James, Kippen & Liamputtong, 2007). This meant that the first three interviews were less directing than they could have been, which meant that participants at times went off topic. Through reflection in supervision and as the researcher’s confidence grew, she learned to be a little more directive and pick up on nuances and implied meanings in the interviews to follow her hunches. This reminded her of some teaching on a trans-diagnostic approach to psychotherapy known as method of levels (Carey, 2006). This approach draws attention to the underlying processes which are prominent across psychological disorders. In doing so, the therapist questions the clients in a way which redirects his/her attention to focus on their background (or unspoken) internal dialogue, which is cued through indirect forms of communication such as: hesitations, excessive fillers, changes in tone of voice or flow of conversation. The researcher found herself at times using these more direct techniques. It is possible that this strategy contributed to the richness of the data.

- Why do I feel this way and what does it mean for my research?

All of the participants at some point evoked powerful emotional reactions in the researcher which is important to reflect upon. The researcher needs to be transparent about the fact that she has an interest in transference and counter-transference; therefore, it was inevitable that the researcher was going to pick up on her emotional exchanges with participants. For example, the researcher was struck by some of the details on the demographic information sheet. Their history, number and length of admissions, low body mass index and their narratives in the interview illustrated how trapped they were in a different world, with a whole set of different norms, expectations, rules and routines. Suffering with anorexia nervosa along with being detained, concurrently strip a person of any typical development trajectories. The researcher was saddened when thinking about
the amount of missed opportunities and life experiences they have lost. The researcher was moved when seeing participants face-to-face. The physical, emotional and mental torment of these participants could not be avoided. They appeared vulnerable, hopeless and elicited the caring response in the researcher. It is possible that the researcher’s emotional responses influenced the findings. For example, the theme of loss, and the development of the institutionalised ‘bubble’ in the grounded theory, paralleled her initial thoughts and feelings upon engagement with this population. It is also possible that when they discussed practices that made them feel powerless, and when they described practices that alluded to a lack of person-centred care, the researcher may have tuned into these experiences more in the belief that services are failing to do enough to help this client group. Although the researcher recognises that this is an erroneous belief and in fact services are doing the best that is available to them with a very complex presentation, this potential bias was instead driven from her need to rescue participants from such mental torment. This was useful to reflect on in supervision and allowed the team to return to the data to ensure the validity of the theoretical model.

As mentioned briefly in the previous section, the researcher’s affective response to the participants made it a constant challenge to remain in a researcher rather than therapist role. She was curious and wanted to explore the development of their anorexia as she would do when carrying out a clinical assessment. She also felt pulled to offer empathic statements, reflections and tentative hypotheses. An excerpt from the reflective journal may highlight this:

“There is so much to this person’s history. I wanted to find out more about her earlier relationships and attachments. What has happened to this person to have some much self-hatred? There is so much going on for her and I just can’t scratch below the surface. It’s hard trying to stay focused on the research. It almost feels against the grain to not respond therapeutically”.
The researcher felt guilty remaining on track and prioritising the research objectives. She felt the participants’ torment and the researcher’s attention was drawn to recognising possible co-morbidities. The researcher caught herself formulating throughout the interview and in her reflective journal; therefore, it could be argued that her formulation skills influenced the synthesis. The researcher learned to manage her feelings by first noticing what was happening. Peer supervision was a pivotal arena to reflect on these issues. This seemed to be a common experience for other trainees carrying out qualitative research, which helped to validate her experience. The researcher also repeatedly went back to her objectives and had them displayed visually in front of her whilst carrying out the interview. This simple strategy, helped immensely to keep her on track.

Some of the participants evoked in the researcher quite different emotional reactions. She noticed she often felt frustrated and exasperated by some participants. On reflection, these participants appeared to be people who possibly held ‘entitlement schemas’ (a term from schema therapy) and this seemed to be associated with a middle class lifestyle. This made it difficult at times for the researcher to maintain empathic and free of assumptions and judgements which is illustrated in the following quotation from the reflective journal:

“This participant seems like she is entitled to a service and tends to not take any personal responsibility for her actions. She portrays that she has no choice in treatment compliance when other participants have said that in fact it was a choice and they made the choice to get better. Certain things she said made me think she was middle class, privileged and that she saw herself as superior in some way. I wonder what she thinks about me. It’s hard knowing how much this client group aren’t ready or motivated for recovery when at the same time other services for vulnerable people are being axed all over and I wonder if my frustration mirrors how staff, who work clinically with this population, may feel”.

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The reflective journal and supervision enabled these feeling to be shared and reflected upon. This helped bring attention to biases and preconceptions and to think about the impact these may have on the coding and the analysis. In line with the social constructivist approach, it is inevitable to a certain degree that the researcher’s feelings, beliefs and assumptions constructed the theory; however, being transparent allows the reader to develop their own opinion about a person’s experiences. These feelings also gave an insight into how staff felt. Although this is outside the remit of the study, it enabled the researcher to develop more understanding and knowledge about possible systemic factors which impact on a person’s experiences of detention and their eating disorder. Overall, the researcher enjoyed the emotional complexity evoked from this of this group of participants.

- Power

Consistent with a social constructivist perspective, the researcher sought to reflect on and erode any power differences between the researcher and the participants (Mills & Bonner, 2006). The researcher noticed that many participants talked about experiences of control, coercion and powerlessness when detained. The researcher wondered what it was like for participants to be in a participant role, in relation to a researcher, who was also a trainee clinical psychologist. Participants may have had their own preconceptions of researchers and psychologists from their own experiences. The researcher ensured participants had some element of choice and control over the interview for example, interview mode, day and time of interview and breaks. The semi-flexible approach to questioning also helped to give participants a bit more power over the direction of the interview. The researcher undoubtedly invested her personality in the research process. She was warm, mirrored their emotional experience, offered empathic statements, was at times informal and honestly answered their questions. The researcher recognised that power is inherent in this relationship and cannot be avoided; however, she believes that her approach enabled this to be kept to a minimum.

- What do I do with all this data?

