The subjective experience of recovery from psychosis in an acute mental health inpatient setting.

Abstract

Background: Experiences of recovery from psychosis have been well explored but not with people in the acute stages of psychosis. This study aimed to explore the subjective experiences of recovery from psychosis from the perspective of service users receiving acute mental health inpatient care.

Method: Ten participants who were acute mental health inpatients experiencing psychosis undertook a semi-structured interview examining recovery from psychosis during acute mental health inpatient care. Data was analysed using Interpretative Phenomenological Analysis (IPA).

Results: Five superordinate themes emerged: "*My future is just being ripped out in front of me*": Living with psychosis is a struggle; "*Would you want to be in here?*": Traumatic experience of being in hospital; "*I know roughly why I got ill anyway and what caused this"*: A journey towards reaching an understanding; Recovery/Rehabilitation/Recuperation: A process of evolution; and *"You need all the help you can get"*: Facilitators of Recovery.

Conclusion: This study highlighted that mental health inpatient settings are not settings where everyone can be in recovery or approaching recovery. For some participants, recovery appeared to be an empty signifier, and is a word used by services but does not necessarily correspond with their experiences of mental health inpatient settings.

Introduction

Psychosis is a mental health difficulty which includes experiences such as hearing voices and holding strong beliefs that others do not share (British Psychological Society [BPS], 2017). Traditionally, psychosis was viewed as a life-long and degenerative serious mental disorder with little hope for recovery. However, due to progressive service user movements challenging this ideology, alongside deinstitutionalisation and advancements in medical and psychosocial treatments, recovery is now seen as possible and achievable (Law & Morrison, 2014). The concept of recovery is embedded in current mental health service provision, including the development of community recovery teams, support time and recovery (STR) workers, and recovery colleges (Taggart & Kempton, 2015). However, there is still no consensus on how recovery from psychosis should be conceptualised. From a medical perspective, recovery is usually perceived to be a reduction or complete absence of psychotic symptoms (Slade, Amering, & Oades, 2008). In contrast, the service user movement would define recovery as living a fulfilling life despite the presence of psychotic symptoms (Pitt et al., 2007). There continues to be a lack of consensus about how recovery should be conceptualised within mental health services (Taggart & Kemption, 2015).

Personal recovery has been explored extensively from both a qualitative and quantitative perspective with those in community settings (Leamy et al., 2011). In a systematic review of both qualitative and quantitative literature, Leamy et al., (2011) identified 13 recovery characteristics (e.g. recovery as an active process, aided by a supportive and healing environment) and five recovery processes (connectedness, hope and optimism, identity, meaning in life, and empowerment), that were outlined to facilitate personal recovery. A number of research studies have also specifically focused on the experiences of recovery from those experiencing psychosis. Wood and Alsawy (2017) conducted a systematic review and thematic synthesis of recovery from psychosis and identified three key themes; the recovery process, facilitators of recovery (e.g. faith and spirituality, social support, personal agency) and barriers to recovery (e.g. stigma and discrimination, social deprivation). Moreover, a service-user led qualitative paper defined recovery from psychosis as rebuilding self, rebuilding life and hope for a better future (Pitt et al., 2007). This demonstrates that personal recovery is a multi-faceted and idiosyncratic concept comprising a broad range of psychosocial factors.

To date, personal recovery has been predominantly explored with people who are under community services and not those who might be in crisis or in acute services. According to current policies (HM Government, 2011) acute mental health inpatient settings should be recovery orientated and collaboratively involve service users in decisions about their treatment and care plans, including those who are forcibly detained under the Mental Health Act (Coffey et al., 2019). However, a number of service users report ongoing dissatisfaction and poor care experiences in acute mental health inpatient settings (Care Quality Commission, 2017). They also report experiences such as disempowerment,

lack of choice and control, and uncollaborative care (Wood et al., 2019), which are at conflict with personal recovery values (Pitt et al., 2007). Collectively, this demonstrates that it is unlikely that their recovery needs are being met. There is a clear gap in our knowledge of how individuals experiencing psychosis accessing acute mental health inpatient services define and experience recovery from psychosis. Understanding this could have important implications for the improvement and delivery of inpatient care. Therefore, this study aims to explore the subjective experience of recovery from psychosis from the perspective of service users currently receiving care from an acute mental health inpatient setting.

