Service Users’ Experiences of “Paranoia” on Psychiatric Wards

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ABSTRACT

Background: Research suggests that admission to an inpatient psychiatric ward can have a detrimental impact on service users' mental health and may give rise to distressing and traumatising experiences. However, there has been limited exploration or conceptual development regarding how or why this may occur, and what the emotional response to these experiences may be. Paranoia can be conceptualised as an emotional threat response to anxiety-provoking and unsafe environments. Consequently, the current study aims to fill a gap in the literature by considering how admission to a psychiatric ward may give rise to experiences which lead people to feel unsafe, threatened, suspicious and paranoid.

Aim: This study aimed to explore what service users perceive to be the factors which influence their experience of paranoia on psychiatric wards and therefore consider what services could do differently to alleviate experiences of paranoia.

Methods: Eight semi-structured interviews were conducted with service users who had previously accessed inpatient psychiatric services. Transcripts were analysed using Thematic Analysis.

Results: The current study found that service users' experiences of paranoia during admission to inpatient psychiatric wards were influenced by five overarching themes: (1) feeling disbelieved, persecuted, stigmatised and discarded (2) feeling unsure of what was going on (3) experiencing the ward as an unsafe place to be (4) paranoia as a coping mechanism and (5) moments of care and connection. A description of these themes and accompanying subthemes is presented.

Conclusion: The findings indicate that a range of factors can influence service users' experiences of paranoia on inpatient psychiatric wards which can lead to mistrust of the mental health system, staff, and other service users. The findings also highlight that certain factors can alleviate paranoia and support a positive inpatient experience. Results have implications for policy, practice, and Clinical Psychology, and support the incorporation of paranoia-reducing practices into Trauma-Informed Care approaches implemented on inpatient psychiatric wards.

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1. INTRODUCTION

1.1. Chapter Overview

To set the environmental and political context, this chapter begins by providing a brief overview of inpatient mental health service provision in the UK. It then outlines some key concerns about the current quality of inpatient psychiatric care and the service user experience, along with significant developments such as least restrictive practice policies and psychologically informed environments. It then discusses Trauma-Informed Care, which aims to tackle the potential re-traumatisation that can occur within mental health services, and highlights some key criticisms regarding the lack of conceptual development about specific emotional responses to re-traumatisation in inpatient services. This chapter then introduces the concept of paranoia as a particular area of interest by discussing the main theories and models that position paranoia as an emotional response to experiences of threat and adversity. Furthermore, it discusses how paranoia could be relevant to the service user experience of inpatient psychiatric wards by drawing on the limited existing literature. Finally, a systematic literature review regarding the more general service user experience of inpatient wards is presented, highlighting the gaps in the current literature and thus providing a rationale for the current study.

1.2. Inpatient Mental Health Care

An inpatient psychiatric hospital can be defined as ‘a unit with hospital beds that provides 24-hour nursing care’ (Mental Health Network, 2012, p.8) which serves to provide a safe and therapeutic space for an individual where community services can no longer meet their needs (Commission on Acute Adult Psychiatric Care, 2015). It can either be accessed voluntarily or by detention under the Mental Health Act (1983, 2007) (see Appendix A for relevant Mental Health Act sections). To further understand the current context, this section describes inpatient mental health care within the UK and discusses the social, political, and theoretical influences on the service user experience.

1.2.1. Inpatient Mental Health Care in the Current Context

Since the NHS's birth in 1948, there has been a 'transformation in mental health' (Mental Health Task Force, 2016, p.4). An increase in treatment options, a drive towards de-stigmatisation, and enhanced emphasis on human rights, has led to a significant shift in the provision of care for people experiencing mental health difficulties (Csipke et al., 2014). This can be characterised by 'deinstitutionalisation', namely the closing down of large asylums, and an increased focus on community mental health provision (Fakhoury & Priebe, 2002). In the current context, inpatient psychiatric care is positioned within the wider mental health system and is now considered the 'last resort' (Commission on Acute Adult Psychiatric Care, 2015) within NHS England's mental health care pathway.

National health policies in England and the UK have developed to reflect this shift, and in 2016, the Five Year Forward View for Mental Health (Mental Health Task Force, 2016) recommended that, by 2020/21, community mental health services should be expanded and improved to reduce unnecessary admission to inpatient psychiatric hospitals. Despite this, inpatient detentions have as much as quadrupled since the introduction of the Mental Health Act (1983, 2007) (Keown et al., 2018). More specifically, a Care Quality Commission (2018) report found a 40 per cent rise in the use of the Mental Health Act (1983, 2007) between 2005/6 and 2015/16, and the most recent figures from 2018/19 to 2019/20 (NHS Digital, 2020) suggest this rise is continuing. In summary, despite the push to increase community provision of mental health care and reduce the need for inpatient admission, inpatient psychiatric care continues to remain a significant part of NHS England's mental health care pathway.

Despite the increase in demand for inpatient beds highlighted above, mental health services have been historically underfunded (NHS Providers, 2020) and the impact of austerity has meant that NHS Trusts have been required to respond to this increase in demand with reduced budgets (Cummins, 2018). The impact of this is perhaps reflected in the decline in the number of inpatient beds, high levels of staff sickness related to anxiety and stress, and understaffed services leading to an increased reliance on bank staff (Gilburt, 2018). These considerable pressures may be significantly impacting the experience of service users considering the increased concerns around the quality and safety of service provision (Care Quality Commission, 2017). In 2004, Mind found that the experience of inpatient care tends to be more custodial and coercive than therapeutic (Mind, 2004). A report seven years on again highlighted concerning findings; inpatient service users continued to report a lack of safety and traumatising experiences (Mind, 2011). Importantly, research suggests that individuals who have a negative experience of inpatient admission may have worse engagement and outcomes (Woodward et al., 2017) meaning that these longstanding concerns about the quality of care could have a long-lasting impact.

In recognition of the lasting impact of negative inpatient experiences, the 2011 Mental Health Strategy (HM Government and Department of Health, 2011) set out six objectives which recognised the importance of quality mental health service provision, positive experiences of service users, and acknowledged the possibility that these services might cause unintended harm. Despite this political agenda, conclusions of a 2015 report by the Commission on Acute Adult Psychiatric Care (2015), and a 2017 report by the CQC (Care Quality Commission, 2017), indicate that such efforts to improve the quality of services have not come to fruition. More specifically, findings suggested that many inpatient environments had an increasingly detrimental impact on service users' mental health and wellbeing (Commission on Acute Adult Psychiatric Care, 2015), and pointed to concerns about safety caused by a lack of staffing and mixed ward environments. These conclusions indicate that there has been little improvement in the inpatient experience since Mind's investigations in 2004 and 2011.

In summary, although inpatient psychiatric care aims to provide a safe and therapeutic space for individuals where community services can no longer meet their needs (Commission on Acute Adult Psychiatric Care, 2015), this aim is often not achieved. Consequently, further exploration of the service user experience may be imperative to highlight the specific experiences which reduce the therapeutic nature of the ward environment and to consider what changes are needed to ensure safe and effective inpatient psychiatric care.

1.2.2. Developments in Inpatient Mental Health Care

Despite the longstanding concerns regarding the quality and service user experience of inpatient mental health care highlighted above, there have been significant changes to medical and psychological practices over the years. Traditionally, inpatient psychiatric facilities have been dominated by the medical model (McCulloch et al., 2005), where psychological distress is seen as an ‘illness’ or ‘disease’, implying that inpatient admission is primarily for medical treatment (Baguley et al., 2007). This has perhaps been maintained by the abundance of medical professionals such as psychiatrists and mental health nurses working on wards (Baguley et al., 2007). However, policy developments put forward in the NHS Long Term Plan (2019) demonstrate an increased awareness of the importance of creating a therapeutic environment for the best chance of recovery (NHS, 2019). This has led to a reallocation of funding to provide additional allied health professional and psychological practitioner posts, to increase access to psychological therapies in inpatient wards (Ebrahim & Wilkinson, 2021). These developments mean that recent guidance advocates for psychological professionals such as Clinical Psychologists to be consistently incorporated into Multi-Disciplinary Teams working on the wards (Penfold et al., 2019) and promotes the incorporation of psychological theories and expertise into practice. The increased focus on a therapeutic environment has also led to the revised Mental Health Act Code of Practice (Department of Health, 2015) and the ‘least restrictive practice’ initiative which recognises the harmful impact of coercive interventions such as physical restraint, seclusion, rapid tranquillisation, and other interventions which limit a person’s liberties (Penfold et al., 2019).

In summary, there have been some significant developments in inpatient psychiatric care which include an increased focus on psychological theories, therapies, and the development of ‘therapeutic environments’ which aim to counter the potential harm that inpatient admission can cause.

1.3. Trauma-Informed Care

The developments outlined above indicate the increased awareness of policy makers and mental health service providers regarding the potentially detrimental and harmful impact of inpatient admission. To understand more about how services are responding to this, this section outlines the development of Trauma-Informed Care (TIC), an approach adopted to reduce the potential harm caused by mental health services and interventions. It discusses the conceptual roots and principles of TIC, how it is being adopted in inpatient mental health settings and discusses some key critiques of these approaches.

1.3.1. The Principles of Trauma-Informed Care

Trauma-Informed Care (TIC) developed and expanded partly in response to the increased awareness that people accessing mental health services are at higher risk of having experienced trauma throughout their lives (Sweeney et al., 2018). Within a mental health context, TIC can be defined as a philosophy or service culture which appreciates the impact of adversity on individuals accessing such services (Isobel, 2016), and seeks to see people's behaviours and 'symptoms' of mental health 'disorders' as responses to the trauma they may have experienced (Huang et al., 2014). Within its very principles, TIC appreciates the risk of unintentionally re-traumatising individuals through the use of certain practices (Huang et al., 2014), and advocates for services to see people in distress as reacting to their context (Academic Health Science Network, 2020).

1.3.2. Trauma-Informed Care and Inpatient Mental Health Wards

TIC advocates for mental health difficulties and psychological distress to be seen as normal reactions to abnormal circumstances and experiences (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Certainly, for most, it can be assumed that the context of being an inpatient on a psychiatric ward could encompass abnormal or unfamiliar experiences, thus justifying the adoption of TIC approaches within inpatient mental health settings. In a review of inpatient TIC, Muskett (2014) concluded that many practices such as seclusion and restraint, ward rules, and mixed-sex wards, risk re-traumatisation as they are often experienced as emotionally dangerous and restrictive. Muskett (2014) also highlighted factors such as the therapeutic relationship and the physical environment as key to developing a TIC approach within inpatient mental health settings. Indeed, at the heart of TIC within inpatient psychiatric settings is the importance of the therapeutic relationship (Wilson et al., 2017). The inherent power imbalance, instigated by the use of the Mental Health Act (1983, 2007), could serve to increase distress through re-enacting operations of power that occur within interpersonal trauma (Sweeney et al., 2018). It has been suggested that TIC approaches should acknowledge and address this by encouraging a mutual and collaborative therapeutic relationship which can help to develop a sense of safety and trust (Elliott et al., 2005) through which relational trauma can be healed (Miller & Stiver, 1998).

1.3.3. Critique of Trauma-Informed Care in Inpatient Settings

Although TIC approaches are slowly being adopted throughout the UK (Sweeney et al., 2016), there has been ongoing criticism regarding the extensive focus on theory with limited attention given to implementation guidance. This may be particularly compromised due to the variation in theoretical definitions of TIC (Hanson & Lang, 2016) and a lack of implementational definitions of TIC approaches (Berliner & Kolko, 2016). Research has highlighted that, in practice, there is considerable uncertainty regarding its implementation (Donisch et al., 2016) and more needs to be done to inform staff about how their responses and practice may re-traumatise individuals (Muskett, 2014).

Criticism of TIC has also focused on the relatively narrow definition of ‘experiences of previous trauma’ which arguably ignores more social determinants of trauma and general experiences of adversity (Birnbaum, 2019). More specifically, the use of the term ‘trauma’ has been criticised for being misleading by implying exposure to a life-threatening, exceptional experience and discounting more repetitive and embedded exposure to adversity which exists within society (Johnstone & Boyle, 2018). Examples of such prolonged and continuous experiences of adversity may include repeated exposure to threats, oppression, and a general experience of lack of safety (Johnstone & Boyle, 2018).

The implementation of TIC has also been criticised for maintaining an individualistic approach by focusing on ‘trauma interventions’ (Becker-Blease, 2017) which risk pathologising the individual by failing to appreciate the importance of societal and collective causes of trauma such as oppression and negative operations of power. Furthermore, such individualistic approaches perhaps neglect elements of trust and relationship building (Gómez et al., 2016) that may be key in reducing the re-traumatising nature of inpatient psychiatric services and interventions (Muskett, 2014).

TIC has also been criticised for its limited exploration of aspects of inpatient mental health care that re-traumatise individuals. Sweeney and colleagues (2018) talk more generally about re-traumatisation in mental health settings and note how the very nature of these contexts relies on coercion and control, for example by use of the Mental Health Act (1983, 2007), which runs the risk of mirroring people’s past experiences of powerlessness and adversity. Some research has also highlighted the link between anxiety-related attachment and the risk of hospital-related post-traumatic stress disorder (PTSD) (Berry et al., 2015) along with potentially re-traumatising practices such as restraint and seclusion (Paksarian et al., 2014; Sweeney et al., 2018). However, much of this research has focused on post-traumatic stress responses. Additionally, there appears to have been limited conceptual development regarding the emotional impact of such experiences, and a lack of exploration of the range of emotional experiences that service users may have in response to re-traumatising environments and practices (Kezelman & Stavropoulos, 2012).

In summary, although TIC approaches are increasingly being adopted in inpatient psychiatric settings, varying theoretical and implementation definitions, a limited definition of ‘trauma’, and a lack of exploration of what could be re-traumatising in the inpatient context means that the impact of TIC may be limited. This highlights a need for further research to understand what the emotional impact of these experiences is for the people who are subjected to them and to explore the emotional responses that re-traumatisation may lead to.

1.4. Paranoia as an Emotional Response to Anxiety, Threat, Power, and Adversity

Although there is evidence of some organic causes of experiences of paranoia, such as following traumatic brain injury (Prigatano et al., 1988) or, as a result of dementia (Pearce et al., 2022), the current study focused on paranoia that has a contextual, social and psychological aetiology and it included participants where an organic cause for paranoia had not been identified. Importantly, the author takes the position that experiences of paranoia cannot be separated from the context within with they occur (Cromby & Harper, 2013). This is in line with the introduction of TIC in inpatient psychiatric care which perhaps represents the beginning of a cultural shift away from the medical model of ‘mental illness’ toward viewing symptoms of ‘mental health disorders’ as understandable responses to the context (Sweeney et al., 2018). Much of this conceptual development has focused on PTSD which, although valuable, perhaps indicates a limited conceptualisation of the wide range of emotional responses to threatening and adverse experiences (Kezelman & Stavropoulos, 2012).