The researcher faced some challenges during the course of analysis. The researcher was a novice in relation to grounded theory and initially she found it difficult to understand the
terminology and procedure for analysis. Charmaz (2006) points out that a skill in the ‘initial coding’ phase consists of remaining close to the data, without making too much of an interpretative leap. The researcher noticed that she was simply coding exactly what the participant said and therefore was offering little interpretation. This was discussed and reflected upon in supervision and the codes were re-coded accordingly. The skill involved a balance between remaining ‘grounded’ in the data, whilst also making an interpretation of the data. Being familiar with the literature on grounded theory was a good foundation; however, her skills developed over time and with practice.

The researcher felt particularly stuck during the course of the analysis. She was struck by the sheer volume of codes that she had to make sense of. This was a by-product of the depth and length that some of the participants talked for. The researcher felt overwhelmed and for a while she was pondering whether to use computer software packages to help with the analysis. However, she felt anxious about learning how to use a new software package within the time limits and her supervisor reported that he had little experience. The researcher found it helpful to break each interview down, grouping the codes and picking out the most salient, which were repeated across the interviews i.e. ‘focused coding’. The researcher often organised her thoughts in diagrams so she constructed diagrams for each interview in order to map out the relationship between the codes. She then compared and contrasted these through a process of ‘constant comparison’, in order to understand how they related to one another and the factors or conditions by which these operated (Charmaz, 1990). Supervision allowed further refinement of the analysis. This strategy enabled her to make sense of the data.

- *Are my results biased?*

The researcher noticed that her therapeutic and clinical experiences had started to shape her interpretation of the data. Similar to what happened in the metasynthesis, the researcher noticed that she started to understand the data in line with a cognitive behavioural model (for example, thoughts, schemas, feelings and behaviours were distinguished). It is also important to point out that her personal experiences could have potentially biased the interpretation. Working with participants with anorexia nervosa
raised some interesting reflections for the researcher because it reminded her of her experience of seeing someone personally suffer from anorexia. The researcher has seen this person become fused with her anorexia and her ‘ill’ identity, which is a dominant narrative within the family and has over time, maintained her behaviour and become a way of maintaining particular roles within the family. The researcher found herself tuning into the ‘illness narrative’ and the ‘anorexia is not a choice’ narrative, which could have potentially closed off other interpretations without adequate supervision. However, these were confirmed to be represented in the data.

All of the researcher’s thoughts and feelings were managed through the use of a reflective diary and supervision which was pivotal in challenging and scrutinising codes, categories and subcategories. The researcher noticed that over the course of the analysis, it became easier to see more interpretations and move away from what felt like fixed pre-conceptions. It became possible to see different ways that these codes related to each other. This could also be a result of the line-by-line coding which allowed the researcher to become increasingly immersed in the data, making room for more developed insights. It could also be due to ‘theoretical sampling’ which allowed the researcher to test out her hypothesis and allowed further lines of enquiry to be opened up. Nevertheless, the analysis was a particular challenge and illustrated to the researcher just how context, experiences and preconceptions can influence qualitative research. The researcher now accords with Thomas and James’s (2006) view, that it is impossible to totally be free of pre-conceptions in the way purported by Glaser and Strauss (1967). By taking a critical realist stance, the researcher acknowledges her potential biases and her role in the analytic process which is a vital skill that will be utilised and upheld in future research.

- **What is the point in a reflective journal?**

The use of a reflective journal is considered to be a key tool in the qualitative process. Strauss and Corbin (1990) advocate that a journal enables researchers to record their thinking about the research area and think about influences on the data. Initially, the researcher thought this was perhaps tokenistic and was unable to understand its importance. However, in line with the model, the researcher completed a reflective
journal from the outset and several references have been made to how helpful it has been as a tool. The researcher documented any observations, thoughts, concerns, reflections, insights and ideas, which tended to emerge spontaneously regardless of whether she was carrying out research or not. She wrote in the journal after interviews to capture thoughts, feelings, impulses and beliefs that may have arisen in the researcher. It allowed her to reflect on the relationship between her and the participant. Over time, the journal became a pivotal tool in the process. It undoubtedly enabled a more sophisticated understanding and insight into the interpretation of the data and served to document various decision-making processes. The journal although typically is used to make the process transparent and avoid bias, the researcher recognises that consistent with a constructionist approach, analysis and theory construction can never be free from bias. Therefore, the journal was invaluable in making explicit the multiple influences i.e. the research team’s theoretical, personal and contextual factors that may have had an impact on the research process and influence the reconstruction of theory. This experience has highlighted the importance and usefulness of this key tool.

- Writing for publication

The researcher acquired experience and skills in writing for publication. Initially, she wrote in accordance with a traditional thesis style. After discussion in supervision, it was important to the researcher and the research team that the work was published. The researcher strongly believes in publishing quality research, regardless of the outcome of the research. The resources that go into research, as well as the use of service-users time, means that ethically, researchers have an obligation to publish the findings.

One of the challenges in writing for publication was ensuring the quality of the study was acceptable. Carter and Little (2007) highlighted that qualitative research is frequently insufficient in the descriptions, explanation and justification of the methodology, and in the procedures, tools and techniques of the method. The underlying epistemology is often the most neglected and can sometimes be internally inconsistent within a study (Carter & Little, 2007). The researcher ensured she had a good enough understanding of the
epistemological position and adhered to guidelines by Walsh and Downe (2006) when writing up for publication.

An additional challenge in writing for publication was writing within the word limits which links to the point above. The researcher found that a lot of the detail in the analysis and the quotations had to be excluded. The researcher struggled to accord with the Walsh and Downe (2006) quality checklist because of the constraints. Many of the researchers' reflections, which are vital in interpretive research, had to be limited. The researcher experienced a first-hand being torn between writing good quality research and meeting publisher’s strict guidelines and she hopes the balance has been reached. Furthermore, the amount and depth of data produced meant that the researcher could see other possible hypotheses, links and lines of enquiry which went beyond the aims of the study. For instance, she wanted to explore the participant’s earlier relational experiences to see how they influenced their patterns in relationships with staff, services and other agencies in the here and now. It is possible that their relational patterns contributed to a feeling of ‘stuckness’ within the system. The researcher could see how the same data could be used to explore other research questions and she learned to distil down lots of data, using the methodology of grounded theory, in order to meet the aims of her study. She found it difficult selecting which quotes to include because there were many which captured so eloquently participant's experiences and therefore the majority were not included. Therefore, the researcher believes that doing this within the word limits set by publishers does not do justice to qualitative research.