Method

Design and ethics

Ethical approval was granted by the NHS Health Research Authority (IRAS ID: 216011; REC reference: 17/EE/0113) and sponsorship given by the University of Essex. This study also adhered to the BPS guidelines on human research ethics (2008). A qualitative approach was adopted utilising semi-structured interview and Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009). The Consolidated Criteria for Reporting Qualitative research (COREQ) was adhered to (Tong, Sainsbury & Craig, 2007).

Materials

An interview schedule was developed drawing upon relevant research (e.g. Wood et al., 2010), and consultation from service users with lived experience of psychosis. Six service users accessing a community psychosis team, some with inpatient care experience, provided feedback on the interview schedule. This resulted in amendments such as the inclusion of a post-interview debrief and the word 'recovery' not being defined so participants could interpret this as they wished. The semi-structured interview schedule enquired about participants' contact and experience with mental health services, participants experiences of living with psychosis, participants experience and conceptualisation of recovery, and the role of recovery in acute inpatient care.

Participants and recruitment

Participants were recruited from three acute mental health hospitals in outer London and Essex. These sites covered both urban and rural areas, allowing for ethnically diverse and representative sampling population. These wards primarily care for patients with acute mental health difficulties such as psychosis and emotionally unstable personality disorder. Purposive sampling was employed and the aim was to recruit eight to twelve participants, as recommended for IPA studies to ensure an idiographic focus (Smith et al., 2009). The analysis of larger samples is not advised as it may result in the loss of the potentially subtle inflections of meaning (Collins & Nicolson, 2002).

The first author attended ward business meetings to promote the study with the ward staff. Potential participants were initially approached by a ward staff member who informed them of the study. If they were interested in taking part their name would be passed to the researcher who would arrange to meet them in person. Overall, ten participants were recruited and participated. Eligible participants were (a) aged between 18 and 65, (b) were currently a mental health inpatient and, (c) had a diagnosis which incorporated experiences of psychosis, as defined by the DSM-V (American Psychiatric Association, 2013). Participants were excluded if they were (a) non-English speakers, (b) currently experiencing severe thought disorder and, (c) lacking the capacity to provide informed consent.

Procedure and analysis

Face to face interviews were conducted in the ward's quiet room by the first author. Interviews were audio recorded and transcribed verbatim. Interviews lasted between 25 and 105 minutes (mean = 46 minutes). IPA was adopted due to its aims of providing a detailed examination of the participant's subjective lived experiences, and a critical realist position was adopted. Transcripts were read and re-read by the first author. Initial observations were recorded in a reflective journal to bracket off preconceptions. Initial coding took place via free textual analysis before the provisional grouping of emerging themes was undertaken (Smith et al., 2009). 826 initial themes emerged which were condensed into 5 superordinate themes and 24 subordinate themes. The initial themes were collapsed by a process of de-duplicating and grouping similar themes together to form broader themes. A final table of themes was then constructed and checked against each interview and finalised by the research team.

Reflexivity

This study was led by author LE, then a trainee clinical psychologist, in partial fulfilment of her Doctorate in Clinical Psychology. LE was working in acute mental health inpatient setting at the time of the study. LE conducted all interviews and led on analysis. LW is a clinical psychologist, lecturer, and researcher working in acute mental health inpatient settings. DT is a clinical psychologist, lecturer, and researcher with an interest in critical approaches to recovery from psychosis.

Results

The sample comprised nine males and one female, aged between 21 and 57 years (M = 39.2, SD = 11.4). The mean number of hospital admissions was 6.8 (SD = 7.3; 2-25) and the mean length of current admission was 94.4 days (SD = 182.2; 18-611). Further sample characteristics are outlined in Table 1.

[INSERT TABLE 1 HERE]

Five superordinate themes were identified in the analysis. Each superordinate theme comprised multiple subthemes. Themes and subthemes are outlined in Table 2.

[INSERT TABLE 2 HERE]

"*My future is just being ripped out in front of me*": Living with psychosis is a struggle

All ten participants expressed how difficult it was living with psychosis and described shared experiences of struggling to survive, alongside experiences of stigma.

Struggle to survive

The struggle to survive encapsulated the significant psychological and social challenges experienced by all ten participants. They described psychological struggles such as suicidal thoughts and extreme worry, and experiences of social marginalisation, including financial hardship, experiences of abuse and trauma prior to hospitalisation. Some participants felt abandoned by society and their families.