The Power Threat Meaning Framework (Johnstone & Boyle, 2018) recognises a range of expressions of psychological distress as being understandable responses to experiences of threat and adversity. Such threat responses are assumed to serve multiple functions, for example, protection from physical danger, protection against attachment loss, and maintaining a sense of control, to name a few (Harper, 2022). Importantly, the experience of paranoia has been highlighted as one such ‘threat response’ (Johnstone & Boyle, 2018) which can be seen as an adaptive and understandable emotional response to adverse circumstances and experience of threat and harm (Freeman, 2007).

The following section outlines some key conceptualisations of paranoia, drawing on both clinical and general population research to explore how paranoia can be seen as an emotional response to adverse experiences. It then discusses why paranoia may be an important focus for research into the service user experience in inpatient mental health settings.

1.4.1. The Paranoia Hierarchy and Paranoia on a Continuum

By definition, paranoia is a phenomenon of interpersonal experience, characterised by relational mistrust and suspicion (Boyd & Gumley, 2007). Critically, research regarding the development of paranoid thinking tends to focus on samples of individuals with a diagnosis of psychosis. This is perhaps reflective of the general perception of paranoia being a 'symptom of a mental health disorder', most commonly found within psychotic 'illnesses'. However, social theories of threat perception suggest that some level of paranoia may be an adaptive survival strategy (Green & Phillips, 2004).

In their cognitive model of persecutory delusions, Freeman and colleagues (2002) suggest that paranoid thinking is just one emotional response resulting from the over-anticipation of social threat (Freeman et al., 2002). This has led to the development of a hierarchical model of paranoia (Freeman et al., 2005) which posits that paranoia happens on a hierarchy of severity. They suggest that the most common form of paranoid thinking is suspiciousness in the form of social anxiety or interpersonal worry and more severe forms of paranoid thinking, for example, ideas of reference, namely, thinking that one is being talked about, build upon these experiences (Freeman et al., 2005). Persecutory thoughts, which entail the belief that other people are trying to cause one harm, may develop where significance has been placed upon ideas of reference (Freeman et al., 2005). This may develop into more severe paranoia whereby the belief is held that there is a serious threat of harm (Freeman et al., 2005).

Over the years, general population research had led to the development of the continuum theory of paranoia which posits that there are four a priori factors related to paranoia; 'interpersonal sensitivity, mistrust, ideas of reference and ideas of persecution' (Bebbington et al., 2013, p. 420). It also suggests that paranoid thinking is not just an experience present within clinical populations with a diagnosis of 'psychosis' but exists on a continuum within the general population (Bebbington et al., 2013). In summary, the theories presented above suggest that paranoia is a relatively common experience and propose that all forms of paranoid thinking are built on normal and commonly occurring emotional experiences.

1.4.2. Paranoia as a Human Heuristic and Anxiety Response

Research has demonstrated the importance of anxiety-related processes in the development of paranoid thinking (Freeman, 2007; Freeman & Garety, 1999), and suggests that paranoia may be perpetuated in circumstances of high anxiety and worry (Freeman et al., 2008; Freeman & Fowler, 2009), and social threat (Saalfeld et al., 2018). Such findings have led to the proposal that paranoia is a human heuristic, defined as a mental strategy or shortcut (Mumford & Leritz, 2005), used to deal with uncertain, anxiety-provoking, and threatening situations (Preti & Cella, 2010). This suggests that paranoia may be an unintentional strategy employed by people to protect themselves in unsafe environments. This may be particularly relevant to service users accessing inpatient psychiatric services where these contexts have the potential to be experienced as coercive, unsafe, and traumatising (see section 1.2.1.).

1.4.3. Paranoia as a Response to Operations of Power and Adversity

General population and clinical sample research highlight a well-established link between the development of paranoid thinking and experiences of childhood adversities and victimisation (Johnstone & Boyle, 2018; Read et al., 2005, 2014). For example, Bebbington and colleagues (2004) found that childhood disadvantage and victimisation were significantly associated with psychotic experiences including paranoid thinking. Additionally, people exposed to adversity in the form of low social status and who see themselves as part of the ‘out group’ are at higher risk of experiencing paranoid thinking (Saalfeld et al., 2018), perhaps due to experiences of powerlessness and beliefs about external control which foster mistrust (Mirowsky & Ross, 1983). This literature proposes a social contribution to the development of paranoia and emphasises the importance of longer-term anticipation of social threats resulting from negative operations of power, such as being marginalised, oppressed, or discriminated against, and experiences of adversity.

Considering its interpersonal nature, it has also been proposed that experiences such as interpersonal trauma and threatening or unsafe experiences within a social context may increase the risk of experiencing paranoia. Indeed, university student population research found that people attributed their experiences of paranoia to historical experiences that fostered suspicion of others (Harper & Timmons, 2019). Moreover, Freeman & Fowler (2009) found that witnessing interpersonal events such as seeing a mugging taking place or witnessing interfamilial violence was a strong predictor of paranoid thinking. Other more direct experiences of negative operations of power and interpersonal trauma such as being the victim of sexual assault (Bebbington et al., 2004) and experiencing bullying (Shevlin et al., 2015) have also been identified as key factors in the development of paranoid thinking.

In summary, the research presented above suggests that the development of paranoid thinking may largely be a response to previous experiences of abuse, negative operations of power, and experiences of adversity. This raises important questions about how the inpatient psychiatric environment might unintentionally replicate negative operations of power and experiences of interpersonal trauma and adversity.

1.4.4. Paranoia and Attachment

Theoretical arguments around the specific development of paranoid thinking, as opposed to other ‘symptoms’ of mental health difficulties, have highlighted that disrupted attachment in childhood may be particularly relevant (Bentall et al., 2014). Theories suggest that insecure attachment can be seen as a useful and adaptive response to experiences of abuse, neglect, and an unpredictable caregiving environment (Wickham et al., 2015) in serving to protect individuals from forming attachments with people who risk causing them harm. Importantly, clinical population research suggests that attachment may mediate experiences of trauma or adversity and paranoia experienced within the context of psychosis (Pearce et al., 2017). This is supported by a recent systematic review which found a significant relationship between an insecure attachment style and higher rates of paranoid thinking, with an anxious attachment style being the strongest predictor of the development and maintenance of paranoia (Lavin et al., 2020). Importantly, a recent empirical study found that positive imagery about secure attachment significantly reduced paranoia and anxiety in a non-clinical population sample (Sood et al., 2021) which implies that forming secure attachments may be protective against the development of paranoid thinking.

The literature presented above suggests that circumstances that activate attachment relationships and consequent interpersonal cognitions, beliefs, and attributes (Bowlby, 1969) may be of particular importance to someone's experience of suspicion and paranoia. This may be particularly relevant to people entering into inpatient mental health settings considering the emphasis on developing therapeutic relationships and exposure to new and potentially threatening social environments, alongside the potential exposure to re-traumatising events such as interpersonal violence, coercive practices, and operations of power through the use of legislation such as the Mental Health Act (1983, 2007).

1.4.5. Paranoia and the Inpatient Experience

Although there is a vast amount of research into the general experience of paranoia in clinical populations, much of the literature focuses on individuals with a diagnosis of 'psychosis'. This suggests a lack of exploration into paranoia experienced by the wider service user community who may have varying diagnoses and experience paranoia in the absence of other unusual experiences such as hearing voices or visual hallucinations. Additionally, the research tends to position paranoia as a response to 'trauma' more generally and perhaps discounts specific exposures to threat and adversity which exists within a person's current context (Johnstone & Boyle, 2018) and which may exist within inpatient mental health settings.

The literature presented in sections 1.4.1. through to 1.4.4. highlights how the development of paranoia may be particularly relevant to people accessing inpatient psychiatric services. However, research into the inpatient experience and how it relates to paranoia is limited. One empirical study found that service users' experiences entailed feelings of paranoia (Fenton et al., 2014) and reported that in the absence of clear information, service users may make sense of experiences of fear and confusion in a way that leads them to believe they are under attack. More recently, Lu and colleagues (2017) found that paranoia and suspiciousness can be one such emotional response to psychiatric treatment, and may lead to disengagement, however, there was no exploration of how this came to be or the specifics of what led to this paranoid thinking. Importantly, another study found that expression of distress and anxiety, which often accompany paranoid thinking (Mind, 2020a), can sometimes lead to an increase in distressing and restrictive practices on inpatient wards (D. Wood & Pistrang, 2004). This draws important parallels to the Trauma-Informed Care literature which describes the risk of re-traumatisation in services and poses important questions about how current practices on inpatient psychiatric wards may be re-traumatising service users and inducing and/or maintaining paranoid thinking.

1.5. Summary of Background

The literature presented above highlights that, although there have been considerable developments in inpatient psychiatric care over the years, there remain ongoing concerns about a lack of safety, harmful experiences of inpatient care, and the risk of re-traumatisation in these contexts. These conclusions are supported by a report by the Commission on Acute Adult Psychiatric Care (2015) which found that many service users reported that the inpatient environments had a detrimental impact on their mental health and wellbeing. Despite these findings, there remains a lack of conceptual development about how the inpatient experience leads to increased distress, and how this distress is experienced or expressed by service users. Whilst Trauma-Informed Care approaches aim to tackle the potentially negative and re-traumatising practices within inpatient mental health settings, they tend to focus on PTSD responses and lack consideration of the range of emotional responses to harmful and re-traumatising practices. Discussion of Trauma-Informed Approaches, and incorporating ideas presented in the Power Threat Meaning Framework (Johnstone & Boyle, 2018), has led the author of this thesis to position the experience of paranoia as one such area of interest, considering that paranoia can be considered a ‘normal’ and understandable emotional response to the experience of threat, lack of safety, adversity and operations of power (see section 1.4.), all of which may manifest in inpatient mental health settings.

1.6. Systematic Literature Review: Service User Experience of Inpatient Psychiatric Wards

Whilst this thesis focuses on the experience of paranoia on inpatient psychiatric wards, there is a need to position this within the context of the general service user experience of inpatient mental health care to consider the existing literature and findings. Consequently, a systematic review was conducted which aimed to understand more about service user experiences in inpatient settings. The Preferred Reporting Items of Systematic Review and Meta-Analysis Protocol (PRISMA-P: Shamseer et al., 2015), a method used to evaluate the quality of systematic reviews, was used to guide the reporting. The authors of PRISMA acknowledge that is it most appropriate for mixed-method systematic reviews and whilst this systematic review did not exclude studies based on methodology, many of the selected studies took a qualitative approach. Therefore, guidance on Enhancing Transparency in Reporting the Synthesis of Qualitative Research has also been incorporated (ENTREQ: Tong et al., 2012).

The following information was extracted from each paper: author(s), country of origin, main aim, participants (including demographics), design and method of analysis, and main findings. Review papers were excluded to avoid duplication. Unpublished theses were also excluded as they are not peer-reviewed. Research related to specific wards such as forensic wards or learning disability wards was excluded due to the unique nature of detention in conjunction with Ministry of Justice restrictions or with additional support needs respectively. A full description of the systematic review strategy and PRISMA diagram can be found in Appendix B and C respectively. A summary table of the literature included in the systemic review can be found in Appendix D.

1.6.1 Key Themes

Seven key themes were identified as being central to the service user experience of inpatient psychiatric wards. The themes identified include distressing or harmful experiences (‘power, coercive control and imprisonment’, ‘feeling mistreated and stigmatised’ and ’the inpatient experience as traumatising’), emotional experiences (‘fear, safety and vulnerability,’ ‘confusion and uncertainty,’ and ‘sense of loss’) and helpful experiences related to ‘the importance of relationships and trust’.

1.6.1.1. Power, coercive control and imprisonment: considering that many admissions occur in the context of the use of the Mental Health Act (1983, 2007), it is unsurprising that many people experience hospitalisation as coercive, for example through the forced administration of medication (Hughes et al., 2009) or seclusion (Chambers et al., 2014). They concurrently experience an individual sense of striving for control (Lilja & Hellzén, 2008), and a loss of control (Secker & Harding, 2002) which is perhaps perpetuated by the impact of power (Goodwin et al., 1999; Stenhouse, 2011) and exertion of power by staff (Loft & Lavender, 2016) which can lead to experiences of disempowerment (Hughes et al., 2009), and a felt power imbalance (Thibeault et al., 2010).

Considering that inpatient experiences are often considered coercive and disempowering, it is consistent that the literature also highlights a common theme of feeling that the hospital replicates a prison (Goodwin et al., 1999), with service users describing feeling trapped (Murphy et al., 2017) in an environment of control both by the physical environment of being on locked wards and by the practices which can be experienced as coercive and ‘surveillance like’ (Chambers et al., 2014; Johansson et al., 2009). Other research has found that service users report feeling imprisoned and trapped by the removal of their liberties (Loft & Lavender, 2016) and experience a lack of freedom through not being allowed out of the ward and limited access to outside space which contributes to mental distress (Gilburt et al., 2008).

1.6.1.2. Feeling mistreated and stigmatised: another theme is of service users feeling mistreated. Chambers and colleagues (2014) considered the specific notions of dignity and respect and identified several factors that caused people to feel that their dignity and respect were compromised, for example not being listened to, receiving poor information about their treatment, and a lack of therapeutic engagement. Similarly, research has also found that service users can feel unsupported and degraded to the point where they feel like they are seen as a ‘disease’ as a result of the dominance of the medical model which often leaves medication as the only treatment option available (Lilja & Hellzén, 2008). Research also highlights that service users can feel dehumanised (Eldal, Veseth, et al., 2019), being seen as ‘ill’ and a ‘patient’ rather than a person with autonomy and agency. The literature also highlights that, although some people anticipate a kind and helping environment, others hold the belief that admission will entail stigmatisation (Nolan et al., 2011), and anticipate searching for care in a stigmatising environment (Molin et al., 2016). Importantly, specific research into the experience of racialised groups has highlighted that discrimination and racism were key aspects of the experience as an inpatient in mental health services (Secker & Harding, 2002). This was supported by Jones and colleagues (2010) who found that service users not only experienced and witnessed racism but also reported being racist towards other people on the ward.

1.6.1.3. The inpatient experience as traumatising: another theme is that many service users view the inpatient experience as traumatising. One study found that the perceived lack of control and feeling of imprisonment led service users to view their experience as traumatising (Emrich et al., 2021). The literature also notes the traumatising impact of being admitted to a psychiatric hospital (Ådnanes et al., 2018; Murphy et al., 2017) with one study finding that service users reported experiencing flashbacks and nightmares about being physically restrained (Murphy et al., 2017). The traumatising nature of certain practices that occur on the ward, such as physical restraint (Hughes et al., 2009) and seclusion (Thibeault et al., 2010), were found to bring back memories of previously traumatising events such as childhood abuse and rape.

1.6.1.4. Fear, safety and vulnerability: another theme is the feelings of fear, lack of safety and vulnerability. For example, service users can often feel fearful of interpersonal contact (Pejlert et al., 1995). More specifically, research suggests that service users often feel fearful in response to the violence they witness on the ward, both towards staff and by staff towards other service users (Gilburt et al., 2008), which can result in feeling fearful of physical attack (Loft & Lavender, 2016).