- What have I learned? What clinical implications have come from this and what does this mean for my career as a clinical psychologist?

This project has enabled the researcher to reflect on the role of the clinical psychologist within acute mental health settings in the NHS. Both of these papers have helped the researcher realise just how much attitudes or ideologies influence mental health care. Psychiatric ideologies of mental illness being biologically orientated can be dominant in influencing the systems, professionals and service users’ perceptions, experiences, feelings and relationship to mental health problems. Ideologies although reflect differences in training and personal opinions, the problems arises when they become the
source of conflict in teams, which fits with the researcher’s clinical experience. This is a vital consideration when working with chronic, complex and treatment resistant mental health problems like anorexia nervosa and under times of economic hardship within the NHS, when there are threats to professional roles and professional identity. Under these conditions, professional groups tend to hold onto their viewpoints more rigidly. Given the move to multi-disciplinary, multi-agency and integrated working, the clinical psychologist has a valuable role in providing consultation to teams. Psychological theory and psychological formulation can address the processes that threaten the ability of teams to provide an integrated, joined up and person-centered service. As a profession, our training has equipped us to fulfil these pivotal roles.

Both papers made the researcher think about the historical, social and cultural context of the mental health system. The researcher was struck by the paternalistic and risk averse nature of services. Although the mental health act and inpatient services have been developed to keep people ‘safe’, the data suggests that these systems are counterproductive in the long-term. They dis-empower service users and remove their sense of responsibility, which reinforces the medical model of mental illness and can lead to an over dependence on services and what may be considered the ‘revolving door phenomena’. Similarly, the researcher hypothesised that the language used by the participants in study two were internalised reflections of the broader social and cultural construction of ‘mental illness’. In line with the social constructivist approach, you can see that having a ‘mental illness’ being ‘assessed’, ‘diagnosed’ and ‘treated’ and the distinctions between ‘normal” and ‘pathological’ and the imperative of ‘compliance’ to ‘cure’ the ‘symptoms’shapes their understanding of reality and ultimately their understanding of themselves. Re-designing services to create the contexts where more recovery-based approaches are implemented is vital. This approach gives back the power to service users who are the experts of their recovery and aims to help people live a quality of life as a valued member of the community. The Wellness Recovery Action Plan (WRAP; Copeland, 2002), developing networks of peer support and the move to increase service user involvement are namely only a few recovery initiatives. Although they are worthwhile, their implementation needs to be more than a ‘tick box exercise’.
There needs to be a paradigm shift where ideologies and language use is challenged and a recovery approach is thoroughly embedded and evaluated throughout services.

The papers illustrate just how wider system factors impact on a person’s mental health difficulties. This enabled the researcher to see the importance of moving away from traditional psychological services to working indirectly with the wider systems, as well as offering support via service consultation, staff training and supervision. The researcher can understand how this way of working is imperative if as a profession we want to increase psychological understanding of service-users’ experiences amongst many more professionals. This in turn we would hope would improve the psychological skills of all staff in assessment, formulation and intervention. Clinical psychologists can formulate how the wider system acts to maintain a person’s problems and therefore think about change on an individual level but also at a systemic and service level. In sum, the clinical psychologist does have a role in changing service-users’ experiences of inpatient care; however, this is a complex task requiring change at many different levels of the system.

- **Summary**

Carrying out a research project as part of a doctorate in clinical psychology has been an invaluable learning experience. From the outset, various challenges have been faced and no doubt will continue until publication. The researcher's clinical skills, guidance from supervision and teaching from the doctorate, have been essential in overcoming the challenges. This experience has allowed the researcher to develop a good foundation of research skills and a better understanding of peoples’ experiences of being detained and how this may influence outcome. These are helpful skills which are pivotal in her career as a clinical psychologist in the NHS. The researcher has developed an understanding and commitment to the changing role of the clinical psychologist in order to improve services users’ experiences of mental health services.
References


Appendix 1. Contributor guidelines for the International Journal of Nursing Studies
Introduction

The International Journal of Nursing Studies (IJNS) provides a forum for publication of scholarly papers that report research findings, research-based reviews, discussion papers and commentaries which are of interest to an international readership of practitioners, educators, administrators and researchers in all areas of nursing, midwifery and the caring sciences. Papers should address issues of international interest and concern and present the study in the context of the existing international research base on the topic. Those which focus on a single country should identify how the material presented might be relevant to a wider audience and how it contributes to the international knowledge base. Selection of papers for publication is based on their scientific excellence, distinctive contribution to knowledge (including methodological development) and their importance to contemporary nursing, midwifery or related professions.

Submission to this journal proceeds totally online and you will be guided stepwise through the creation and uploading of your files. The system automatically converts your files to a single PDF file, which is used in the peer-review process.

Amongst the many submissions received we recognise that some will have been previously formatted for another journal. The Simpler Submission service (described later) means that authors can submit these papers to the IJNS without worrying about formatting the manuscript again to exacting specifications.

The IJNS also offers a rapid review service for newsworthy papers under our 4* submission service.

Types of papers

The IJNS publishes original research, reviews, and discussion papers. In addition we publish editorials and letters. Where a case is made we will also publish protocols of trials which meet our general criteria for interest and significance.

Editorials — 1,000–2,000 words
Authors who have ideas for editorials which address issues of substantive concern to the discipline, particularly those of a controversial nature or linked directly to current/forthcoming content in the journal, should contact the Editor in Chief (ijns@kcl.ac.uk)

Research Papers — 2,000–7,000 words
Full papers reporting original research can be a maximum of 7000 words in length, although shorter papers are preferred. Research papers should adhere to recognised standards for reporting (see guidance below and the Author Checklist).

Reviews and Discussion Papers — 2,000–7,000 words
• Reviews, including:
- systematic reviews, which address focussed practice questions;
- literature reviews (scoping reviews, narrative reviews), which provide a thorough analysis of the literature on a broad topic;
- policy reviews, i.e. reviews of published literature and policy documents which inform nursing practice, the organisation of nursing services, or the education and preparation of nurses and/or midwives).

• Discussion Papers, i.e. scholarly articles of a debating or discursive nature.