> When I first got brought in I was on 60 pound a week and I had to pay gas, electric, water and TV licence and I smoked and drunk, and obviously you've got to eat and I found it very hard to cope with that. So…I did get in arrears of payments of bills and stuff, so I was pretty messed up (Tony).

"I hate myself": Internal struggle with self

Nine participants described struggling with their self-worth. Their low self-worth appeared to be linked to participants' internalisation of society's stereotyped or discriminatory views of mental illness, and their individual struggle in their change of identity as a result of their experiences.

> I tried really hard for my dissertation but all throughout that period it manifested as something in my head that was telling me you're not worth it, you're not intelligent enough, that sort of thing…and you know it would sort of manifest in me sort of still

> trying to improve my fitness, improve myself, but not really inside having the self-worth and not being able to cope with the things going on. (Ben).

"I'm not a psychopath, I'm not genuinely a psychopath, I've just had a lot of hurt in life.": Experiences of stigma.

Experiences of stigma and discrimination were identified as a barrier to recovery by all participants in relation to employment, reconnecting with others, and being accepted by society Participant were worried about accepting help due to the stigma attached to it.

> Do I want to take all the services that they may offer like for instance community housing? Err disability allowance things like that. Very nervous about accepting anything that colours me in a certain way, you know erm do I have to admit that to someone? Am I now in a system on that? So, I'm very erm kind of…feeling a bit careful.... (Sebastian).

"I don't want their help; they didn't help me before why would I want their help now?": Rejecting help/struggling to accept help.

Seven participants expressed their struggle to accept help from mental health services due to previous negative experiences of services, which appeared to impede recovery. It was also highlighted that when participants did get help, they did not find it met their needs.

> …I went into the sectioning I was like oh I shouldn't be here, I don't, I don't want to be here, I'm fine, I can be released you know…then I managed to get released, I got released the next day, erm that was from a 136, yeah and then I guess I could say gradually I realised that I needed, that I needed some support, I had too much stuff going on in my head, in my head that you know I've been lying to myself really about…" (Ben)

"I find it hard to cope so I do draw back to the drugs and alcohol": A struggle with substances.

Eight participants spoke about substance misuse as the reason why they were admitted to hospital. They explained that they had been using substances as a way of coping with their difficulties but it had the opposite effect and eventually led to an admission.

> I did cocaine for a while and yes that may have been me to be honest trying to deal with depression at certain points. When I was younger, I had a lot of anxiety erm and I would say depression as kind of bedfellows, naughty bedfellows. You know I didn't enjoy myself when I was out erm therefore I drank quite a lot… (Sebastian).

"Would you want to be in here?": Traumatic experience of being in hospital

All ten participants described their hospital experience as traumatic which is conceptualised within the subordinate themes. These negative experiences of hospitalisation were seen by participants as preventing their recover journey from progressing.

"I'm in a real situation now where I don't feel I have a huge amount of control": Lack of control.

A feeling of having a lack of control over aspects of hospitalisation was identified by six participants, including being hospitalised against their will under the Mental Health Act (MHA), feeling under external pressure to agree to admission, having no say in their treatment or discharge, and a general sense of feeling excluded.

> … the only reason I came into hospital this time was because my dad was out of the country and my wife convinced me to come here as an informal patient but then I ended up getting sectioned because I absconded. (Mohammed).

"The worst I have ever been dealt with by anyone in the whole of my past, that was just wrong.": Inhumane treatment.

Seven participants described experiences of inhumane treatment which understandably made them feel very unsafe on the ward. This treatment led to a breakdown in relationships with staff and hindered recovery.

> They literally took me, 5 of them, I didn't resist if you like but I didn't help, they took me round there and jabbed me in my ass…and when I actually walked out of that room I turned to[name], the ward manager and to others who are with him and said I'm just going to leave this in here, that was morally corrupt, deal with that…I never ever had anything like that happen to me before, you know I wasn't bawling my eyes out but I actually felt that I'd literally had a kind of human right there denied me. (Sebastian).

"Incarcerated, institutionalised, log cabin coglaben hypnogogic fever": Incarceration creates more problems.