Linked to this, perhaps, is the importance of a sense of safety (Koivisto et al., 2004; Roe & Ronen, 2003) within the service user experience. In 2004, Mind conducted a national survey and utilised focus groups to explore people’s experience of inpatient mental health services. They found two contrary experiences; for some, the inpatient experience was a positive one where they felt supported and safe, but for others, inpatient stays were characterised by a lack of safety, boredom and inhumane treatment (Mind, 2004). Similarly, in 2009, a survey conducted by the Care Quality Commission found that, although many service users felt safe during admission, the majority of respondents either only felt safe some of the time or did not feel safe at all (Care Quality Commission, 2009). Further research highlights that both feeling safe (Jones et al., 2010) and unsafe (D. Wood & Pistrang, 2004) are common experiences for service users in inpatient psychiatric hospitals, providing a somewhat contradictory picture (Eldal, Veseth, et al., 2019). Similar findings by Fenton and colleagues (2014) illustrated that patients felt both safe and contained in the inpatient setting, whilst also feeling unsafe in a chaotic environment. More specifically, although some service users felt their inpatient stay occurred in a safe place away from the stress of life, it was also experienced as a place devoid of comfort and connection which led to conflicting feelings of both ‘safety’ and a ‘lack of safety’ (Fenton et al., 2014). Moreover, it appears that service users within the same hospital can have different experiences in the same setting, whereby some feel cared for and safe, whilst others feel unsafe and experience the environment and interactions with others as non-therapeutic (Jones et al., 2010). Similarly, whilst some service users experience inpatient wards as a negative and restrictive experience, others experience the ward as a safe shelter (Andreasson & Skärsäter, 2012; Lindgren et al., 2019), seeing it as a place of refuge (Johansson et al., 2009; Thomas et al., 2002) where they can gain relief from external life stressors (Ådnanes et al., 2018; Nolan et al., 2011).

There have been several studies that have more specifically explored service users’ experiences of safety in psychiatric hospitals (Stenhouse, 2013; D. Wood & Pistrang, 2004). Stenhouse (2013) found that whilst patients initially expected to feel safe from themselves, other people, and the external world, they tended to feel vulnerable because of either not having enough information or being around fellow patients. Importantly, D. Wood and Pistrang (2004) found that certain factors impacted on patients’ experiences of safety, such as interactions with other service users, staff behaviour and experiences of coercive treatment. Although some research has found that service users see the ward as a safe place which allows for vulnerability (Emrich et al., 2021), other research has found that service users often feel vulnerable and helpless (D. Wood & Pistrang, 2004). Research exploring vulnerability has also reported mixed findings whereby some service users tended to feel vulnerable but continued to hope for protection against vulnerability (Koivisto et al., 2004).

1.6.1.5. Confusion and uncertainty: much of the literature highlights that service users report an absence of informational provision (Chambers et al., 2014; Fenton et al., 2014; Gilburt et al., 2008; Goodwin et al., 1999) and a lack of informational support (Murphy et al., 2017). Considering this, many empirical studies have highlighted that the inpatient experience is characterised by confusion and uncertainty. Fenton and colleagues (2014) found that service users can feel overwhelmingly confused by the process of admission and certain practices, for example being transferred to different hospitals or being given medication for the first time, which can lead to confusion and paranoia. This was supported by Loft & Lavender (2016) who found that a lack of awareness of procedures led to considerable distress and feelings of paranoia. Similarly, other research highlights a sense of uncertainty where service users regularly wonder ‘what is going on?’ (Mcguinness et al., 2013), with a lack of information about the care process leading to confusion and a sense of not knowing how to get help (Molin et al., 2016). Importantly, Andreasson & Skärsäter (2012) found that compulsory treatment could be seen as a positive experience if service users were given sufficient help in understanding typical practices and procedures.

1.6.1.6. Sense of loss: another theme is that service users’ experiences of inpatient admission can often be filled with experiences of loss, in many senses of the word. Some service users can feel a strong sense of loss in terms of how they are perceived by other people in their life (Roe & Ronen, 2003). The sense of loss described in the literature also pertains to service users’ experience of losing their sense of themselves (Thibeault et al., 2010), their identity (Hughes et al., 2009), and their self-worth (Roe & Ronen, 2003), where they often no longer feel ‘themselves’ (Pejlert et al., 1995). Service users may try to cope by striving to maintain their identity (Fenton et al., 2014). The literature also notes a sense of loss in terms of service users’ losing their freedom and independence by being locked on a ward (Johansson & Lundman, 2002).

1.6.1.7. The importance of trust and relationships: the final theme is the importance of both trust and the significance of therapeutic relationships with staff. Trust and the therapeutic relationship can be particularly defining to the service user experience of inpatient stays (Fenton et al., 2014; Secker & Harding, 2002; Stenhouse, 2011). Molin and colleagues (2016) found that trusting and 'normal' relationships with staff can make a substantial difference to the experience of service users on inpatient psychiatric wards and Eldal, Natvik, and colleagues (2019) found that positive therapeutic relationships and trust can be fundamental to recovery. More specifically, Johansson and colleagues (2009) found that staff trying to build trust could lead service users to feel strengthened and respected, whereas poor service user-staff relationships could lead service users to feel degraded (Chambers et al., 2014).

Importantly, factors influencing trust and relationships have been documented in the empirical research, for example, Secker and Harding (2002) reported that degrading experiences such as racism (Gilburt et al., 2008) and inhumane experiences such as forced medication (Emrich et al., 2021) contributed to a lack of trust. Importantly, experiences of safety can help in the formation of trust and positive therapeutic relationships and mistrust can contribute to a negative experience of being an inpatient (Gilburt et al., 2008).

Whilst research has highlighted the importance of service users being able to trust staff, other empirical research highlights the importance of service users being trusted by staff, and has found that service users believe that staff do not trust them (Gilburt et al., 2008; Koivisto et al., 2004).

1.6.2. Evaluation and Critique of the Literature

1.6.2.1. Description of the research: a total of 30 articles were included in the review, which includes two papers which would be considered grey literature, for example, published reports in non-commercial publications, or government reports (Paez, 2017). Including grey literature in systematic literature reviews can reduce the chance of publication bias (Paez, 2017). 17 were conducted in the UK and Ireland (seven UK generally, one England and Wales, five England, two Scotland, two Ireland), two were conducted in Norway, six were conducted in Sweden, one was conducted in Finland (Koivisto et al., 2004), two were conducted in the USA, one was conducted in Canada (Thibeault et al., 2010) and one was a cross-European study (Ådnanes et al., 2018).

Although the majority were conducted in the UK, much of the literature relates to service user experiences from other European countries and the United States of America or Canada. Research into the mental health policy and legislation differences across nations has highlighted a general alignment between countries (Cronin et al., 2017). However, there is some difference in the definitions of what constitutes a ‘mental disorder’, the timing of Mental Health Act reviews and how service users are supported to make decisions about their care (Cronin et al., 2017), which could impact the service user experience of being an inpatient within different regions of the world. Consequently, it is unclear whether non-UK research can be generalised to the service user experience in England and the UK.

The studies conducted in England span 22 years, ranging from 1999 (Goodwin et al., 1999) to 2021 (Emrich et al., 2021). Critically, during this two-decade timespan, notable changes to the inpatient mental health service provision and Codes of Practice have taken place (see section 1.2.2.). There have also been significant changes to medical and psychological practices during this time. Traditionally, inpatient mental health facilities have been dominated by the medical model (McCulloch et al., 2005) and a ‘firefighting’ approach (McKeown et al., 2019). Over the years, however, there has been an increased focus on staff training, service user engagement and supervision and leadership within inpatient settings (Clarke, 2004). Additionally, the NHS Long Term Plan (NHS, 2019) advocates for increased psychological services within inpatient settings and focuses on the importance of a therapeutic environment as recommended by the (Care Quality Commission, 2019). Concurrently, reduced funding for beds has led to an increase in the threshold for admission (Allen & Jones, 2002), meaning that the presentation and demographic of service users who access inpatient services may differ considerably from those included in previous research. Consequently, it can be assumed that research spanning across this wide time frame may reflect varied service user experiences and may be difficult to generalise to the current NHS context.

1.6.2.2. Critique of sample and methodology: the majority of the qualitative studies used semi-structured interviews, either in the form of focus groups or individual interviews and had sample sizes between 5-110 service users. The larger survey studies included samples between 280 and 335 respondents. The age of participants ranged from 16 to 75 but the majority of the studies had participants in their 20s, 30s and 40s. Whilst this is a fairly robust range of sample sizes and age ranges, it is important to note that self-selection bias (Heckman, 1990) may be particularly prevalent within this area of research since it requires considerable self-disclosure and discussion of experiences (Robinson, 2014) which, in light of the literature presented above, may be distressing and emotionally burdensome to recall.

Although many of the studies included in this review sought to explore the views of both men and women participants, many studies had significantly more male participants than female participants, with some reporting as many as 80-90 per cent of their participants as male. This unequal focus on the male experience is consistent across much of the health and mental health research and can lead to inherent maleness in the experiences described (Holdcroft, 2007). Moreover, there were no studies that included the views and experiences of non-binary or transgender individuals. This is perhaps representative of the continued exclusionary and binary definition of gender that exists within psychological research and is problematic since it represents a limited white-western conceptualisation of gender and is not representative of the changing social conceptualisation of gender (Cameron & Stinson, 2019).

Moreover, very few studies reported the ethnicity and/or race of the participants. This absence of race or ethnicity reporting is a common finding (Roberts et al., 2020) which highlights systematic inequalities. This is of particular importance considering the well-documented disparities between racialised groups and White groups concerning the impact of social determinants of poor mental health and the risk of involuntary detention under mental health legislation (Barnett et al., 2019; Bignall et al., 2019).

There were also several studies which excluded individuals from participating if they were currently experiencing psychosis. This is an ethically complex issue, one which is regularly considered in research ethical guidelines but one which is often not explicitly discussed in the methodology of research

(Carlsson et al., 2017). Many ethical guidelines suggest that people with mental health difficulties are ‘vulnerable’ and may be unable to consent to take part in research (Koivisto et al., 2001). However, many of the individuals accessing inpatient mental health hospitals may indeed be experiencing psychosis and excluding them from research risks missing important narratives from the perspective of people in the height of their need for such services. Additionally, sampling methods used in many of the qualitative studies asked ward staff to nominate service users for involvement in the research. This raises considerable ethical questions regarding potential ‘gatekeeping’ of who is invited to participate, and therefore whose voices are heard (Allbutt & Masters, 2010).

1.6.2.3. Critique of the focus of the literature: the systematic review highlights that the topic of service user experiences in inpatient settings is a relatively highly researched area. However, much of the previous research into service user experiences has a more general aim, drawing conclusions that tend to relate to the overall general experience of people accessing inpatient services. Very few studies focused on a more in-depth exploration of these general experiences, or even the emotional impact of these experiences.

Whilst some research does highlight specific experiences such as the feeling of safety (Jones et al., 2010), there is little exploration of the factors which contribute to these experiences, or the emotional or psychological consequences. Whilst Fenton and colleagues (2014) found that service users gave accounts of feeling paranoid as a result of inpatient experiences, there was a limited exploration of the contributing factors. Whilst this gives some insight into the emotional responses to hospitalisation, it provides a narrow exploration of the contributing factors to such experiences.

Finally, although themes of safety, threat, operations of power, and experiencing the inpatient experience as traumatic have dominated the literature, there appears to be a limited exploration of common emotional responses to trauma included within the service user experience literature, resulting in a limited understanding of what causes people to feel unsafe, threatened, and mistrustful within these settings.

1.6.3. Comparison to Other Systematic Reviews: A Meta-Synthesis

Whilst conducting this systematic review, a large number of other reviews were identified. These were excluded from the systematic review presented above to not duplicate findings (see PRISMA diagram, Appendix C). However, a summary of and comparison to the current systematic review was deemed important to evaluate the findings of the current review and consider the consistency of findings across the research.

12 reviews were identified and synthesised (Appendix E). Seven themes were identified: dehumanised and stigmatised; coercion, control, and powerlessness; boredom; lack of and importance of information; fear, lack of safety and distress; feeling of safety; the therapeutic relationship. The findings of the meta-synthesis reflected similar themes to that of the systematic literature review presented in section 1.6.1. and did not add considerable novel insight into the service user experience of inpatient psychiatric wards that had not already been explored. Therefore, for reasons of space and readability, the meta-synthesis has been presented in the appendix (Appendix F).

1.7. Rationale for the Current Study

The literature presented in the sections above highlights ongoing concerns about a lack of safety, harmful and distressing experiences of inpatient care, and the risk of re-traumatisation in these contexts. TIC approaches to inpatient mental health care advocate for increasing our understanding of what contributes to distressing and re-traumatising experiences to be able to consider what could be done differently. However, they have tended to prioritise PTSD responses over other emotional responses to trauma and adversity. Moreover, the role of anxiety, victimisation, and experiences of threat in the development of paranoid beliefs has been highlighted as an important area for future research (Bentall et al., 2014) and if paranoia is considered through the lens of the Power Threat Meaning Framework (Johnstone & Boyle, 2018), there is significant rationale to explore the meaning-based threat response of paranoia within the inpatient setting.

The systematic literature review presented in section 1.6.1, along with the meta-synthesis regarding the service user experience in inpatient settings (Appendix F), has highlighted some key themes around the service user experience in inpatient settings, for example, a lack of safety, vulnerability, exposure to threatening situations, and feeling coerced and imprisoned. However, critique of this literature emphasises a lack of exploration of the emotional and psychological responses to such experiences.

Although some research has named paranoia as one possible emotional response to inpatient admission and experiences on the ward, there is a lack of conceptual understanding of the situations and circumstances that lead to these outcomes, highlighting a gap in the literature. Consequently, the current study aims to fill this gap in the literature by exploring service users' experiences of paranoia as one such emotional response to situations and experiences that occur during admission to an inpatient psychiatric ward. More specifically, it seems important to explore the sense that people make of their experiences of paranoia within an inpatient mental health setting to understand more about what makes people feel paranoid, and what could be done differently to alleviate the experience of paranoia.

It is strongly advised that inpatient settings and policies should be influenced by service user views (NHS England, 2016). Consequently, there is a strong rationale for conducting qualitative research that specifically explores the views and experiences of service users who have accessed inpatient settings. Exploring what leads people to feel paranoid during admission is clinically relevant since the experience of paranoia may create significant barriers to engagement (Lu et al., 2017) and may reduce how useful and effective inpatient treatment may be. Additionally, there is particular importance in understanding the experience of paranoia in inpatient psychiatric settings considering that the development of trust and therapeutic relationships are key to the delivery of effective mental health care (P. Brown et al., 2009).