Letters to the editor — upto 1,000 words
Designed to stimulate academic debate and discussion, the Editor invites readers to submit commentaries (up to 1500 words) or short comments (about 500 words) on papers recently published in the IJNS. Contributions that are of general interest, stimulating and meet the standards of scholarship associated with the Journal may be selected for publication in a commentary section or as a standalone contribution. Contributions should be submitted as in the usual way.

CONSIDERATIONS SPECIFIC TO TYPES OF RESEARCH DESIGNS
The editors require that manuscripts adhere to recognized reporting guidelines relevant to the research design used. These identify matters that should be addressed in your paper. The checklists identify essential matters that should be considered and reported upon. They are not quality assessment frameworks and your study need not meet all the criteria implied in the reporting guideline to be worthy of publication in the journal. For example, a controlled trial may or may not be blinded but it is important that the paper identifies whether or not participants, clinicians and outcome assessors were aware of treatment assignments.

You are encouraged to submit a checklist from the appropriate reporting guideline together with your paper as a guide to the editors and reviewers of your paper.

Reporting guidelines endorsed by the journal are listed below:
• Observational cohort, case control and cross sectional studies - STROBE - Strengthening the Reporting of Observational Studies in Epidemiology http://www.equator-network.org/index.aspx?o=1032

Qualitative researchers might wish to consult the guideline listed below:
• Qualitative studies - COREQ - Consolidated criteria for reporting qualitative research.
All research papers reporting the development or testing of scales must include a copy of the full scale as a Supplementary file at submission stage so it can be published as an appendix online; the IJNS does not accept scale development papers which are not accompanied by a copy of the full scale. Authors are required to obtain written permission from the copyright owner of the scale to reproduce it, and ensure that it is credited appropriately and the correct copyright line qualifying the permission to use/translate the scale is supplied underneath the submitted scale. If authors want to retain copyright of their scale they can mark it as reproduced with their permission.

If the scale is in a language other than English, then it must be accompanied by an English translation. If the newly developed scale is a translation of an existing scale then the IJNS requires author(s) to obtain written permission from the copyright owner of the original scale to publish the translated version with full credit given also to the original scale (an English translation is still also required).

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Appendix 2. Critical Appraisal Skills Framework
Screening Questions
1. Was there a clear statement of the aims of
<table>
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<tr>
<th><strong>the research?</strong></th>
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<tbody>
<tr>
<td><strong>Consider:</strong></td>
</tr>
<tr>
<td>☐ What the goal of the research was</td>
</tr>
<tr>
<td>☐ Why is it important</td>
</tr>
<tr>
<td>☐ Its relevance</td>
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<th>2. Is a qualitative methodology appropriate?</th>
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<tr>
<td><strong>Consider:</strong></td>
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<tr>
<td>☐ If the research seeks to interpret or illustrate the actions and/or subjective experiences of research participants</td>
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<tr>
<th><strong>Detailed questions</strong></th>
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<th>3. Was the research design appropriate to address the aims of the research?</th>
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<tr>
<td><strong>Consider:</strong></td>
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<tr>
<td>☐ If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?</td>
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<tr>
<th>4. Was the recruitment strategy appropriate to the aims of the research?</th>
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<tr>
<td><strong>Consider:</strong></td>
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<tr>
<td>☐ If the researcher has explained how the participants were selected</td>
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<tr>
<td>☐ If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study</td>
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<tr>
<td>☐ If there are any discussions around recruitment (e.g. why some people chose not to take part).</td>
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<th>5. Were the data collected in a way that addressed the research issue?</th>
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<td><strong>Consider:</strong></td>
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<tr>
<td>☐ If the setting for data collection was justified</td>
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<tr>
<td>☐ If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)</td>
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<td>☐ If the researcher has justified the meth-</td>
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<th>6. Has the relationship between researcher and participants been adequately considered?</th>
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<td><strong>Consider:</strong></td>
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<td>☐ If the researcher critically examined their own role, potential bias and influence during:</td>
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<tr>
<td>Question</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td><strong>Formulation of the research questions</strong></td>
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<tr>
<td><strong>Data collection, including sample recruitment and choice of location</strong></td>
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<tr>
<td><strong>How the researcher responded to events during the study and whether they considered the implications of any changes in the research design</strong></td>
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<tr>
<td><strong>7. Have ethical issues been taken into consideration?</strong></td>
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<tr>
<td><strong>8. Was the data analysis sufficiently rigorous?</strong></td>
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<tr>
<td><strong>9. Is there a clear statement of findings?</strong></td>
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<tr>
<td>If there is adequate discussion of the evidence both for and against the researcher’s arguments</td>
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<tr>
<td>If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)</td>
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<tr>
<td>If the findings are discussed in relation to the original research question</td>
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**10. How valuable is the research?**

*Consider:*
- If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature?
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research maybe used

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**Appendix 3. Walsh and Downe Evaluation**
Appendix 4. Example Data Extraction Form
### Appendix 5. Reviewed studies and themes

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<td>Sub-themes</td>
<td>Staying safe</td>
<td>Restoration to normality</td>
<td>Loss of normality and perceived independence</td>
<td>Loss of identity</td>
<td>Fluctuating emotions</td>
<td>Working with me versus steamrolling</td>
<td>Connecting and disconnecting practices</td>
<td>I am a person versus I am an illness</td>
<td>You’re disempowering me</td>
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Appendix 6. European Eating Disorders Review Author Guidelines
Author Guidelines

Manuscript Submission
European Eating Disorders Review has now adopted ScholarOne Manuscripts, for online manuscript submission and peer review. The new system brings with it a whole host of benefits including:

- Quick and easy submission
- Administration centralised and reduced
- Significant decrease in peer review times

From now on all submissions to the journal must be submitted online at http://mc.manuscriptcentral.com/erv. Full instructions and support are available on the site and a user ID and password can be obtained on the first visit. If you require assistance then click the Get Help Now link which appears at the top right of every ScholarOne Manuscripts page. If you cannot submit online, please contact Maurine Balansag in the Editorial Office (EEDRedoffice@wiley.com).