The language that seven of the participants used to describe the hospital environment provoked the image of being in prison such as "incarceration", "imprisoned" and "trapped", with the general consensus being that hospitalisation created more problems, rather than facilitating recovery.

> I made it up…incarcerated, institutionalised, log cabin coglaben hypnogogic fever…erm it's just how I was feeling erm and so how you start behaving when you become institutionalised. You feel incarcerated, you feel trapped, you feel you have no freedom, you feel these inside walls and the garden is all you have in life, that's all that exists, it exists forever. (Richard)

"They're overworked and there isn't genuinely enough staff": Concerns regarding resources.

Half of the participants expressed their concerns or frustrations regarding a lack of hospital resources or effective care, which reflects the current budget cuts within mental health services, including feeling the need to exaggerate one's presentation in order to meet criteria for acute services.

> My sister in law said why don't you lie to the doctor to get yourself a hospital bed otherwise these aren't going to give you a hospital bed, so I said to the doctor yeah I've been killing people in the street, I've been killing doctor and I'm going to stab you as well… (Mohammed).

"It takes for me to come somewhere like this and have a break yeah, for me to start thinking about things again.": Provides a break from life to reflect.

This subtheme highlights that a positive aspect of hospitalisation included the experience of being cared for and having a break in order to rest and reflect, which was seen as vital to begin recovery for five participants

> So, it would be nice to have sort of a little bit of a period of time, like I noticed it has helped me in here having meals cooked for me and things done for me**.** (Ben)

"*I know roughly why I got ill anyway and what caused this*": A journey towards reaching an understanding

All ten participants described a unique journey to recovery through reaching a personal understanding of their experiences of psychosis. This appeared to be a developmental process with some participants passing through each stage, having to challenge the misconceptions that themselves and others held about their experiences.

"*How the hell did I go from there to there?": Trying to make sense of the experience.*

Eight participants described that hospital allowed them the space and time to try and process their experiences of psychosis, and how this was quite a challenge in the initial stages where reality was harder to identify. It appeared that hospital allowed some people to reground themselves with reality and question their experiences.

> Erm and everything had some kind of connection, erm everything was being related in some way to everything else, you know the levels, the channels, the sections, the dimensions and everything all merging into one big state of mind. Erm and yeah, I was having a lot of delusional beliefs, but also was realising a lot of things in reality, all at the same time. (Richard).

"*There's a lot of confusion that people think I've actually done worse things than I actually have done.*": *Being misunderstood.*

Nine participants described difficulties connecting with those around them, both in hospital and in their personal relationships, due to feeling misunderstood. As a result, they, for example, found it challenging to communicate with those around them.

> I mean I find these new true bonds but I find it more difficult to relate to my family and friends. I just don't have the time for friends and family, and it's not in a rude way, it's not because I don't want anything to do with them, it's just I can't communicate with them. I'm in a different communicative place, I can't, I don't know how to go about communicating with the people I need to communicate with. But I find, I often find new bonds or kinships or soulmates in those states. (Richard).

Process of proving yourself to others.

Six of the participants described that an important part of their recovery was proving to themselves, but almost even more importantly to others, that they are in control of themselves, not a danger, and a good citizen. In particular, participants often emphasised that they needed to prove that they were not a threat or danger, which arguably may be an internalisation of the recovery indicators expressed by the ward staff necessary for people to be discharged.

> I think that I've showed that I'm genuinely not a threat to society if I was to enter back into society, I would be fine and I would never really have had, had a really bad heart. I've had a lot of hurt and it's caused me to have low self-esteem and I've got to maybe sort of take the right steps but erm yeah I think that I've realised that the only way that I can…erm sort of move forward in life is by having some self-respect because if I don't stand up for myself then no one will, if that makes sense? (Ben).

"*I understand myself a lot more": Reaching an understanding*

Eight participants explained that they often felt that they had reached an understanding of themselves whilst in hospital, which was facilitated in a number of ways including psychological support and group work.

> I use my own thinking to understand how to deal with it if you know what I mean. Sort of, it's becoming a little bit ingratiating, and you think to yourself is that all there is to it? Who knows? Like that's it, that's an example of me doing it. You become introspective and I turn things in and I look in on myself and I start to project, my illness projects itself, that's how it works. (Alex).

Recovery/Rehabilitation/Recuperation: A process of evolution

All ten participants described recovery as a process which involved change. All participants, except Miriam, believed recovery was possible, which may have been linked to the enduring nature of her experiences.