1.8. Aim of the Study and Research Question

This current study aims to build on the current inpatient service user experience literature, with a particular focus on what makes people feel paranoid[1] within inpatient mental health settings, and what services could be doing differently to help service users feel less suspicious, threatened, and paranoid.

The main research question is as follows:

1. What do people perceive to be the factors which influence their experience of paranoia on inpatient psychiatric wards?

1.9. The Author’s Position to the Research Area

As an Assistant Psychologist, the author worked for several years within inpatient mental health services. The author consistently reflected on the practices being used, along with the privilege the author had to be able to physically leave the ward, and the feeling of safety and relief she would feel upon leaving the ward environment. There were several times that the author felt unsafe and threatened on the ward, both due to incidents occurring on the ward, but also interpersonal experiences with other staff members and service users. This feeling of lack of safety often made the author feel ‘on edge’ and weary of the surroundings. This sparked a particular interest regarding what the service users might feel, how they might be impacted by such experiences, and what service providers could be doing differently to alleviate distress experienced on the ward. The author also noticed particular examples of epistemic injustice, specifically testimonial injustice (Fricker, 2007), whereby the service users had a reduced likelihood of being believed and were seen to have reduced credibility as a consequence of being diagnosed with a ‘mental illness’ (Crichton et al., 2017). This has motivated the author to focus on conducting research that gives service users a voice, to hear their perspectives and experiences, and have these accounts be seen as informative and useful to current practice.

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[1] The working definition of paranoia used throughout this thesis is an interpersonal experience characterised by relational mistrust and suspicion (Boyd & Gumley, 2007).

2. METHODOLOGY

2.1. Chapter Overview

This chapter outlines how the research question of ‘What do people perceive to be the factors which influence their experience of paranoia on inpatient psychiatric wards?’ was answered. It outlines the rationale for the methodology employed, the study design, a description of the participants, materials used and how data was gathered and analysed. It also introduces quality assurance principles and reflexivity and explores key ethical considerations related to the methodology employed.

2.2. Rationale for Methodology

This section outlines the epistemological and ontological position and the rationale for methods employed for data collection and analysis.

2.2.1. Epistemological and Ontological Position

Throughout all research, it is important to outline the assumptions that are being made about reality and how we can come to know what we know (Hathcote et al., 2019). Ontology is concerned with what exists, the structure of reality, and the nature of being (Hathcote et al., 2019). Epistemology, the ‘philosophical theory of knowledge’ (Harper & Thompson, 2011, p.4), relates to questions about how we know what we know and the limits of this knowledge. The research question presented in section 1.8. assumes that there is something objectively real and measurable about the experience of paranoia in inpatient mental health settings and that there may be multiple perceptions and experiences of this reality that may be influenced by internal and external factors. Consequently, this thesis takes a critical realist stance (e.g., Bhaskar, 2008) by seeking to understand the underlying unobservable structures and processes that may be involved in producing particular outcomes (Leung & Chung, 2019), more specifically, paranoia on an inpatient psychiatric ward.

The critical realist stance assumes that an external world exists independent of our constructions of reality and is therefore ontologically ‘realist’ (Liamputtong, 2019). It is however epistemologically ‘constructivist’ or ‘relativist’ in that it recognises that the methods available to explore the knowable external world are imperfect (Harper, 2011), and there therefore may be multiple perspectives of the same reality, influenced by individual, historical and cultural contexts (Denzin & Lincoln, 2011; Pilgrim, 2019). Considering this, a cross-sectional qualitative interview method was used to enable in-depth exploration of service users’ experiences of paranoia on inpatient psychiatric wards and to gather a wide range of experiences. Additionally, since the research question highlights a particular interest in the individual experience of paranoia, a qualitative methodology was adopted due to its strength in exploring the experience and individual meaning-making (Harper & Thompson, 2011).

2.2.2. Rationale for Method of Data Collection

Data was gathered using individual interviews with participants. This methodology was chosen because it enables each participant’s experience of paranoia on the ward to be given adequate space and importance within the research whilst allowing the participant to make meaning in their own way (Frith & Gleeson, 2011). This method of data collection is consistent with the critical realist position as it assumes that an external world exists independently from our construction of it but seeks to understand it through multiple perceptions of the same reality (Khanna, 2019).

Focus group interviews were considered. However, this research aims to explore deeply personal and emotional experiences related to inpatient admission, and the use of focus groups can limit disclosure (Liamputtong, 2011), therefore focus groups were not deemed appropriate. Additionally, this research is specifically interested in the experience of paranoia, which, as discussed in section 1.4., can be understood as a relational experience which can be exacerbated in social contexts or interpersonal exchanges (Boyd & Gumley, 2007). Consequently, an individual interview method was used to reduce the likelihood of increasing people’s sense of social threat.

2.2.3. Rationale for Method of Analysis

2.2.3.1. Consideration of Grounded Theory and Interpretative Phenomenological Analysis: Grounded Theory (Glaser & Strauss, 1967) was considered as a possible methodology since it is widely used to analyse qualitative data and can be applied to the critical realist stance (Willig, 2017). However, Grounded Theory is more concerned with theory generation (Willig, 2017). Considering the limited research into what makes service users feel paranoid on inpatient psychiatric wards, it felt premature to employ Grounded Theory methodology to develop a theory of why people feel paranoid within the inpatient mental health ward context.

Interpretative Phenomenological Analysis (IPA: J. A. Smith, 1996) was also considered as a possible methodology since it can be applied to the critical realist stance and is often used to analyse qualitative interview data. However, IPA is more concerned with the individual experience of how participants perceive their world, rather than exploring reasons for experiencing a particular phenomenon (Willig, 2017). The current research aims to map the phenomena of paranoia across people who have been admitted to psychiatric wards and explore why and how paranoia manifests and develops in these contexts. It does not aim to provide an in-depth exploration of the phenomena itself. Consequently, IPA was not deemed appropriate for this thesis.

2.2.3.2. Using critical realist Thematic Analysis: Thematic Analysis is a method of qualitative analysis that can be conducted from different epistemological positions (Braun & Clarke, 2013). In general, Thematic Analysis aims to identify patterns and meaning from qualitative data (Braun and Clarke, 2013). Thematic Analysis was used in this research since it is deemed particularly relevant to ‘applied research’ that is concerned with developing an understanding of experiences within mental health settings (Braun & Clarke, 2014). Additionally, employing Thematic Analysis to analyse the qualitative interview data allows for in-depth exploration of the factors and processes that give rise to paranoia in the context of an inpatient psychiatric hospital. Consequently, considering the research aims, research question, data collection methodology, and the limitations of alternative methods of analysis, Thematic Analysis was deemed the most appropriate methodology.

Thematic Analysis is consistent with the critical realist stance since it relies on the researcher's interpretation of participants' experiences and aims to identify general themes that could be seen to represent an external reality, whilst also not assuming one version of reality (Braun & Clarke, 2013). Additionally, Thematic Analysis places importance on the meaning that people give to their experiences which allows for a personal reflection of reality, which reflects the epistemologically 'constructivist' or 'relativist' position, whilst also taking the ontologically 'realist' position through the exploration of people's multiple and perhaps differing experiences of reality (Braun & Clarke, 2006).

Considering the limited research regarding the experience of paranoia within inpatient mental health settings, this research is exploratory. Consequently, an inductive Thematic Analysis approach was taken as this invites the generation of themes that remain very close to the data and does not rely on trying to fit the data into a pre-existing coding framework (Braun & Clarke, 2006). However, an inductive approach is not without pre-conceptions and researcher bias (Braun & Clarke, 2006) since any generation of themes will be based on the researcher's interpretation of the data (Braun & Clarke, 2013). This will be discussed further in the Critical Review (section 4.3.)

2.3. Ethical Approval

Ethical approval was gained from the University of East London School of Psychology Research Ethics Committee (Appendix G and Appendix H). Since the study only involved a general population sample, NHS ethical approval was not required. Further exploration of methodological ethical considerations is discussed in section 2.6.

2.4. Participant Identification and Recruitment

This section describes the rationale for the sample, how participants were recruited, along with the rationale for the sample size.

2.4.1. Rationale for a General Population Sample

Using a clinical sample, meaning current inpatients, was considered. However, recruitment of current inpatients would have required NHS ethical approval, and at the time of recruitment, the ongoing covid-19 pandemic meant that non-covid related research had been suspended, therefore limiting the ability to gain approval to proceed with the study. Additionally, recruiting current inpatients may have skewed the sample towards people who are still engaged with mental health services, thus providing a limited range of experiences and viewpoints. Consequently, recruiting a general population sample was preferred to allow for the exploration of multiple viewpoints.

2.4.2. Inclusion Criteria

This research aims to explore the adult experience; therefore, participants needed to be aged 18 to 65 years to fall within the NHS adult population definition and to represent service users of general adult psychiatric wards. Participants must have been previously admitted to a general adult psychiatric ward within the last five years. This time frame was agreed upon through discussion with the research supervisor to ensure participants’ experiences not only related to current practice but were also recallable. Theories of paranoia position it as an experience spanning across and beyond formal mental health diagnostic criteria. Therefore, participants were not required to have any specific mental health diagnosis. Participants had to be able to read and speak English since the recruitment advert and information sheets were developed in English and the ability to read and speak English was important for ensuring this research gained informed consent from participants. Additionally, there were no resources to translate the study information or provide an interpreter during the interviews.

2.4.3. Exclusion Criteria

Participants were excluded if they had only been an inpatient on a child/adolescent psychiatric ward and/or if they had difficulty communicating in English for the reasons stated in the section above. Participants were excluded if they had only been an inpatient on a specialist ward (e.g., a learning disability or forensic ward) since these settings may give rise to specific experiences which may not apply to general adult mental health wards due to the unique nature of detention in conjunction with Ministry of Justice restrictions or with additional support needs respectively. Participants were also excluded if they were currently an inpatient on a psychiatric ward since being interviewed in a busy ward environment could be challenging for participants and increase distress. Additionally, the researcher anticipated that, considering the research topic of paranoia, being asked about what makes them feel paranoid might increase participants' concerns about where the information gathered may go, and who on the ward might be privy to their interview content.

2.4.4. Recruitment Strategy

Recruitment utilised a non-probabilistic purposive sampling method. More specifically, a social media post (Appendix I) was publicised on social media websites/apps such as Twitter, Facebook and Instagram in August 2021. Individuals, mental health professionals, and organisations deemed to have a high number of service user followers were asked to share it. The advert outlined the main aims of the study, along with the main inclusion criteria and a link to a website which provided further information about the research study and also included a link to the information sheet (Appendix J). Prospective participants were asked to email the researcher if they were interested in taking part in the research study. At this initial point of contact, participants were given to opportunity to ask questions, and then they were invited to attend an individual interview (see Appendix K for example confirmation email). Here, a snowballing method of sampling was employed whereby potential participants were asked to forward the details of the study to other individuals who may be interested, however, no further participants were recruited via this method. A copy of the participant information sheet and the consent form was then sent to the potential participants (Appendix J and Appendix L respectively) before attending the interview.

2.4.5. Sample Size

Guest and colleagues (2006) suggest that a sample of six participants can lead to the generation of meaningful themes and that saturation can be reached with a sample of 12 participants. The final number of participants in this research study was eight, which is appropriate for the methodology employed in data analysis (Braun & Clarke, 2013). The sample size of eight is also in line with other published research concerned with the general service user experience of inpatient psychiatric settings, for example, Fenton and colleagues (2014) had a sample of six participants.

2.5. Data Collection

This section describes how demographic data and interview data were collected.

2.5.1. Description of Sample

A demographic questionnaire was developed (Appendix M) which aimed to gather information about the sample of people taking part in the research study. This considered the participants' age, gender, length of time and number of admissions to psychiatric wards, any mental health diagnosis, and current vocation. The questionnaire was developed in line with other research's demographic collection methods and was influenced by Cameron & Stinson's (2019) guidelines for respecting gender diversity within research.

Table 1. describes participant demographics which were collected at the start of the interview to gain a description of the sample included in this research study. To maintain anonymity, this data is presented collectively. The sample had a mean age of 30 years, and the majority identified as female and White. They had an average of two admissions with a mean length of 28 days and the majority were under section at the time. The sample also had a range of psychiatric diagnoses and current occupations. See Appendix A for relevant Mental Health Act (1983, 2007) sections.

Table 1.

Participant Demographic Information (N = 8).

Demographic	Description
Age range and mean (years)	Range = 23-40 Mean = 30
Gender	Female (5), Female/Non-binary (1), Non-binary (1), Transgender man (1)
Ethnicity	White[2] (8) which includes self-described ethnicities of White British (6), British (1) and Half Romani (1)
Number of admissions range and mean	Range = 1- 4 admissions Mean = 2 admissions
Length of Admission range and mean (days)	Range = 1 - 75 Mean = 28
Frequency of Type of Admission*	Section 2 (4), Section 2 and Section 3 (1), Section 136 (1), Voluntary (3)
Mental Health Diagnoses*	Depression and anxiety (1), Manic episode with psychotic symptoms (1), Bipolar Affective Disorder-type 1 (1), Bipolar Affective Disorder (3), PTSD (2), Complex PTSD (1), Depression (3), Asperger's (1), Autism (1), Emotionally Unstable Personality Disorder and Severe Depression (1), Psychosis (1), Delusional Disorder (1)
Occupation*	In training (1), At college or university (2), Working full or part-time (5), Not working due to long term physical or mental health difficulties (1)

* *more than one count per participant*

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[2] White ethnicity, as defined by the 2021 Census of England and Wales includes the following: English, Welsh, Scottish, Northern Irish or British, Irish, Gypsy or Irish Traveller, Roma, Any other White background (Race Disparity Unit, 2021).

Table 2 provides a list of participant pseudonyms and contextual information relevant to understanding the context of participants' experiences on the ward.

Table 2.

List of Pseudonyms and Relevant Contextual Information.

Pseudonym	Age range	Gender
Marina	20-24	Female
Zosia	20-24	Female/Gender non-conforming
Esther	25-29	Female
Will	25-29	Transgender
Jade	20-24	Female
Cassie	30-34	Female
Abigail	35-39	Female
Molly	40-44	Gender non-conforming

2.5.2. Interview Schedule

A semi-structured interview schedule was developed (Appendix N) in discussion with the research supervisor and was informed by the existing literature on the development of paranoia more generally and the inpatient experience. A semi-structured interview design was used as opposed to alternatives such as structured or unstructured interview schedules since it allows for the discovery and exploration of information provided in the interview, whilst also providing some structure through the guidance of key questions that participants can find helpful (Gill et al., 2008). Additionally, semi-structured interviews are compatible with many forms of data analysis, including Thematic Analysis (Willig, 2017).

2.5.3. Interview Procedure

Data was gathered via individual interviews conducted via Microsoft Teams. Microsoft Teams was used as opposed to face-to-face interviews due to the context of the Covid-19 pandemic. Interviews took place between October and November 2021. The interviews were recorded to allow for verbatim transcription post-interview without the need for rigorous notetaking which can be distracting for both the interviewee and interviewer and can reduce the development of rapport (Willig, 2017). Participants were emailed a debrief sheet (Appendix O) after the interview and all data was stored in line with the data management plan (Appendix P).