**Illustrations** must be submitted in electronic format. Save each figure as a separate file, in TIFF or EPS format preferably, and include the source file. We favour dedicated illustration packages over tools such as Excel or Powerpoint. Grey shading (tints) are not acceptable. Lettering must be of a reasonable size that would still be clearly legible upon reduction, and consistent within each figure and set of figures. Supply artwork at the intended size for printing. The artwork must be sized to the text width of 7 cm (single column) or 15 cm (double column).

**Manuscript style.** All submissions, including book reviews, should be double-spaced and clearly legible.

The first page should contain the **title** of the paper, full names of all authors, the address where the work was carried out, and the full postal address including telephone, fax number and email to whom correspondence and proofs should be sent. The name(s) of any **sponsor(s)** of the research contained in the paper, along with **grant number(s)** should also be included.

The second sheet should contain an **abstract** of up to 150 words. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work. Include up to five **keywords** that describe your paper for indexing purposes.

- **Research articles** reporting new research of relevance as set out in the aims and scope should not normally exceed 6000 words with no more than five tables or illustrations. They should conform to the conventional layout: title page, summary, introduction, materials and methods, results, discussion, acknowledgements and references. Each of these elements should start on a new page. Authors may not find it necessary to use all of these subdivisions, and they are listed here only as a guide.
• **Review articles** should offer a synthesis of current knowledge in a field where rapid or significant progress has been made. The text should ideally not exceed 7000 words, 50 references and 5 figures or tables.

• **Brief reports** should concisely present the essential findings of the author's work and be comprised of the following sections: Abstract, Introduction and Aims, Method, Results, Discussion, and References. Tables and/or figures should be kept to a minimum, in number and size, and only deal with key findings. In some cases authors may be asked to prepare a version of the manuscript with extra material to be included in the online version of the review (as supplementary files). Submissions in this category should not normally exceed 2500 words in length.

Brief reports bring with them a whole host of benefits including: quick and easy submission, administration centralised and reduced and significant decrease in peer review times, first publication priority (this type of manuscript will be published in the next available issue of the journal).

• **Case Reports** The journal does not accept case reports for publication. Authors of case reports are encouraged to submit to the Wiley Open Access journal, Clinical Case Reports [www.clinicalcasesjournal.com](http://www.clinicalcasesjournal.com) which aims to directly improve health outcomes by identifying and disseminating examples of best clinical practice.

**Reference style**. The APA system of citing sources indicates the author's last name and the date, in parentheses, within the text of the paper.

**A. A typical citation of an entire work consists of the author's name and the year of publication**.

Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.

**B. If the author is named in the text, only the year is cited**.

Example: According to Irene Taylor (1990), the personalities of Charlotte. . .

**C. If both the name of the author and the date are used in the text, parenthetical reference is not necessary**.

Example: In a 1989 article, Gould explains Darwin's most successful. . .

**D. Specific citations of pages or chapters follow the year**.

Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).
E. When the reference is to a work by two authors, cite both names each time the reference appears.

Example: Sexual-selection theory often has been used to explore patterns of various insect matings (Alcock & Thornhill, 1983). . . Alcock and Thornhill (1983) also demonstrate. . .

F. When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by et al. (meaning "and others").

Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas et al., 1997). When the reference is to a work by six or more authors, use only the first author's name followed by et al. in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.

G. When the reference is to a work by a corporate author, use the name of the organization as the author.

Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).

H. Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text.

Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas.

I. Parenthetical references may mention more than one work, particularly when ideas have been summarized after drawing from several sources. Multiple citations should be arranged as follows.

Examples:

- List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)
- Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)
- List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

All references must be complete and accurate. Where possible the DOI for the reference should be included at the end of the reference. Online citations should include date of
access. If necessary, cite unpublished or personal work in the text but do not include it in the reference list. References should be listed in the following style:

**Journal Article**


**Book**


**Book with More than One Author**


The abbreviation *et al.* is not used in the reference list, regardless of the number of authors, although it can be used in the text citation of material with three to five authors (after the initial citation, when all are listed) and in all parenthetical citations of material with six or more authors.

**Web Document on University Program or Department Website**


**Stand-alone Web Document (no date)**


**Journal Article from Database**


**Abstract from Secondary Database**

**Article or Chapter in an Edited Book**


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Additional material such as video clips, lengthy Appendices (e.g. extensive reference lists or mathematical formulae/calculations), etc, that are relevant to a particular article but not suitable or essential for the print edition of the Journal, may also be considered for publication. Please refer to all supporting information in the manuscript using Table S1, Figure S1, etc, and supply such information as separate files (i.e. not embedded within the main manuscript). Further information on suitable file formats etc may be found here.

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**Appendix 7. Ethical Approval Letter**

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Appendix 8. Participant Information Sheet
Participant Information Sheet

Title of project: Understanding experiences of involuntary detention under the Mental Health Act.

Researchers: Tara Seed, Dr John Fox, Dr Magdalene Sampson and Dr Katherine Berry.
You are invited to take part in a research study. Before you decide, it is important for you to understand why the research is being carried out and what it will involve. This study is being carried out as part of a doctoral qualification from the University of Manchester. Please take your time to read the following information and you can discuss it with others if you think that would be helpful. If there is anything unclear, you have any questions, or would like more information, please feel free to contact me. Take your time to decide whether you wish to take part.

**What is the purpose of the study?**

This research project aims to explore your experiences of being detained under the Mental Health Act for Anorexia Nervosa. It is hoped that an improved understanding of how people experience detention will be useful for services, and for staff, when caring for people who suffer from Anorexia Nervosa.

**Why have I been invited to take part?**

You have been invited because you have currently, or you have in the past, been diagnosed with Anorexia Nervosa and detained under a Section 2 or 3 of the Mental Health Act and we are interested in hearing what that experience was like for you.

**Do I have to take part?**

It is your decision if you would like to take part or not. This information sheet should help you to decide and you have 48 hours to decide if you wish to take part. If you do decide to take part and contact Tara from the research team, she will talk you through this sheet and any questions you have can be answered. You will be asked to sign a consent form and you will be given a copy to keep. If you decide not to take part, your decision will be respected and the standard of care you receive will not be affected.

**Is there someone I can talk to get advice about taking part?**

You can talk to friends, family and staff and anybody you like about taking part.

**What if I change my mind?**
You are free to withdraw at any time up to 6 weeks after the interview, without giving a reason. Your decision will be respected and the standard of care you receive will not be affected.