Reclaiming a purpose

All ten participants described the importance of having a purpose in life, which included life goals, living life in line with personal values, responsibilities, and contributing to society. A particular goal was improving relationships with others, whether it be being a better father, or generally socialising with others.

> …go back to being the sociable person that I used to be erm yeah, just sort of enjoy being a confident sociable you know person that could probably contribute at some level but I don't want to do that in isolation anymore. (Graham).

"A fine life is a fine balance": Finding a balance/stability

Five participants spoke about the importance of finding a balance or middle ground in their lives, whether it was a balance in mood or lifestyle, and that recovery was about continuing to move forward despite challenges.

> …but there's sort of like a balance, a fine balance between being unwell and being well. I mean, it's like, so like going along, so it's like a train or a plane, it's driving in a little bit of wind turbulence, so it rocks from side to side, some days are better than others, some days are worse than others, so forth and vice versa. (Alex).

"*Bringing it all back together": Re-integrating the self*

Six participants describe a process in recovery of re-integrating the self, for example, integrating psychosis into part of one's life story. One participant explained that psychosis may result in the self being pulled apart and then recovery being the process of reintegration of those pieces.

> Well it means bringing it all back together. Pick up the pieces you could create a picture puzzle, shuffle them all up, drop loads of them on the floor and you pick them up and put the picture back to how it should be and it's still the picture you started with. (Richard).

Being reborn/evolving

Five participants described psychosis as an evolutionary process and emphasised the importance of growth and discovery to further develop as human beings and move towards recovery. One participant used the metaphor of a hedgehog to symbolise this process.

> **…**a hedgehog because hedgehogs hibernate and being mentally ill is like being asleep, but when you're awake you know why you were ill and all those little prickly experiences when you were mentally ill. (Alex).

Accepting the self and others

Eight participants spoke about recovery involving acceptance, whether that be acceptance of the self, accepting others, or accepting psychosis. Several participants described a process of acceptance through forgiveness, loving yourself, and finding peace.

> Erm…you know…in a way forgiveness, being able to move on and to find peace with myself erm…yeah. (Ben).

"Back to life, back to reality": Getting back on track

Seven participants described some form of 'getting back on track' or back to the life that they were living prior to their admission. Several participants indicated that hospital may be preventing them from recovering. Recovery seemed to happen once they were discharged.

> I'm not in hospital, or I see friends and family or I go to my activities. Just look after myself a bit better, I wash, I eat and drink. (Miriam).

***"You need all the help you can get":* Facilitators of recovery**

This theme included the components that all participants felt facilitate recovery including faith, time, reconnecting with nature, and support from others.

"It's God that's what gets me through this": Faith in recovery.

Faith was key to recovery for four participants, and important in understanding their mental health crisis.

> You've missed a major part of my recovery, it's my religion and my faith. It's God that's what gets me through this. It's the only thing that's got me through here. (Mohammed).

Importance of time in intervention and recovery

The importance of needing time to recover was emphasised by seven of the participants, the positive impact of early intervention as well as the time living with psychosis and using this knowledge to prevent relapse.

> My experience is as you get older, my age and my maturity are helping me feel more relaxed about things. With age comes wisdom and you tend to learn more from about what you knew when you were younger and you look at things and you ask questions about things, rather

> than rushing head long into new directions to change things to sort yourself into a situation that's either apparent to you or not apparent to you. (Alex)

"Seeing nature reminds me of why I'm alive": Reconnecting with nature.

Reconnecting with nature emerged in five of the participants interviews and was described as being back in one's natural environment, having freedom, and being out of hospital. This indicated that recovery may not be able to begin until discharge.

> Nature is the key to recovery, not buildings…it's untouched, it's innocent, it's pure. It's how things should be not these concrete jungles, taking away the natural habitat, I suppose, it's the animals that should be there, putting the building there for humans. (Paul).

"She's like an anchor, no matter how far I drift, she's always got me": Support from others.

For seven of the participants recovery was deemed impossible in isolation. Support from others was described as support from family, friends or healthcare professionals. For many, key attachment figures provided a connection when they felt disconnected from reality.