2.6. Data Analysis

This section outlines the process of data analysis. NVivo 12 software was used to code the data and store annotations, notes, memos and mind maps.

2.6.1. Transcription

All transcriptions involve some form of 'translation' of the spoken word (Willig, 2017). This research aims to explore the content of the interview and is less concerned with the nuance of what is said, transcription, therefore, included the words of the interviewee and did not include non-linguistic features of what was being said (Willig, 2017). This is in line with Thematic Analysis as this methodology does not require a detailed transcription, but does require a thorough 'verbatim' account of what was said (Braun & Clarke, 2006)

2.6.2. Phases of Qualitative Analysis

Braun and Clarke's (2006) six phases of Thematic Analysis were used to guide the analysis of the data collected. The process undertaken at each stage is detailed below.

2.6.2.1. Phase 1: familiarising self with the data: this phase of analysis involved the researcher immersing themselves in the data (Braun & Clarke, 2006). Listening to the recordings of interviews and transcribing the data was arguably the initial stage of familiarisation (Braun & Clarke, 2006). The author also familiarised themselves with the data by re-reading the interview transcripts (Braun & Clarke, 2006).

2.6.2.2. Phase 2: generating initial codes: the researcher kept the research question in mind and looked at the semantic and latent meaning of the data, meaning that labels were given based on the explicit content of the data, and the underlying assumptions in the data (Braun & Clarke, 2013). See Appendix

Q for an example of a coded extract. Codes were ‘data-derived’ but critically involved the role of the researcher in choosing what and how to code (Braun & Clarke, 2013). The software NVivo 12 was used to note down initial codes which generated a collection of codes that were identified across the data. Annotations and memos were used to record the researcher’s ideas and sense-making process and enable reflexivity.

2.6.2.3. Phase 3: searching for themes: a theme is an outcome of coding (Saldaña, 2013) and refers to the sorting and combining of codes into broader themes (Braun & Clarke, 2006). This was an active and multi-stage process. Codes were grouped based on relationships or unifying features to develop an initial set of candidate themes (Appendix R). Mind maps and memos were used to record the researcher’s ideas and sense-making process and enable reflexivity (Appendix S).

2.6.2.4. Phase 4: reviewing themes: whilst phase three involved developing ‘candidate themes’, phase four involved consolidation of these themes. The researcher considered whether the themes generated were representative of the data and took a two-level approach; initially, the researcher considered if the extracts linked to each theme illustrated a consistent pattern. Next, the researcher looked at the whole data set and considered the validity of the individual themes (Braun & Clarke, 2006). See Appendix T for an extract of the reflective journal concerned with developing themes from the initial candidate themes.

2.6.2.5. Phase 5: defining and naming themes: this process involved writing a clear and comprehensive description of themes generated (see Appendix U)

2.6.2.6. Phase 6: producing the report: this involved producing a clear and coherent account of the data across and within themes. Vivid quotes and extracts from the data were used to evidence and capture the essence of the themes.

2.6.3. Evaluating the Quality of Analysis and Reflexivity

Whilst the methods of evaluating the quality of qualitative analysis are widely debated (Harper & Thompson, 2011), it remains important to consider some general principles for evaluating the quality of the thematic analysis conducted.

Spencer & Ritchie (2011) suggest considering three guiding principles of contribution, credibility and rigour. A description of these can be found in Appendix V. These were considered throughout this research, from the stage of proposing the research through to conducting the interviews, analysing the data, and writing the discussion. They will be discussed in more depth, along with personal and epistemological reflexivity, in the critical evaluation section (see Section 4.3.2)

2.7. Ethical Considerations

This section discusses key ethical considerations related to the methodology.

2.7.1. Informed Consent

Informed consent was gained from all participants who took part in the study. To ensure informed consent, potential participants were given an information sheet (Appendix J) via a link included in the recruitment advert. This included details about the research aims, what participation would entail, data management, confidentiality, and dissemination of the findings. Another copy was emailed to them on initial contact, and they were invited to ask questions before proceeding. Confirmation of consent was obtained using a signed consent form (Appendix L). Participants were asked to read and sign the consent form and return it via email before commencing the interview. Before commencing the interview, the consent form was reviewed, and they were invited to ask any questions and were reminded of their right to withdraw. After the interview, participants were reminded of the next stages including transcription, data management, data analysis, write-up, and dissemination. Participants were again invited to ask questions, and a debrief sheet (Appendix O) was emailed to them after the interview.

2.7.2. Confidentiality and Anonymity

Before commencing the interview, participants were reminded of confidentiality and its limits, and the anonymity of taking part. To minimise the risk of breeching confidentiality, the names of participants were removed and replaced with pseudonyms at the transcription stage. Additionally, identifiable data such as the name of mental health hospitals or the names of fellow service users were removed during transcription. To minimise the risk of participants being identified, the demographics of participants are only linked to extracts of transcripts in cases where the context gives further meaning to the extract and where participants explicitly linked elements of demographics to their experience.

2.7.3. Data Storage and Management

Data management and storage complied with the Data Protection Act 1998 and followed a detailed data management and storage plan which was approved by the UEL Data Management Officer (see Appendix P).

2.7.3.1. Contact information: contact information in the form of email addresses was erased once the interview was conducted, except in the cases where participants requested a summary of the research findings. In these cases, contact information will be erased once the summary has been emailed to them.

2.7.3.2. Audio recording: Microsoft Teams recordings of interviews were stored and managed in line with the data storage and management plan (Appendix P). Recordings will be erased once they are no longer required for university approval, e.g., by October 2022.

2.7.3.3. Electronic data storage: all anonymised data and metadata will be stored in the researcher's personal UEL OneDrive for Business which is secure and encrypted. On completion of the Doctorate in Clinical Psychology, the data will be transferred to the research supervisor's UEL OneDrive for Business, as outlined in the Data Management Plan (Appendix P). After five years, all anonymised data and metadata will be erased.

2.7.4. Wellbeing and Risk Management

A low to moderate level of risk to participants was identified. The researcher appreciates that the research topic and interview schedule required participants to reflect on potentially emotional and distressing experiences. Additionally, conducting individual interviews has been criticised for potentially feeling intrusive (Frith & Gleeson, 2011). Consequently, a semi-structured interview schedule was used to minimise the risk of the interview feeling intrusive as it allows for flexibility to go where the interviewee feels comfortable (Gill et al., 2008). Additionally, participants were informed that they could ask to take a break during the interview if needed, and they were informed that they did not have to answer a question if they did not want to. In addition, a debrief sheet (Appendix O) was emailed to participants after the interview which outlined contact details of services and organisations which could support them if they were affected by any part of the interview process.

The researcher was aware of the potential disclosure of instances of poor practice when participants were asked about their experiences on inpatient mental health wards. Since the aim of this research was not to identify and report instances of poor professional practice, the researcher decided that they would not make a complaint on behalf of the participants. Instead, in discussion with the research supervisor, it was agreed that, if serious instances of abuse came to light, the researcher would make the participant aware of their rights should they wish to make a formal complaint themselves.

3. ANALYSIS

3.1. Chapter Overview

This chapter begins by setting the context and presenting the themes and subthemes that were developed during the analysis of the interviews. These themes and subthemes are explored and illustrated using vivid extracts from the data to answer the research question of what people perceive to be the factors which influence their experience of paranoia on inpatient psychiatric wards. Minor changes were made to the extracts for readability. For example, the use of […] indicates where words have been removed and [word] indicates where words have been inserted. The use of three dots … indicates pauses in speech and the interviewer’s question has been included in brackets where necessary to aid understanding.

3.2. Setting the Context and Introduction of Themes

The critical realist position highlights the importance of the participants' contexts (Pilgrim, 2019). Whilst Table 1. and Table 2. describe the general sample demographics, this section will describe key aspects of participants' circumstances that were brought to light in the interviews to contextualise the development and understanding of the themes and subthemes.

3.2.1. Setting the Context

Six participants were sectioned under the Mental Health Act (1983, 2007) for either some or all of their admission. Half of the participants were sectioned for the entire duration of their admissions (Marina, Will, Abigail, Molly). One participant (Zosia) started their admission under section and then had the section removed and remained in hospital voluntarily. One participant (Jade) initially entered the ward voluntarily but was then sectioned. Two participants entered the ward voluntarily (Esther and Cassie).

Seven of the eight participants had a generally negative experience of their inpatient stays and reported feeling paranoid in hospital. One of the seven was in hospital voluntarily (Esther), however, she described a generally negative experience and explained that she often wanted to discharge herself because she didn't think she needed to be there anymore but felt worried that she would be sectioned if she left the ward. In contrast, one participant (Cassie) had sought admission to a psychiatric ward at a time of distress and described a very positive experience during her stay on a psychiatric ward. She spoke about how many experiences she had on the ward allowed her to feel safe and prevented her from feeling paranoid during admission. As coding progressed, it became apparent that many of the positive experiences that Cassie described, which helped to minimise her experience of paranoia on the ward, were opposite to what other participants described. This helped to strengthen the development of the themes and enabled exploration of what services could be doing differently in inpatient psychiatric wards to reduce the paranoid experience. This will be explored further in the discussion section of this thesis (see section 4.)

3.2.2. Themes and Subthemes

When seeking to answer the research question of what people perceive to be the factors which influence their experience of paranoia, critical realist thematic analysis led to the development of five main themes and 15 subthemes. A summary of the themes and subthemes is presented in Table 3. and a detailed description of the themes and subthemes is presented in Appendix U.

Table 3.

Themes and Subthemes

Theme	Subtheme	No. of participants represented
"The whole system is sort of geared towards making people paranoid": Feeling Disbelieved, Persecuted, Stigmatised and Discarded		
	Not Feeling Believed: Epistemic Injustice	8
	Feeling Trapped, Controlled and Persecuted	8
	Experiencing Staff as Judgemental and Uncaring	7
	"Being Left to Sit in Your Own Illness": Lack of Routine and Feeling Like There is Nothing to Do	6
"It was just so confusing": Feeling Unsure of What Was Going On		
	Feeling Confused, Unsure and Questioning Reality	8
	Paranoia-Inducing Interactions with other Service Users	6
"I felt completely unsafe": Experiencing the Ward as an Unsafe Place to Be		
	Experiencing a Lack of Physical Safety	7
	Feeling Violated by Ward Practices	5
	Experiencing a Lack of Relational Safety	8
"It's like a survival mechanism going a bit haywire": Paranoia as a Coping Strategy		
	Paranoia as a Response to Past Trauma	5
	Paranoia as a Coping Strategy and Experienced by Participants as a Valid Response to the Ward Environment	8
"We're all human and we all need that sort of connection": Moments of Care and Connection		
	Coping by Disengaging and Distancing from Others	7
	Building Connections with Staff and Service Users	6
	Experiencing Staff as Kind and Caring	6
	Seeking Support from Friends and Family	5

3.3. Theme 1: “The whole system is sort of geared towards making people paranoid”: Feeling Disbelieved, Persecuted, Stigmatised and Discarded

This theme describes how many participants tended to feel like they were disbelieved throughout their inpatient experience. This often began at the point of admission since many participants initially did not think they needed to be in hospital. Feeling like they were not being believed also related to experiences of epistemic injustice in the form of testimonial injustice, meaning that they felt disbelieved because of their status as a ‘mental health patient’. Not being believed often led to paranoid thinking as it was hard to trust staff or the mental health system when participants felt as if they were imprisoned and trapped within the ward environment and persecuted by interactions with staff. This was often compounded by experiencing staff as judgemental and uncaring and having limited activities on the ward, which led participants to feel dismissed and disregarded and left to ruminate on their experiences in a paranoid way.

3.3.1. Not Feeling Believed: Epistemic Injustice

Marina, Zosia, Will, Jade, Abigail and Molly, who were sectioned for all, or some, of their admissions, described feeling initially angry and frustrated because of the difference between their beliefs and the beliefs of others regarding their need for hospital admission. Not being believed in this sense often led participants to feel like their views and opinions were being disregarded. Others felt as if stories they were telling staff about their past experiences, such as their family life or previous occupations, were not believed and felt labelled as delusional which led them to feel belittled and on edge.

> Jade: when I was originally sectioned and they [staff] asked about my home life and I told them the truth sort of […] they wrote, erm, on my notes, that erm, I had, what was it?... secondary persecutory beliefs about my mum's abusive attitude towards me and basically thought that I was, I dunno, either making it up or delusional. (224)

> Will: he [staff member] was like kind of saying to me like you've never worked for the CQC, which is not true, I have worked for the CQC […] He thought like I was basically delusional and chatting shit from that, but that

> made me feel really unnerved because the arrogance and the anger he was saying it with, he was like you're not worth working for the CQC, you’re nothing, do you know what I mean. Like that's how he was saying it and he proper terrified me. (337)

For others, they perceived that the psychiatrist did not believe the distress that they were expressing and felt like they were kept in hospital against their will without any help or support.

> Zosia: She [the psychiatrist] took me off that [the medication] cold turkey, without my consent or opinion or anything, and kept me there for 26 days. Unmedicated, unbelieved, disregarded. (208)

Being met with disbelief and being labelled as delusional meant that service users found it very difficult to trust staff from that point on, which increased their suspicion and paranoia.

> Jade: I saw my name and next to mine they had “suicidal”, and then they had “delusional question mark” underneath…which you could imagine didn't fill me with trust. (192)

> Molly: it becomes very hard to trust somebody who's broadcasting loud and clear, “I don't trust you”. (105)

Participants who were sectioned often anticipated or experienced epistemic injustice, more specifically, testimonial injustice (Fricker, 2007), and felt like they would not be believed by staff simply by the very nature of being a ‘patient’ and being sectioned.

> Abigail: people generally don't believe you if you've been sectioned (18) […] I mean it’s natural I guess, if you've been sort of declared mad, people are very unlikely to believe you, even when you know, people are abusive. (39)

> Molly: There is a bit of a credibility gap there. Patients are seen as not credible and staff are seen as credible by default. (Int: And what impact do you think that has?). Well, it certainly creates an environment in which abuse is quite rife. And it certainly, you know, it undermines patients as well. It undermines patients' rights. It protects abusers. It protects staff. (462)

This credibility gap tended to lead the participants to feel powerless and concerned about the injustices that could happen as a result, leading them to feel wary of staff.

Conversely, Cassie, who wanted to be in hospital and had a positive inpatient experience, generally felt like she was believed by staff. This highlights the importance of this theme since feeling believed allowed her to feel safe and engage with the admission in a helpful and meaningful way.