**What if I change my mind after the 6 week cut off?**

If after this point in time the researcher has not started the analysis, the researcher will work hard to withdraw the information from your interview, if this is practically possible. If this is not the case, the researcher will remove any reference to you and will not put any quotes from your interview in the write-up.

**What if I consent to take part in the study and then lose capacity to consent during the study?**

This is unlikely but if this happens, identifiable data that has already been collected will be kept for the purposes of the study. Any identifiable details will be removed. At the point of you losing capacity, no further questions or interviewing will be carried out.

**What will I be asked to do if I take part?**

You will be asked to complete 2 brief psychological questionnaires and fill out a sheet asking about demographic details (such as age, gender, number and dates of previous admissions). You will also be asked to give approximately 40 minutes to an hour of your time to talk to Tara from the team about your experiences. This can be either in person or over the phone, depending on what you choose. This will be an informal, one-to-one discussion. If you are already in hospital, it will take place in the hospital you are in. If you are not, it may take place in a daycentre if you attend one, in your outpatient clinic if that’s how you heard about the study or over the phone. An interview could also be carried out at your home depending on what is best for you. The interview will be audio-recorded so that the researcher can listen back to it at a later date and write down what was said.

**Will the research team look at my clinical notes?**

The researcher will need to ask you about the number of previous admissions, dates and length of those admissions and the nature of the admission i.e. was it
involuntary detention. This is to help the team understand your experiences a bit more. Your clinical notes will not be accessed by any of the research team.

**Will my personal details be kept private?**

Yes. All personal identifiable information will be kept anonymous and strictly confidential. This means that your identity will be kept private at all times. John Fox, Magdalene Sampson and Katherine Berry may see anonymised transcripts of your interviews so they will not be able to link the transcript to the participant. Only these researchers who are involved in this study will have access to the anonymised interview transcripts. The anonymised data will be stored on confidential University computers and hardcopies will be in a locked filing cabinet at the University of Manchester, Zochonis building and all data will be destroyed confidentially after 5 years. Any personal contact details will be also be destroyed confidentially after 5 years.

Your personal data may be accessed by individuals responsible for auditing and monitoring the conduct of the study on behalf of the University, NHS or regulatory authorities who will have access for this purpose. This is routine for research.

**Are there any exceptions?**

If you told the researcher something that made her worry about your safety, or the safety of others, she would have to inform the person responsible for your care. If this did happen, this would be discussed with you at the time.

**Will my GP or Psychiatrist know that I am taking part in the study?**

Yes, if you have a Psychiatrist, they will be informed that you are taking part in the study. Your GP will also be informed.

**What will happen to the results?**

It is the intention of the researcher that this research will be written up and published in relevant journals that are read by health professionals. No identifiable details will be published. For example, we would never use your name, contact details or date of birth. Anonymised quotes may be used in the publication. If you wish, you can have access to a summary of the results of the study by ticking the relevant box on the consent form. The results of the final analysis from all participants will be fed back to interested staff and service-
users from the Priory and from the Salford Eating Disorders Service, and BEAT charity as these are the sites where participants have been recruited from. However, you will never be identified.

**Will I be involved in looking at my analysis?**

Four people will be randomly selected to look at the analysis from their interview and give their opinion about it. If you would like to be potentially involved in this (i.e. if yours is picked), you can consent to this on the consent form.

**If I have a complaint about the way I have been approached or treated before, during or after the research, how do I go about doing this?**

If you have a concern, complaint or worry about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If you have seen and heard about the study through Salford Eating Disorders service, you could contact the Patient Advice Liaison Service (PALS) on 0800 587 4793 (Monday to Friday, 9.00am to 5.00pm) or email: pals@gmw.nhs.uk. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Co-ordinator on, 0161 2757583 or 0161 2758093 or by email: research-complaints@manchester.ac.uk. They will manage your complaint as soon as possible.

I would like to thank you for taking the time to read this information sheet.
Please keep this for your reference. I hope it has been helpful for you.

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**If you are interested in taking part, register your interest in seconds using the following link:**
www.manchester.ac.uk/psychology/experiencesdetention

Alternatively, you can contact Tara on any of the details below, and she will get back to you as soon as she can:

**Email -** tara.seed@postgrad.manchester.ac.uk
Appendix 9. Recruitment Advert

Telephone - 07581350387

Address - Division of Clinical Psychology, 2nd Floor, Zochonis Building, University of Manchester, Brunswick Street, Manchester, M13 9PL.

Many Thanks, Miss Tara Seed, Trainee Clinical Psychologist
Seeking volunteers for research to explore the experience of involuntary detention under the Mental Health Act for Anorexia Nervosa.

University of Manchester
Central Manchester Foundation NHS Trust

Mental Health
Being detained is a controversial subject. We want to explore how the experiences of being detained, against someone’s will, under the Mental Health Act, for Anorexia, impact on psychological functioning. You will be asked to talk to a member of the research team for about an hour, about your experiences, understanding and perception of being admitted and treated under the Act. It may involve a follow up meeting to check that the results fit with your views.

If you have been detained under the Mental Health Act, with a diagnosis of Anorexia and this has been within the last 10 years, we would like to invite you to find out more about the study. If this interests you, contact us below:

Appendix 10. Demographic Information Sheet
Demographic Questionnaire

This information collects information about yourself and your background. Please read and answer every question. All information provided will be treated in confidence and will not be made available to any other source without your approval.
1. **About you**

   Are you?  
   □ Male  
   □ Female  

   How old are you?  

   What is your estimated body mass index?  

   If you do not know please, please could you provide us with an estimate of your weight and height so we can calculate this for you?  
   Height:  
   Weight:  

2. **Your Family**

   What is your current relationship status?  
   □ Married  
   □ Living together  
   □ Separated or divorced  
   □ Other  
   Please describe:  

   Do you have any children?  
   □ Yes  
   If so, how old are they?  
   □ No  

3. **Your ethnicity**

   With which ethnic group do you identify?  

   **White**  
   A) British  
   B) Irish  

   **Black or Black British**  
   M) Caribbean  
   N) African  

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4. **Education**

What is your highest level of education?