> I do find…my mum is like a rock for me, she's, she never, she's always there for me. She always helps me out when I need help or she'll try and knock some sense into me, even, I'm still her little boy even though I'm 50. I'm still, still, it's still me mum, she's like an anchor, she always, do you know what I mean, no matter how far I drift, she's always got me. (Alex)

Discussion

This study aimed to examine the personal recovery experiences of those currently receiving care from an acute mental health inpatient setting. Five superordinate themes were identified.

All participants described the struggle between living with psychosis and recovery. Participants described a multitude of struggles including psychological difficulties, for example low self-worth and suicidal ideation, social difficulties, such as stigma and financial problems, and substance misuse, all of which are well-documented in the literature as important recovery factors in psychosis (Pitt et al., 2007). However, it appeared to be the cumulation and severity of problems and associated distress, which made recovery a significant challenge. This suggests that inpatient care needs to be equipped to address a wide array of psychosocial difficulties, with a particular focus on the issues outlined above. However, more comprehensive psychosocial support is needed in the community to prevent the cumulation of distress and prevent admission. Community services need to improve access, as participants highlighted that accessing services were a challenge, and that some even had to exaggerate their distress to get help. This may suggest that engagement interventions may be required for those who have a history of hospital admission.

Despite participants' difficulties, many participants did not want to be hospitalised. All participants described some aspect of their hospital experience as traumatic or distressing, which hindered recovery. Although traumatic hospital experiences have been documented in the literature (Wood et al., 2019), its impact on recovery is a novel finding for this study. Participants described acute mental health inpatient settings as inhumane and not conducive to recovery as they felt out of control, with little say in their care, which reflects the existing literature (Barker, 2003; CQC, 2017). A novel finding was that participants felt they had to prove to those around them that they had recovered, which was demonstrated by a reduction in risk. This suggests that participants' felt they had to meet professionals' recovery standards. This is in direct conflict with the recovery literature which states that recovery should be personally defined. This may be why some participants reported needing to leave hospital before recovery could begin. This may indicate that inpatient care should be a last resort and that other alternatives may be helpful, for example crisis houses (Lloyd-Evans et al., 2009). It also suggests that there is an ongoing need to continue to improve the quality of inpatient care and reduce restrictive practices, which is an ongoing UK priority. A recent study has demonstrated the importance of trauma-informed inpatient care, which includes developing a safe environment, minimising retraumatisation, and the comprehensive assessment and treatment of trauma (Muskett, 2014), which may be a helpful approach to supporting the initial first steps in the recovery process. Inpatient care may be best placed to support early stabilisation, which was indicated in some participant accounts, but for recovery to be continued in the community. Moreover, staff training on psychosocial approaches to inpatient care, for example, interventions to improve therapeutic

relationships have been demonstrated to improve service user outcomes, but research is limited and further research is required (Hartley, Raphael, Lovell, & Berry, 2020).

The majority of participants still described recovery as a journey, which is possible and achievable, supporting existing literature (Leahy et al., 2011). A crucial stage for participants was getting back to the life they were living prior to admission, and an important component of this was reintegrating their fragmented sense of self Participants described a number of key facilitators to this, including having faith, time, support from others, and reconnecting with nature. Faith and spirituality have been repeatedly cited as an important recovery factor, particularly in inpatient settings (Heffernan et al., 2017). Time was discussed in relation to early intervention preventing admission and supporting a quicker recovery, which has been established in existing literature (NHS England, 2016). Reconnection with nature has not been as explicitly linked with recovery within existing literature, but it is likely that the restrictive nature and being locked within an acute hospital has made this an important recovery priority. Therefore, promoting access to outdoor space and considering creative ways to connect to nature within the inpatient ward may be helpful. Finally, ensuring maximum access to their support networks whilst in hospital, was seen as crucial to their recovery, supporting previous literature (Pitt et al., 2007). Collectively, this demonstrates the importance of inpatient services having access to a wide variety of psychosocial intervention, and not just prioritising the medical model, which is often the case.

There were a number of strengths to the study. A strength is that recovery appeared to be conceptualised quite differently compared to the existing evidence base with community samples. Several quality assurance measures were applied including, ensuring self-reflexivity, quality checking of transcripts, and service user involvement in various aspects of the study (MacLean, Meyer, & Estable, 2004). A number of limitations to the study are also important to note. Firstly, participants were relatively stable in their mental health and engaged with staff meaning the perspectives of more vulnerable patients were arguably missed. Moreover, recruitment was a challenge with proportionately few inpatients volunteering to take part. Another limitation is the few participants from black and ethnic minority backgrounds given it is well-documented that they are disproportionately represented in this setting (NHS Benchmarking, 2018). There was also only one female participant which means the views of women receiving inpatient care are not represented in this research study. Further research should explore women's perspectives on this topic.