> Cassie: it just felt such a relief that I didn't have to justify myself and that I was believed and that I was safe. (80)

3.3.2. Feeling Trapped, Controlled and Persecuted

This subtheme encompasses the experiences of seven participants (Marina, Esther, Zosia, Will, Jade, Abigail and Molly). Those who were sectioned and/or did not agree with their hospitalisation often felt trapped and imprisoned, and many compared it to being treated like a prisoner. Abigail, who had also been admitted to a psychiatric ward 12 years prior, described feeling very paranoid during her second admission because she believed the mental health system was geared towards punishing and locking people up.

> Abigail: you just can't ignore that the whole system is sort of geared towards making people paranoid. Do you know? I mean, it really is. So you can't ignore the nature of the psychiatric system, which is, [to] lock people up against their will, take away their human rights, and drug them. (654)

Feeling trapped in that environment tended to make participants feel paranoid and suspicious because they felt powerless to be able to do anything about the situation.

> Zosia: I was sectioned and there was nothing to do and I couldn't leave. I couldn't do anything. I felt like I had been kind of locked up and forgotten about. (182)

> Abigail: when you're trapped there, I guess that puts you on guard all the time then. (208)

Participants described feeling on guard and untrusting as a result. This was even the case for Esther who, despite being able to physically leave the ward if she wanted to because she was not sectioned, described the impact of the locked doors on the ward.

> Esther: I just didn't trust anyone then because it's like well, yeah, this is meant to be a safe place and I'm locked inside this ward (49)

Participants who felt trapped and imprisoned often also felt as if the purpose of the admission was to control them and punish them, rather than to help them.

> Molly: it means that if you have needs, they’re not met because the priority isn't helping you, it's controlling you, making you less of a problem for the public. (96)

> Zosia: I was very suspicious and very paranoid that they were punishing me, that they didn't believe me and they thought I was attention-seeking and they were ignoring me because they didn't want to validate that (217)

Some participants also described how being disbelieved and physically locked on the ward led them to feel suspicious and paranoid about staff intentions, and they felt concerned that they were being punished and persecuted by staff. For example, Jade described being accidentally locked in her room, but at the time she believed that the staff members had done it deliberately to punish her.

> Jade: all of these incidents, being locked in a room, also that did feel like a prisoner and it did feel like I had been, cause I thought they had done it deliberately as well, I was like I don't understand why I'm locked in. (385)

Esther spoke about how the side effects of the medication made her feel tired, and she concluded that staff were deliberately making her drowsy to control and sedate her.

> Esther: This is not normal. But then I thought they were doing it on purpose and they wanted me to be sleepy even though I wasn't causing any trouble. (151)

Importantly, feeling trapped and imprisoned tended to exacerbate any paranoid thinking that was present in the lead up to the admission, which led some participants to make sense of their experience in a more paranoid way. Here, Zosia is referring to a social media post she made whilst in hospital.

> Zosia: I had posted that they were intimidated by my knowledge and that they were punishing me because they knew that I had the power to get on their level and become as powerful as them, and all of this nonsense about they're locking me up as punishment, which I now retrospectively realize that was paranoia […] like that was part of my delusion that they were drugging me to stop me from becoming powerful. (171)

Similarly, many participants spoke about feeling like the admission and experiences during the admission were part of some sort of plan or conspiracy.

> Marina: I thought it was all set up (364)

> Zosia: I thought it was kind of like a grand plan, like from the government to break…break me, and to stop me from doing my master's in psychology because they didn't want me getting powerful. (213)

> Will: I thought they were like working for MI5 and they were keeping me locked in there, so like they were the ones who were there, the MI5 people. (679)

Whilst the experience of feeling trapped was highly distressing and led to suspiciousness and paranoid thinking, four of the participants also spoke about the relief they felt when they gained some freedom, or when the environment felt less restrictive.

> Will: so when I went to the other ward it was a bit more open, you had your own garden and I felt a lot more free there [….] because you're allowed to come and go, go for cigarettes and stuff like that. But it felt like it was less bad on my paranoia because I wasn't kept locked in. (431)

3.3.3. Experiencing Staff as Judgemental and Uncaring

Participants who had a generally negative experience of their inpatient stay (Marina, Esther, Zosia, Will, Jade, Abigail and Molly) spoke about their experience of feeling especially paranoid and persecuted because they experienced staff as uncaring. This was often based on the perceived moral judgements that participants believed staff were making about them, with many thinking that staff perceived them as dangerous or attention-seeking.

> Molly: [staff are] still viewing patients as something to be controlled, forced to comply by any means necessary because they're dangerous, that they're threatening (92) […] That they don't really think of you as a person. They think of you as a problem, something to be controlled by all means necessary. (108)

> Zosia: so yeah, that… that's kind of what happened when I was trying to ask for help. They [staff] just wouldn't, they'd just say that I was attention-seeking and then leave. (474)

Feeling judged as attention-seeking came up many times in the interviews, and was often felt by those who had been given the label of a 'personality disorder'. They believed that any expression of distress or help-seeking would be viewed negatively by staff because of this diagnosis.

> Jade: I had a meeting with the ward psychiatrist at the start of that week and, who is a complete arsehole, and basically sat there and went "you've got BPD [Borderline Personality Disorder], we don't like to have people with BPD in hospital". (58)

This often led them to feel worried that, if they reached out for help and support, they would be ignored or dismissed.

Many participants also felt that the social stigma of being a 'mental health patient' meant that they would be mistreated during their admission.

> Abigail: I think it's historical and you know people erm, with those types of conditions have always been treated appallingly, and erm you know, like years ago, you'd never have got out again, would you, if you were locked up? (608)

Some participants also felt that staff often did not demonstrate any interest in them or take the time to engage in meaningful conversation, which made them believe that staff saw them as insignificant. This perceived lack of care made it difficult for participants to trust that staff were there to help them and tended to lead participants to feel increasingly paranoid and worried about staff intentions.

> Marina: it's when they were looking for you, they'd ask you like what number you were… like you wouldn't even be like what name you are. It was like what number are you? And it just felt really like…un…unhuman (284)

> Esther: I didn't feel like they [staff] wanted to help. I don't really know why they were doing their job, and I think then that makes you more like worried. It's like, well, if you're not here to help people, what are you here for? (107)

> Molly: So it's like you don't trust the staff because the staff are broadcasting at you that they have complete disdain for you. That they don't really think of you as a person. They think of you as a problem, something to be controlled by all means necessary. (107)

3.3.4. "Being Left to Sit in Your Own Illness": Lack of Routine and Feeling Like There is Nothing to Do

Marina, Esther, Will, Jade, Abigail, and Molly spoke about how the experience of paranoia was made worse because, not only were they physically locked on the ward, but, with limited care and engagement from staff, there was nothing to do. Many service users suggested that having a daily routine that included activities on the ward would have helped ease their paranoia because, with nothing to do, they tended to ruminate in a paranoid way.

> Will: I think it felt like I was locked in basically and I didn't like it and I was stuck there and there was nothing I could do about it and that made me more paranoid because you had nothing else to do but sit there and think about why I'm in hospital. (430)

> Esther: Yeah, so I think maybe, I overthought stuff more because I had so much time (404) […] I think it was the overthinking or the time to think (Int: yeah) And over analysing everything so… these people are watching him, you're like, why are they doing that? What were they thinking? What they're writing down like? Are they actually watching me or are they watching him like? (432)

Being in a locked environment with limited activities meant that participants often became consumed with their thoughts, leading to a spiralling of suspiciousness and paranoia about what was happening around them.

3.4. Theme 2: “It was just so confusing”: Feeling Unsure of What Was Going On

This theme describes how participants often felt very confused, disorientated, and often described being unsure of what was going on, both in terms of aspects of the ward and common practices as well as in interactions with other service users. This tended to make them feel paranoid because they were left guessing and many described making sense of the unusual experiences or ‘the unknowns’ in a paranoid way. It also described how clarity about procedure and practice helped to alleviate paranoia.

3.4.1. Feeling Confused, Unsure, and Questioning Reality

This subtheme encompasses the experiences of Marina, Esther, Will, Jade, and Abigail who all described feeling very confused during the admission, and the differing experience of Cassie. Marina and Jade reported finding it hard to remember what had happened during the admission, particularly when they were first admitted. This was perhaps a result of feeling highly distressed and medicated at the time. It tended to be the emotionally salient experiences which remained in their memory, which perhaps made it difficult for them to make sense of their experience, leaving them confused.

> Jade: to be honest most of my memories from the first admission, those three hospitals, I only really remember the really dramatic things because from those admissions I think I was so out of it the rest of the time, that I just wasn't really like taking anything in (446)

Experiences of confusion were exacerbated and compounded by what participants described as chaos on the ward, for example, alarms going off and the array of new and unfamiliar people they met on the ward. This tended to lead participants to feel on edge and paranoid about what was going on.

> Marina: I remember that an alarm went off once and it was just so confusing. Didn't know what was happening…erm… I don't know if that was a…an alarm because some of that…like a restraint… someone was

> being restrained or something, or if it was a fire alarm or something. I'm not sure. (182)

Here, Will speaks to feeling confused about who were staff and who were patients because the staff were not wearing uniforms.

> Will: it's a busy place at hospital, at hospital with a lot of people coming in and out. So if you can't see who's a staff member, who's a patient quite clearly, it can get a bit confusing and that kind of induced my paranoia to be a bit more extreme. (43)

Similarly, participants also described a lack of communication about staff identification which meant that participants often did not know who they could seek support from.

> Will: But like some of the things I noticed, that made me more paranoid. But things like the staff not introducing themselves. So every time, like every new shift, I didn't know who the staff were or who the patients were. (32)

For Marina, Zosia and Will, this led them to make sense of the situation in a paranoid way that related to previous paranoid thinking that they had experienced.

> Zosia: I thought that the people all in the room taking notes about me were part of some like government agencies to try and track me and on reflection, that, that isn't correct, but it is weird that there were that many people in the ward round who just weren't introduced and it's just bad practice. (282)

Participants reported that experiences of confusion were exacerbated because they perceived a lack of explanation and communication related to ward practices such as 1:1 observations, what medication they were being given, and how long their admission would last. Not knowing the rationale for people being on 1:1 observation increased paranoia because service users couldn’t make sense of the decisions that staff were making and were often suspicious of staff’s intentions.

> Will: I think it was more like because I didn't know… there was no structure to it. Like somebody would be on 1:1 and some people wouldn’t, and I couldn't understand like why I wasn't like… sometimes I was on 1:1 and sometimes I wasn't and I couldn't understand why that was, if that makes sense. So that kind of did make me a little bit paranoid. (494)

> Esther: he [service user] often had like two people watching him […] I felt I sort of watched them watching him. And I'd be like…what are you doing? Or like, why? (423)

Similarly, not knowing what medication was being administered or what the side effects might be tended to make participants feel suspicious and fearful of the intentions of staff, leading them to question whether staff were trying to control them.

> Esther: I feel like there's just loads of things you get worried about. Like you're worried about what are they gonna do to me and then from like the medical side of it, you're worried, almost paranoid like, are they just increasing my medication so they can control me? Or is it to actually help? (129)

All the participants who were sectioned spoke of being unsure of how long their admission would be and reported a lack of communication about their rights to a Mental Health Tribunal or Mental Health Act review. This made them feel extremely concerned and paranoid that they might never be discharged from hospital.

> Abigail: Well, you just don't know, like you've no idea. Am I going to be in here the rest of my life? And you know, when might they let me out? Like what is happening to me? Do I have any rights? (702)

This was particularly compounded by not knowing when ward round would be, meaning that some participants were unsure of when they could speak to the psychiatrist, the person with the power to discharge them.

> Jade: I think I got there on the Thursday or something and they were like, "Oh yeah [ward round's] on the Friday" and then I found out it wasn't on the Friday so then I wasn't gonna see [the psychiatrist] till the next week. And that feels like you're trapped there then (405)

Importantly, Cassie, who did not experience paranoia during her admission, spoke of knowing exactly how long the admission would be. This clarity and knowledge helped to ease her concerns about being kept in hospital. Additionally, Cassie explained how clear communication from staff allowed her to understand what was going on and enabled her to feel at ease and trust that staff were taking care of her.

> Cassie: So from the moment I got in there I knew what was going on and what was going to happen, and also where I was going, and you know what er…what I needed to do basically (164) […] I don't have to worry about that. I know what's happening. I know that these people have got, got it and are taking care of it (Int: uh-huh) and I can again just 'be'. (170)

Having had previous admissions to hospital, either as a child or an adult, allowed some participants to make sense of the unknowns, thus easing paranoia.

> Will: I knew about all of that [staff observations] sort of thing because I'd been in hospital as a kid. I think if I didn't know about it because I'd been in as a kid, I think that would have made me more paranoid like, from like

> not already knowing about it, because I already had a bit of information about it. (491)

The feelings of confusion and the multitude of unknowns led some participants to start questioning their sense of reality, which further perpetuated experiences of paranoia and led participants to feel scared and confused.

> Esther: did I just dream that that happened or did it actually happen 'cause I get dreams that are like really realistic but slightly changed and something could be a little bit odd. But then when you're in [hospital] that is a little bit odd anyway, you're like "what actually happened" […] and it just makes you really disorientated. (240)

For some, their experience of fear, confusion, and questioning reality felt linked to past experiences of childhood trauma, which served to compound the level of distress they were feeling.

> Jade: I just remember feeling this overwhelming like fear and confusion […] I spent a lot of time like trying to figure out if I was dreaming and that sort of thing […] all I could feel really was fear and like that's… that was my childhood. So then when I was on that ward, I was back sort of there, feeling like I was dreaming again and feeling like I was waiting to be attacked. (251)

3.4.2. Paranoia-Inducing Interactions with Service Users

Feelings of confusion, worry and suspicion also increased because of unusual interactions with fellow service users. Marina, Esther, Zosia, Will, Jade and Abigail described being unnerved and paranoid about what was going on because other service users were paying them unusual attention or were interacting with them in a paranoid way. This was particularly the case for those who had not been admitted to hospital before and who had not interacted with people experiencing mental health difficulties.

> Zosia: I was in the smoking area and this guy comes up to me and he's talking to me and he's telling me I'm like a government plant and that I'm one of the staff and that I'm spying on him. And I'm like “dude, I'm literally just trying to smoke” erm, so that was really nerve-wracking as somebody who'd never been in that situation before or had never been around people as unwell as I was, erm, just never had that interaction before so it was really unsettling. (48)

Jade described how speaking to another service user, who was expressing paranoid ideas about staff being part of a government plan, led her to feel suspicious of staff intentions.

> Jade: I don't have like a paranoid disorder, but when you're in that environment [hospital], and I was aware that she wasn't well, but no matter how well aware of that I was, that she wasn't well, that still puts doubt into your mind (Int: yeah) like it's when she's like ‘they’re [staff] working with them’ like it still makes you think like ‘maybe they are’ (458)’

For those who were already feeling suspicious and paranoid because of the ward environment, interactions with other service users who expressed paranoid ideas tended to make them feel even more paranoid and on edge.