- [ ] No qualifications
- [ ] GCSEs, CSEs, or O-levels
- [ ] A levels/ BTEC
- [ ] Trade/apprenticeship
- [ ] University degree
- [ ] Other (please specify) ____________________

5. **Employment Status**

- [ ] Full time
- [ ] Part time
- [ ] Home duties
6. **Health**

*Name and address of care-coordinator*

………………………………………………………………………………………………………………………………………………………………
………………………………………………………………………………………………………………………………………………………………
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……………………..

*Name and address of GP (if I don’t have a care coordinator)*

………………………………………………………………………………………………………………………………………………………………
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**Current difficulties**

Have you been diagnosed with a psychological or psychiatric disorder? □ Yes □ No

If so, please specify………

How severe would you say your difficulties are at the moment?

1......2........3......4......5......6......7......8......9......10

Not at all severe .......... Very severe

Are you currently taking any medication? □ Yes □ No

If so, what is it?

………………………………………………………………………………………………………………………………………………………………

Past difficulties

Have you experienced emotional or psychological difficulties in the past? □ Yes

□ On Maternity Leave

□ Unemployed
7. **Admissions**

Have you been admitted to hospital before for Anorexia Nervosa  

Yes ☐

No ☐

How many times have you been admitted? ...........................................................................................................

Please can you tell me each time you were admitted where you were admitted to, if you were voluntarily or involuntarily detained and approximately how long you were admitted for:

..........................................................................................................................

..........................................................................................................................

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Appendix 11. Pre and post interview consent forms
Consent form (pre-interview)

Project: Understanding experiences of involuntary detention under the Mental Health Act
Researchers: Tara Seed, Dr John Fox, Dr Magdalene Sampson and Dr Katherine Berry.

I confirm that I have read and understand the information sheet dated…………………..for the above study and I confirm that I have had the opportunity to think about if I want to participate or not and I have been given the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

I understand that if I do not have a care-coordinator or Psychiatrist, the research team will notify my GP that I am taking part in the study. I understand that if I have a care coordinator, they will be notified instead of my GP that I am taking part.

I understand that if I consent to take part in the study and then the research team or clinical team judge that I may have lost the capacity to consent during the study, any data that has already been collected will be kept for the purposes of the study. Any identifiable details will be removed and none of the quotes from my interview will be put into the analysis. I understand that at the point of losing capacity, I will not take part in any further interviews.

I understand and consent to the interview being audio recorded.

I understand that direct, anonymised quotations from my interview may be used to illustrate study findings in reports and presentations.

I understand that relevant sections of data collected during the study may be looked at by responsible individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in the research. I give permission for these individuals to have access to this data.
I understand that there may be the possibility that a member of the research team will contact me after the interview to discuss the analysis of my interview. I confirm that they may contact me and the best details to contact me are:……………………………………………………………
………………………………………………………………

I would like to receive information on other studies which I may be suitable for.

I agree to take part in the above study

Name of participant       Date       Signature
----------------------------  ----------  ------------

Name of researcher        Date       Signature
----------------------------  ----------  ------------

A copy of this consent form will be sent to you for your own records.

Consent form (post-interview)

**Project:** Understanding experiences of detention under the Mental Health Act

**Researchers:** Tara Seed, Dr John Fox, Dr Magdalene Sampson and Dr Katherine Berry.
I understand that I can withdraw my interview from the study and this will not affect any benefits or services.

I confirm that my interview data can be used for this study.

I give permission for my direct, anonymised quotations to be used if required to illustrate study findings in research publications.

I would like to be sent a summary of the final analysis. Please send it to:

Name of participant  Date  Signature

Name of researcher  Date  Signature

A copy of this consent form will be given to you for your own records.

Appendix 12. Full Interview Schedule
Interview Schedule

Note – To be used flexibly in line with participants experiences. Some sections may, or may not, be applicable.

1) Can you tell me a bit about your history of being treated as an inpatient?

Probes:
Diagnosis/Presenting difficulties/Experience
When was onset/how long have you been experiencing mental health issues?[associated with anorexia]?
How many times have you been detained, compulsorily or voluntarily?

I would now like you to think about the last time you were compulsorily detained under the Mental Health Act (1983/2007) (if they are currently detained, ask them about their current experience). From your perspective, I am now going to ask some questions about this experience and how you think the process impacted upon you psychologically?

2) Can you describe what was going on in the lead up to your last compulsory detention?

Probes:
What was going on in your life at the time?
What do you think might have triggered it?
How did this make you feel?
What impacted upon how you felt during this time?
What were your thoughts about being detained?

3) Can you describe how you were last compulsorily detained?

Probes:
What happened,
where were you detained
who detained you?
What thoughts were going through your mind?
How did this make you feel?
What impacted upon how you felt during this time?
How do you think this had an impact on you then?
How do you think this had an impact on you now?

4) Can you describe what happened when you were admitted?

Probes:
What treatment did you receive,
How long where you in hospital for?
Who was around at the time?
What thoughts were going through your mind?
How did this make you feel?
What impacted upon how you felt during this time?
How do you think this had an impact on you then?
How do you think this had an impact on you now?

5) Can you tell me a bit about what happened when you were being treated for Anorexia?
6) I am going to ask you more about specific treatments the ward may have used and ask you what your experience of them was like:

Probes:

Diagnosis – what was it like getting a diagnosis at this time? What thoughts were going through your mind? How were you feeling? How did it affect you?

Feeding/meal times - What thoughts were going through your mind? How did this make you feel? How did this impact on you at the time? How did the feeding and eating aspects impact on you now?

Tube-feeding – If you were tube fed, can you tell me a little bit about what that was like for you? What went through your mind? How were you feeling? How did it impact you/affect you then and now?

Restricted exercise - What thoughts were going through your mind? How did this make you feel? How did this impact on you at the time? How did that impact on you now?

Day-to-day routines - How did this make you feel? How did this impact on you at the time? How did that impact on you now?

Staff - How were staff involved in your treatment? How did this make you feel? How did this impact on you at the time? How did that impact on you now?

Medication – Some people take medication as part of their treatment. What was this like for you? How did this make you feel? How did this impact on you at the time? How did that impact on you now?