In conclusion, recovery was an important concept to people in acute mental health inpatient care. However, many participants did not believe their inpatient care was optimised in supporting recovery. A large number of participants found their hospital stay a challenging experience, even if there were some positive components to it. Recovery did not seem to be a congruent experience for participants

at the current time. Further research is required to examine how inpatient settings can be more recovery focused.

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Table 1. Participant demographics

Allocated Pseudonym	Gender	Age	Marital status	Ethnicity	Formal Diagnosis	Number of hospital admissions	Length of current hospital admission
Mohammed	M	37	Married	Indian	Bipolar Affective Type II	10	23 days
Paul	M	40	Separated	White British	Bipolar	2	18 days
Christopher	M	47	Single	White British	Schizophrenia	2	25 days
Sebastian	M	40	Single	White British	Bipolar Affective Type II	2	55 days
Richard	M	28	Single	White British	Paranoid Schizophrenia	4	69 days
Alex	M	50	Single	Iraqi English	Paranoid Schizophrenia	25	611 days
Graham	M	57	Divorced	White British	Bipolar	9	47 days
Miriam	F	26	Single	White British	Schizoaffective Disorder	10+	23 days
Tony	M	46	Single	White British	Paranoid Schizophrenia	2	37 days
Ben	M	21	Single	White British	Schizophrenia	2	36 days

Note: M = Male, F = Female

Table 2: Structure of superordinate and subordinate themes

Superordinate themes	Subordinate themes	Number of participant endorsements
1. *"My future is just being ripped out in front of me"*: Living with psychosis is a struggle	1.1 Struggle to survive	10
	1.2 *"I hate myself"*: Internal struggle with self	9
	1.3 *"I'm not a psychopath, I'm not genuinely a psychopath, I've just had a lot of hurt in life"*: Experiences of stigma	10
	1.4 *"I don't want their help, they didn't help me before why would I want their help now?"*: Rejecting help/struggling to accept help	7
	1.5 *"I find it hard to cope so I do draw back to the drugs and alcohol"*: A struggle with substances	8
2. *"Would you want to be in here?"*: Traumatic experience of being in hospital	2.1 *"I'm in a real situation now where I don't feel I have a huge amount of control"*: Lack of control	6
	2.2 *"The worst I have ever been dealt with by anyone in the whole of my past, that was just wrong"*: Inhumane treatment	7
	2.3 *"Incarcerated, institutionalised, log cabin coglaben hypnogogic fever"*: Incarceration creates more problems	7
	2.4 *"They're overworked and there isn't genuinely enough staff"*: Concerns regarding resources	5
	2.5 *"It takes for me to come somewhere like this and have a break yeah, for me to start thinking about things again"*: Provides a break from life to reflect	5
3. *"I know roughly why I got ill anyway and what caused this"*: A journey towards reaching an understanding	3.1 *"How the hell did I go from there to there?"*: Trying to make sense of the experience	8
	3.2 *"There's a lot of confusion that people think I've actually done worse things than I actually have done"*: Being misunderstood	9
	3.3 Process of proving yourself to others	6
	3.4 *"I understand myself a lot more"*: Reaching an understanding	8
4. Recovery/Rehabilitation/Recuperation: A process of evolution	4.1 Reclaiming a purpose	10
	4.2 *"A fine life is a fine balance"*: Finding a balance	5
	4.3 *"Bringing it all back together"*: Reintegrating the self	6
	4.4 Being reborn/evolving	5
	4.5 Accepting the self and others	8
	4.6 *"Back to life, back to reality"*: Getting back on track	7
5. "You need all the help you can get": Facilitators of recovery	5.1 *"It's God, that's what gets me through this"*: Faith in recovery	4
	5.2 Importance of time in intervention and recovery	7
	5.3 *"Seeing nature reminds me of why I'm alive"*: Reconnecting with nature	5
	5.4 *"She's like an anchor, no matter how far I drift, she's always got me"*: Support from others	7