> Will: some of the patients said some really crazy things to me like ‘oh I, I gave my sperm to be Prince William and Prince Harry’. Like it was one of the things that I remember being told by a patient, but that to me like, by the point he told me, yeah, I was really unwell so I kind of like got crazier because of the things he was saying to me. (170)

3.5. Theme 3: “I Felt Completely Unsafe”: Experiencing the Ward as an Unsafe Place to Be

This theme includes the experiences of Marina, Zosia, Esther, Will, Jade, Abigail and Molly, who consistently described experiencing the ward as an unsafe place to be. This was related to a lack of physical safety, feeling violated by certain practices, and a lack of emotional and relational safety. This led them to feel very mistrustful, on edge, and paranoid about their physical and emotional safety during their admission.

3.5.1. Experiencing a Lack of Physical Safety

The lack of physical safety reported by participants was often related to negative experiences with staff. Participants described believing that staff did not want to help them and some even believed that staff had the intention of abusing them. This was often related to perceiving staff as uncaring or hostile and a general mistrust of the psychiatric system which they viewed as punitive and coercive.

> Will: So like I felt really unsafe on that ward and I think it was partly because like a few aggressive staff and they're kind of… like the more secure it was [locked doors], it felt like they had to be nastier to us as well. (363)

> Abigail: I do think the psychiatric system seems to attract people who want to abuse their power in some way. It's a natural place to go isn’t it? If there's all these vulnerable people who don't have, you have all your rights taken away. (103)

Many participants spoke of feeling traumatised by seeing other service users being restrained and/or forced to take medication, which led them to feel extremely suspicious of staff and feel fearful of the repercussions if they were to refuse treatment.

> Abigail: Well yeah, it's really traumatic. […] you feel really sad for the person that they're doing it too, and….yeah, it's horrible […] watching other people being pinned down and injected. (339)

Furthermore, participants often described experiencing staff interventions with other service users as aggressive and threatening, leading them to feel unsafe around staff.

> Will: there was another lad there was proper manic […] and hadn't slept one night and he [staff member] just like dragged him around and that kind of stuff. Like witnessing that and seeing that happen and other staff members not doing anything. Even though this was in the better hospital, in that ward, I felt completely unsafe. (355)

The experience of a lack of physical safety was often related to certain aspects of participants' identity or ability. For example, Molly is a wheelchair user and described feeling very unsafe as a result of being physically manhandled by staff.

> Molly: I am actually a part-time wheelchair user because of my conditions and so many times staff would just grab me and physically move me which is so disrespectful […] And so it's like, I mean, you wouldn't physically manhandle someone else, but it seems OK for me. (387)

Additionally, many spoke of the paranoia and lack of physical safety they experienced being a woman in a mixed-sex ward.

> Esther: It was mostly men I was suspicious of…erm, so there were like men and women on the ward […] And like some of the ways that they [male service users] like, stand too close to you, like if you were in the queue for dinner or like waiting for medication or they'd like, push in, push into the queues. (349)

> Abigail: I know some of the women there were really frightened and had been like victims of sexual violence in the past, and so to me seemed really inappropriate (66)

Similarly, Will spoke about feeling unsafe and hyper-vigilant as a transgender man in an all-male environment.

> Will: So like I was just kind of hyper-vigilant because I was in an all-male ward and it kind of like felt like anything could happen […] the fear was, at the time, was because I was trans like I'm not used to being in a hyper-masculine environment. (273)

Some participants also noted how this lack of physical safety was exacerbated by the mix of young and older service users on the ward, leaving the younger service users vulnerable to influence and intimidation by the elder ones.

> Abigail: like there was a girl who was 18 there in the same ward as like men in their 40s/50s. I don't think that that seemed right. She was very vulnerable and having a difficult time and so yeah it didn’t, that didn't seem right to me. (69)

A lack of psychical safety was also felt in relation to experiencing or anticipating physical violence or unpredictable behaviour from other service users. This caused participants to feel worried and paranoid about the potential harm that other service users could cause them.

> Zosia: I was paranoid that they [service users] were gonna like murder me in my sleep because of just all the stuff that was happening […] So there's a lot of paranoia in that sense (104)

This not only related to experiencing conflict on the ward but was also associated with being unaware of the histories of the other service users on the ward and hearing rumours about them.

> Will: Basically like one of them was technically a murderer so it's quite [a] scary situation to be in. (275)

3.5.2. Feeling Violated by Ward Practices

Participants described a considerable lack of privacy on the ward which often felt violating and intrusive. This included experiences such as staff looking into their rooms through windows in the doors every 15-minutes for observation checks.

> Abigail: there was this screen outside each room so the staff could watch you whenever they wanted. So you could be getting changed, could be naked and there could be staff members looking in at you and that was really horrible. Really uncomfortable. (30)

Whilst many of the participants understood the need for staff to check on service users regularly, many found the experience intrusive as if they were being watched all the time.

> Marina: you just felt like there was eyes and ears everywhere. (259).

This was particularly the case if this was their first inpatient admission experience.

> Zosia: I've never experienced a psych ward before and sure, when I had been in crisis houses they would check up on you, but it wouldn't be every 15 minutes and there wouldn't be a window on your door and they wouldn't be coming in when you're showering and all of this stuff. So that was, that was difficult and that definitely adds to the paranoia that you're being watched all the time. (293)

One participant also described the staff team entering her room to see her for the ward round. This left her feeling vulnerable and exposed.

> Marina: I hated them coming into my room when I was like just in my pyjamas, it felt very vulnerable (234)

For many, having their own private bedroom on the ward helped to make them feel safe as if they could escape from the dangerous environment. Cassie described sleeping in a dormitory-style room with other service users for the duration of her admission. Although she did not mind at the time, reflecting on the lack of privacy led her to notice how difficult that experience could have been.

> Cassie: To be honest, I was so out of it, erm, quite a lot of the time […] I mean like to think that I sat there for three days […] I'd have gone… gone mad. (229)

3.5.3. Experiencing a Lack of Relational Safety

Many participants described experiencing a lack of relational safety which made them feel paranoid about interacting both with staff and service users. Here, lack of relational safety refers to participants not knowing who they could trust, and not trusting or being trusted by both staff and/or service users. This tended to leave participants feeling very suspicious of others' intentions.

> Marina: so you never really knew where you stood with people [service users] […] There's a big thing about not knowing who you could trust erm…, and people [other service users] didn't trust you either. So it…you, you…Yeah, it was hard to get on much of a stand with people. (84)

> Jade: I think because I didn't know what anyone [staff] was thinking, I didn't know what anyone [staff] was gonna do next. (291)

Many participants felt mistrust towards staff which was often influenced by experiencing paranoia-inducing interactions with staff. Some participants believed staff were trying to induce their paranoia by saying unusual things to them.

> Will: I told [staff] a bit about my life and how I went to the local primary school and everything and she said the weirdest thing to me and I thought she was a spy because of it because she said “if I don't be good then she'll tell the head teacher of my school”, but obviously I was an adult. (231)

> Abigail: a staff member told me that erm, I was being given placebos and it's just, you know, basically she was intentionally trying to feed into my paranoia […] I had enough sort of insight to think why, you know, she's totally making this up. Why would she do that? You know, who else is she saying things too? (19)

Some participants also reported that they witnessed staff not telling the truth about other service users, which significantly impacted their ability to trust those staff members. A perception that staff were lying also made them feel paranoid about what staff were saying about them to other members of the team and how this might impact the length of their admission.

> Esther: I'd heard them lying about other patients, like situations that happened, and they’d go back to the nurse's station and be like “oh, she just did this”. Even though I'd seen it and I was like it's completely different to how you've just described it […] so then you do get paranoid. You're like “well, what are they saying about me” and what… is that why the doctor is saying, “oh no, you should, I recommend that you should still stay here”. (70)

> Marina: It's very confusing because you think “why are you lying to me” like you're, you're a nurse like you shouldn't be lying to me […] You don't know if you can trust them because you think they're being disingenuous (552)

Participants also described suspicion arising from being around new service users and trying to determine which service users they could trust and who was safe to be around.

> Esther: I was like trying to work out these people, trying to like work out like, […] what they're like and work out how I should be around them, and how, if I should be worried about them or scared of them (356)

The lack of trust and paranoia was also influenced by participants feeling like other service users did not trust them, creating a cycle of suspicion and paranoid thinking.

> Zosia: It’s just having to kind of keep your guard up because I mean, I suppose that ties into paranoia 'cause, everybody there who was in a, a, like psychosis… they were paranoid about me. (96)

3.6. Theme 4: “It’s Like a Survival Mechanism Going a Bit Haywire”: Paranoia as a Coping Mechanism

This theme explores how suspicion as a result of past experiences of abuse was often exacerbated by the ward environment which led participants to feel on edge and paranoid. Additionally, paranoia was often described by participants as a valid way of coping with the confusing, unusual, and unsafe ward environment.

3.6.1. Paranoia as a Response to Past Trauma

Esther, Jade, Will and Abigail spoke about their experience of past trauma and adversity and how they were reminded of these during their admission. One participant spoke about how unsettling it was to know that their Nearest Relative, who had been abusive throughout their life, had the power to get them sectioned which made them feel powerless and paranoid.

> Abigail: my mum was really really abusive like my whole life, so for her to be like my Nearest Relative with the power to get me sectioned, you know it's gonna make you paranoid (661)

Another spoke about how years of abuse from her parents led her to feel particularly suspicious and paranoid within the ward context where she felt watched and observed by staff.

> Jade: Like at times, like a little bit before, but more in terms of like I panic that my parents have like bugged my phone or something or like I've got cameras in the house like I dunno know, like years of abuse ends up with you a little bit paranoid (475)

Molly also spoke about past trauma and how not being believed or listened to brought back memories of when she tried to report abuse as a child.

> Molly: I've got this whole history, the reason I have CPTSD [complex post-traumatic stress disorder] is because I was a severely abused child and I kept reporting it and reporting it and reporting it and just nobody did anything apart from yell at me for reporting it. I was a bother and a nuisance and so I went through this whole cycle of being re-traumatised on the ward because staff were doing the exact same things to me that had caused the original complex PTSD [post-traumatic stress disorder] (221)

Paranoia-inducing experiences on the ward often reminded participants of abuse and mistreatment in the past or as children, leading them to feel increasingly paranoid and mistrustful during their admission.

3.6.2. Paranoia as a Coping Strategy and Experienced by Participants as a Valid Response to the Ward Environment

Suspicion and paranoia could be conceptualised as coping strategies employed to deal with many of the uncertainties and lack of safety on the ward. Although Cassie did not feel paranoid on the ward, she spoke of how paranoia had operated like a coping mechanism for her in the past.

> Cassie: I think paranoia occurs, well, well for me anyway, it would occur if I was in a situation where I was really unwell and I didn't know what was going on or what they were giving me […] it's like a survival mechanism that's going a bit haywire, right? So you use it as a sixth sense that something’s not quite right, but then it becomes obsessive and blown out of proportion I suppose (259)

Some participants spoke about how it was hard to disentangle what was paranoia and what was a rationally-based concern, leading them to feel like the paranoia they felt was valid within the ward environment which they perceived as dangerous and unsafe.

> Will: It's hard to say what is paranoia and what's a rational fear (54)

> Zosia: It was kinda like the fears, my personal fears about the staff and them being against me, which aren't really founded in reality, versus the very real danger of the people on the ward and situations and the violence and the anger and all of that stuff. (506)

Zosia, Jade and Molly requested their medical notes after being discharged and, on seeing what was written about them, their paranoid beliefs about what staff were saying about them were confirmed.

> Zosia: when I saw what they [staff] had written about me, it had validated my suspicions and my paranoia that they were saying all these things about me in that they were purposefully not treating me (229)

This meant that, when reflecting on their inpatient experience, they felt like their paranoia had been valid, and that most people would feel paranoid in that environment.

> Abigail: it was the reality 'cause I was locked up and I was trapped, so it wasn't like it was a delusion (284)

3.7. Theme 5: “We’re All Human and We All Need That Sort of Connection”: Moments of Care and Connection

This theme explores how participants managed experiences of paranoia during their admission and aspects of the ward environment that helped to prevent, counter or reduce feelings of paranoia. Many described the initial tendency to disengage and withdraw from staff, other service users, and the environment. However, a key factor which allowed participants to feel safer, less suspicious and less paranoid were moments of care and connection with staff and fellow service users. Additionally, connection with their external support networks such as friends and family allowed them to feel grounded in reality and supported during their admission.

3.7.1. Coping by Disengaging and Distancing from Others

This subtheme encompasses the experiences of Marina, Zosia, Esther, Will, Jade, Abigail, and Molly, who reported initially coping with feelings of suspicion and paranoia by disengaging from staff and distancing themselves from other service users.

Some participants spoke about staying away from other service users to keep themselves safe.

> Marina: I was just very suspicious of them and kept my distance (572)

> Esther: some of them [other service users] were trying to hurt the staff and I just didn't […] wanna get near certain people because I was like worried about it (127)

Others described wanting to lock themselves in their rooms to keep themselves safe.

> Jade: would anyone wanna come out of their room really? Like you're in a psychiatric ward. Whenever you come out of your room, there's someone kicking off or like getting restrained or sedation or something like it's not exactly like you know, like come out your room and you know chat to people (82)

> Marina: I guess for me, a major part of feeling safe I think would be being able to lock your own door […] you do need to claim some, some sort of space because otherwise…you just…feel, yeah, really unsafe and scared. (627)

Four participants (Abigail, Marina, Will and Zosia) also described disengaging from staff and not telling staff about the paranoid thoughts they were experiencing. This perhaps resulted from the lack of relational safety they felt on the ward, and some participants spoke about how building trust might have allowed them to open up to staff about their emotional experience.

> Zosia: I learned like midway through the admission that they weren't going to help me, so it would be better if I just didn't speak to them (459)

> Abigail: if I felt I really trusted somebody I might like discuss what was going on in my head and how I'd got there, what had been happening, you know? (689)

3.7.2. Building Connections with Staff and Service Users

For many participants, there was a strong sense that paranoia decreased over the time of the admission, for example, Marina said "I was definitely less suspicious by the time I was leaving" (529). Although many participants described initially wanting to disengage and withdraw, perhaps as a way of keeping themselves safe, many participants described meaningful moments of connection which allowed them to let their guard down.

Marina explained that, although staff observations tended to feel intrusive, being on 1:1 observation (where a staff member was with her the whole time) could be a positive experience when staff engaged in meaningful conversations. This allowed her to start building a relationship with the staff member.

> Marina: I quite liked that time as well to sort of get to share a bit about me because I found that there wasn't often that many people to talk to,

> staff wise, erm… because they're all so busy. So, it was quite nice to actually have someone with, with you and have that bit of conversation and feel like you get to know them a little bit (55)

Building relationships with staff seemed integral to the positive experiences that participants had in hospital and allowed them to move past the paranoia.