Environment on the ward – Can you tell me a bit about what the atmosphere and environment was like on the ward. How did this make you feel? How did this impact on you at the time? How did that impact on you now?

Ward rounds – Patients have ward rounds. Can you tell me a bit about what your experience of these was like. If you were involved or you weren’t, how did they make you feel? What thoughts were going through your mind? How did this impact on you at the time? How did they impact on you now?

Care planning – I am wondering if you were ever involved in your care and if so, what was that like for you? If not, what was that like for you?

Visiting hours – What was the restricted access for seeing family and friends like? How did this make you feel? How did this impact on you at the time? How did that impact on you now?

Resistance to treatment – Some people have mentioned similar experiences to you, where they have been scared of following the treatment programme. For you, how do you think being on a section influenced, or had an impact on, those worries or fears?
The discharge process: Can you describe how you were discharged?

Probes:

Did you know you were going to be discharged?
What did you have to do?
How did this make you feel at the time?
What impacted upon how you felt during this time?
What impact do you think this has had on you now, psychologically?

6) What do you think about the overall process of being compulsorily detained now?

Prompts:

Helpful/unhelpful
Short/long-term effects of detention
How do you think the whole process impact upon you?
How do you think the whole process has impacted on you psychologically?
How do you think the whole process has left you feeling?

7) For you, what are the main differences in being section on a general unit as opposed to a specialist eating disorder unit? (addition after interview 3)

Prompts: Were there any differences in your beliefs/feelings about it?
Were your responses to being detained different or similar?

8) You have mentioned that you have been detained involuntarily on more than one occasion. I am just wondering what has that been like for you? (addition after interview 3)

Prompts:
Good and bad things?
How has it made you feel?
Impact on: beliefs about self, others and the world and understanding of sense of self?

Improvements and closing

7) Can you think of any ways in which the detention process could be improved for people with anorexia?

8) Finally, do you have any final thoughts or comments that you would like to make about what we have discussed today?
Protocol for participants who are in emotional distress during an interview

Distress will be deemed to include:

- Major acute distress
- Long-term distress
• The researcher will consistently and continuously monitor for any signs of distress throughout the interview.

• If a participant becomes a little distressed in the interview, the distress will be acknowledged, and it will be normalised and they will be asked if the researcher can do anything to support them. They will be offered a tissue as a comfort and they will reassured that they can take their time.

• If a participant continues to show signs of distress or their distress escalates, this will be acknowledged with the participant and he or she will be asked if they wished to continue the interview or take a break.

• Participants interviewed on the inpatient ward or at the daycentre will be asked if they would like to speak with a nurse on duty. The nurse will decide if the on call doctor would need to be approached. Participants recruited from the outpatient service will be asked if they would like to speak to a member of their clinical outpatient care team. Participants recruited through BEAT will be encouraged to contact their care-coordinator if they have one. If they do not have a care-coordinator they will be asked if they would like to speak with someone from BEAT or someone at the Samaritans.

• If distress continues to escalate, participants will be asked again if they would like to end the interview. If they specified that they wished to continue, they will be informed that they could take a break at any point at their request. If they decided to end the interview, the participants’ wishes will be respected.

• For participants recruited via BEAT who may not have a care-coordinator, the researcher will ensure that the participant knows the name and contact number of their GP. This will be collected in the demographic information sheet.

• If it is out of hours, the participant will be directed to the emergency GP contact number or emergency psychiatrist.

• Participants will be provided with the following contact numbers as extra support if needed:

  - Samaritans: 08457 909090
  - SANEline is a specialist mental health helpline, providing a national out of hours helpline: 0845 767 8000
- BEAT is an eating disorder support service offering online and telephone support: 0845 634 1414, Email: help@b-eat.co.uk. If participants are under 25 they can call the Beat Younline: 0845 634 7650, Email: fyp@b-eat.co.uk, Text: 07786 20 18 20.

- Participants will be provided with the researcher’s contact number should they experience any distress in the short or long-term.

This research does not involve an intervention component and therefore the researcher will not be providing psychological intervention in the interview if the participant becomes distressed. The researcher will, instead, signpost the participant to the appropriate support (detailed above).

However, the researcher has experience of managing emotional distress as part of her clinical training and will be able to assess acute and chronic distress and would use clinical judgement as appropriate.

Additionally, the researcher is supervised by three Chartered Clinical Psychologists who are also skilled in managing participants’ distress. The researcher will take any issues regarding participants’ distress to supervision.

**Risk Management**

- If a participant expresses any thoughts of harming themselves or others, or if they provide information to the effect that a child may be in danger, then the researcher has a legal duty to break confidentiality. The participant will be informed that confidentiality needs to be broken and, if at all possible, will be encouraged to work in collaboration with the researcher to this end.

- The researcher will have to inform the lead nurse on duty that day either from the inpatient ward or from the day centre depending on where they were recruited from. The nurse will make a clinical decision to pass the information onto the Consultant Psychiatrist. If a participant has been recruited from the outpatient service, the researcher will contact the outpatient clinical team and they will make a clinical decision to pass the information onto the Consultant Psychiatrist. If a participant has been recruited from BEAT, the researcher will contact their care coordinator and if they do not have one, the researcher will contact their GP.
• The immediacy of this action will depend upon the time frame involved. If the individual reports that they intend to harm themselves or another person within the following 48 hours, immediate action will be taken and the research will immediately change focus to the imminent threat. However, if the individual reports that they intend to act on their thoughts in a few days, or longer, action by the researcher may involve continuing with the interview in light of the information discussed, reviewing how they are feeling at the end of the session and bringing in the lead nurse/ care-coordinator or psychiatrist following this.

• If a participant indicates that a child may be in danger, the researcher will act on this by talking with the clinical team (if they were an inpatient or recruited from the day service or outpatient service) or participants GP (if they were recruited from BEAT) and if appropriate, a referral will be made to the child protection team.

• When risk has been disclosed, the participant will be asked to wait in the interview room which will be a safe place. The researcher will ask the lead nurse to join the session, and the participant will be asked to explain what they had said to the lead nurse. The researcher will act on any part of the action plan generated that involves action on their part.

• If risk has been disclosed during a telephone interview or home visit, the researcher will contact their GP, another member of the research team and if appropriate, the police.

Appendix 14. Example coding transcript