> Will: it's more like a little community you build up around you. So then I got to know like the staff here on shift and gave them nicknames, said hello and have a bit of banter, have a bit of banter when you're getting your meds. It was like just getting to know people and building up a rapport that kind of helps me get better basically. (591)

Building these connections with staff allowed participants to feel as if they were being listened to and like they were treated as human beings which reduced their experience of paranoia and suspicion.

> Jade: it felt like when there was some sort of connection like they were actually listening to me and like it felt like what I was saying was actually being listened to. (634)

> Will: I think it’s 'cause we're all human and we all need some kind of connection and interaction. I think that like creating a weird little system around me of support kinda helps (598)

Additionally, for some, building a connection with staff allowed them to speak openly about the paranoia they were experiencing, and staff were able to support them.

> Zosia: when I was like feeling suspicious or paranoid or just unstable really I would go and speak to [staff] and they would be really helpful in trying to talk me out of it. (442)

Importantly, building relationships with staff tended to feel easier with those who were perhaps seen as lower down the staff power hierarchy, for example, the cleaners, who were separate from the regular ward staff.

> Will: the things that got me better was building a little mini-community like with the staff. So um, like I'd get to know everyone. Like literally the cleaners, I'd say hello to the cleaners, is like my little routine, like say hello to the cleaners, learn their names, have a chat with them. (587)

Here Jade speaks about finding it easier to build a connection with the Occupational Therapist because she saw them as being separate from the core staff team who, at the time, she felt very suspicious of because she believed they were keeping her imprisoned.

> Jade: So like you saw them [the Occupational Therapist] as like a person who was sort of neutral and not actually keeping you imprisoned and was actually like, helping you […] I was definitely much more willing to open up to an Occupational Therapist who was coming in and doing an activity and going, than an HCA [Health Care Assistant] or a nurse who was keeping me, like in my view, keeping me imprisoned. (645)

Participants' experiences of paranoia were also eased by the connections they made with fellow service users. Engaging in activities with fellow service users felt like a positive experience for many participants.

> Abigail: She [service user] did my whole face of makeup one day, which was really lovely and made me feel, you know, really erm… much better than I had for a while, and that was lovely (510)

> Marina: One lady did henna, and she bought some henna kits, and she did henna for me. So that was really nice. (99)

Importantly, some participants reported being able to move past the paranoia they felt around certain service users once they started to get to know them better. Here, Zosia talks about building a friendship with a man who had initially intimidated her.

> Zosia: Yeah, it was weird, but he was pretty chill, like towards the end he like, we… we'd kind of been talking and stuff because I wasn't sectioned I was able to go out and go to the shops and stuff and I'd be like do you, do you want anything? Uhm, I thought I would bring him like chocolate and cigarettes and stuff which was nice. (147)

Here, Marina speaks about how the small acts between her and another service user allowed her to feel at ease and as if she had support on the ward.

> Marina: me and this girl, my friend [name removed], we like got this little handshake together where we'd like fist pump and we'd just sort of do that when we saw each other and it just made me feel at ease, like Oh yeah, we've got each other's backs, like just a little symbolic thing (509)

3.7.3. Experiencing Staff as Kind and Caring

Many participants also reported meaningful interactions with staff who they experienced as kind and caring. This allowed them to feel cared about and listened to which helped to alleviate paranoia.

> Jade: you get this feeling from like one person on the ward that like they genuinely give a crap or like they've made an effort (601)

This was key for the experience of Cassie who did not feel paranoid on the ward and found staff to be kind and caring, which was expressed by them checking in with her regularly.

> Cassie: I just felt, just felt safe and everyone erm there, all the, all the staff there were just really caring and they checked up on you and it was a really nice [experience] (131)

Participants tended to experience staff as caring if they perceived staff to notice that they were distressed and took an interest in what was going on for them.

> Jade: like one nurse I remember, er, she could tell I was upset like one night and she actually came in and sort of like offered to chat and stuff (618)

Experiencing staff as kind and caring was also particularly meaningful if participants felt like staff took the time to speak with them about what could help. This could also counteract some of the more distressing and paranoia-inducing events that were occurring on the ward.

> Cassie: it was time. Like it wasn’t like you’ve literally just got 5 seconds, give me a brief synopsis. It was they sat with me until we sort of got to the bottom of it and figured out exactly what we could do. There wasn't a time limit on it. (150)

> Zosia: in the first hospital I was in, despite it being very violent and chaotic, low-key traumatizing, the staff were very kind and responsive and they almost always had time if you were like “hey can we have like a one to one” or whatever? 'cause I just needed to speak to somebody. They always had time to do that, and they were really caring and really understanding (438)

3.7.4. Seeking Support from Friends And Family

Feeling paranoid and suspicious about staff, other service users, and the ward environment often meant that participants sought support from outside of the hospital environment. Whilst some participants wanted to keep their family at a distance during the admission and did not want them to know that they were in hospital, others explained how speaking with family and friends often helped them to re-connect with normality and gave them some relief from the chaos of the ward.

> Esther: I think like me contacting like my family and friends from like, who were outside the hospital, just talking about normal stuff or like being me I guess, that made me feel better or, like more reassured that I hadn't just completely gone mad and like, I, I was just in a strange place with a lot of strange people. (510)

Connecting with family and friends also allowed participants to feel comforted and validated by people who cared about them.

> Zosia: My only comfort came from texting my friends. And them kind of validating what I was feeling and kind of letting me know that some of my beliefs weren't real, but also validating the ones that were (451)

Sometimes speaking with family and friends helped support participants to engage with their admission and treatment and encourage them to trust that the admission would help them.

> Marina: I think I was sort of ringing my mum saying “they tell me I need to take this” and they were… or everyone around was just saying “it's for the best […] it will make you feel better”. Uh, so I guess I was just trying to have faith in the people that I care about that it was the best thing for me to do (235)

4. DISCUSSION

4.1. Chapter Overview

This study explored what people perceive to be the factors which influence their experience of paranoia on psychiatric wards. This chapter discusses the findings in relation to the research question and the existing service user experience literature outlined in the Introduction. A critical review of the study is also presented to consider the study's strengths and limitations, along with quality assurance principles and reflexivity. Finally, implications for policy, practice, clinical psychology and future research are discussed.

4.2. The Research Question, Summary of Findings and the Existing Literature

In seeking to answer the research question of what people perceive to be the factors which influence their experience of paranoia on inpatient psychiatric wards, five main themes were identified: (1) feeling disbelieved, persecuted, stigmatised, and discarded (2) feeling unsure of what was going on (3) experiencing the ward as an unsafe place to be (4) paranoia as a coping mechanism and (5) moments of care and connection. This section will summarise each main theme and how the findings relate to the existing literature.

4.2.1. Paranoia as a Response to Epistemic Injustice, a Lack of Freedom, Stigma, and a Perceived Lack of Care

Past research has suggested that service users feel like they are often not trusted by ward staff (Gilburt et al., 2008; Koivisto et al., 2004). The findings of the current study build on this by suggesting that experiences of not being trusted or believed by staff provoke paranoia. The current findings also suggest that this is compounded by the experience of 'epistemic injustice' (e.g., Fricker, 2007), where perceiving staff to judge them as ‘ill’ and ‘mad’ led service users to feel paranoid about the injustices that could occur because they feared they would not be believed if they speak out against these.

The current study found that service users who were sectioned, and/or who disagreed with the need for their admission, tended to feel trapped, imprisoned and punished by ward staff and the mental health system more generally. This is consistent with findings by Johansson and colleagues (2009) and Murphy and colleagues (2017) who found that service users who were detained under section tended to feel trapped and imprisoned within the ward environment. Whilst Gilburt and colleagues (2008) found that a lack of freedom contributed significantly to mental distress, the findings of the current study elaborate on this by highlighting that a lack of freedom can initiate and perpetuate mental distress in the form of paranoia and suspicion. Importantly, many participants in the current study noted the benefits and relief from paranoia once they gained some freedom such as being allowed to leave the ward (e.g., Section 17 leave, see Appendix A) or going into the garden for a cigarette.

In the current study, the impact of feeling trapped, persecuted, and experiences of epistemic injustice seemed to be intertwined with and exacerbated by the participants' awareness and perception of societal stigma and the perceived moral judgements of ward staff. Epistemic injustice is intrinsically linked to prejudice and judgements, where a person may be disbelieved because of prejudice and stigma that the listener holds about that person and their credibility (McKinnon, 2016). The negative impact of experiences of mistreatment and stigma have been well documented in the literature; service users report that not being listened to and a lack of therapeutic engagement leaves them feeling disrespected (Chambers et al., 2014) and treated inhumanely (Eldal, Veseth, et al., 2019). The findings of the current study support the existing literature since many participants reported feeling judged, punished and mistreated during their admission. Importantly, the current study found that paranoia was often the emotional response to such experiences; participants reported that it was difficult to trust the psychiatric system and ward staff because they perceived a lack of care and felt like they were treated as less than human.

Research regarding stigma towards mental health ‘patients’ and moral judgments of staff has tended to focus on people given a label of ‘personality disorder’ who are seen as more in control of their behaviour and tend to elicit more negative responses from staff (Markham & Trower, 2003). This was also found to be the case in the current study; participants with a Personality Disorder label spoke of feeling judged by staff and dismissed as ‘attention seeking’ when they expressed their distress or sought support from staff. However, the current study highlights that even those without a label of a ‘personality disorder’ felt hyper-vigilant of the potential judgements that staff were making. This led them to feel paranoid about who they could trust and left them feeling persecuted and punished because they felt deemed as threatening or dangerous.

Additionally, participants generally felt like the limited access to activities on the ward led to paranoid rumination. This is in line with other service user literature discussed in the meta-synthesis (see Appendix F) which highlights boredom as a common experience on inpatient wards (Akther et al., 2019; Modini et al., 2021; Staniszewska et al., 2019; L. Wood & Alsawy, 2016) which can often exacerbate experiences of distress and lead to violence and aggression on the ward (Staniszewska et al., 2019). The findings of the current study expand on the existing literature by suggesting that the combination of feeling disbelieved, persecuted, and stigmatised, with nothing to do on the ward (theme 1.) tended to make participants feel suspicious and paranoid because they ended up ruminating about their experiences and what was going on around them.

4.2.2. Paranoia as a Response to Feelings of Confusion and a Lack of Information

Many participants of the current study described feeling confused and disoriented during their admission. This was related to difficulties remembering what happened as a result of being highly distressed and highly medicated, and not knowing what was going on in terms of common practices and interactions with other service users (theme 2.). The existing literature has widely reported on the confusion felt by service users throughout their admission (Chambers et al., 2014; Fenton et al., 2014; Gilburt et al., 2008; Goodwin et al., 1999) with some noting how this can lead to paranoia thinking (Fenton et al., 2014; Loft &

Lavender, 2016). In the current study, ‘not knowing’ and perceived poor communication from staff often meant that participants were left guessing about the rationale for clinical decisions and when they would be discharged from hospital which led them to feel paranoid about staff intentions. This is consistent with the findings of Fenton and colleagues (2014) who suggested that service users may make sense of their experiences of fear and confusion in a way that leads them to believe they are under attack. However, the findings of the current study build on the existing literature in suggesting that feeling trapped and persecuted may be important precursors to service users making sense of the unknowns in a suspicious and paranoid way, for example, questioning whether the medication was increased to help them or to control them. Importantly, clear communication was named as something that helped prevent or alleviate paranoid thinking, which is consistent with existing research that suggests that compulsory treatment could be seen as positive if service users are given sufficient information (Andreasson & Skärsäter, 2012).

4.2.3. Paranoia in the Context of Feeling Unsafe

Most participants in the current study described feeling unsafe on the ward (theme 3). Experiencing the ward as an unsafe place has been widely documented and researched (e.g. Care Quality Commission, 2009; Fenton et al., 2014; Mind, 2004; Stenhouse, 2013; D. Wood & Pistrang, 2004). In the current study, feeling physically unsafe resulted from staff behaviour, experiences of violence and aggression from fellow service users, as well as witnessing coercive practices such as restraint and forced medication. This is consistent with the findings of D. Wood and Pistrang (2004) who noted that interactions with other service users, staff behaviour and experiences of coercive treatment led service users to feel unsafe on the ward. However, the current study’s findings expand on this by suggesting that these experiences, which have been labelled as ‘traumatising’ by the existing literature (Hughes et al., 2009; Thibeault et al., 2010), are also experienced as intrusive and contribute substantially to experiences of suspicion and paranoia. This is consistent with literature that positions paranoia as a ‘threat-response’ (Johnstone & Boyle, 2018) and an emotional response to experiences of threat and harm (Freeman, 2007). The experienced lack of safety (theme 3) was also connected to feeling relationally and emotionally unsafe through not knowing who they could trust. This is in line with social theories of threat perception which position hyper-vigilance and paranoia as ‘survival strategies’ (Green & Phillips, 2004). Importantly, the current study also found that service users can feel safe on the ward if certain steps are taken, for example, being given sufficient information, good communication with staff and feeling believed, all of which can ease suspicion and paranoid thinking.

The findings of the current study highlight the importance of service users’ identities. Namely, being a woman on a mixed ward, being a trans-man on a male ward, and being a wheelchair user, led service users to feel particularly unsafe and vulnerable on the ward. These findings are in line with other research which has considered women service users’ experiences specifically, and found that fear, inadequate acknowledgement of abuse histories and coercion all impacted their experience of inpatient admission (Scholes et al., 2021). Importantly, the current study enhances understanding of how identity impacts the service user experience; factors such as age, gender and ability factored into participants' experiences of paranoia. Participants described feeling unsafe and paranoid as a result of being a young woman on a mixed-sex ward, being a transgender man on an all-male ward, or being a wheelchair user in a majority able-bodied context. This supports existing literature that highlights how paranoia is influenced by the environmental and social context (Harper & Timmons, 2019) and feeling part of an outgroup (Saalfeld et al., 2018). Moreover, the current findings support the well-established link between social inequalities, discrimination, and paranoia (Cromby & Harper, 2009).

4.2.4. Paranoia as a Coping Strategy and Linked to Past Experiences of Trauma and Adversity

The current findings suggest that paranoia was often used as a coping mechanism in the uncertain and unsafe ward environment (theme 4). This is in line with the current view of paranoia as a ‘human heuristic’ for dealing with anxiety-provoking and threatening situations (Preti & Cella, 2010). It also supports the literature which positions paranoia as an understandable response to adversity and threat, that is perpetuated in contexts of high anxiety and worry (Freeman et al., 2008; Freeman & Fowler, 2009), rather than simply a ‘symptom of a mental illness’ (Johnstone & Boyle, 2018).

Many participants of the current study described how paranoia-inducing experiences on the ward echoed past experiences of abuse and explained that any mistrust or suspicion they had on entering the ward was exacerbated by the ward environment. These findings suggest that experiences of paranoia emerged from being re-exposed to negative operations of power and unsafe circumstances via admission to a mental health hospital. This supports research by Sweeney and colleagues (2018) who noted that the inpatient context relies on coercion and control, which risks mirroring people's past experiences of powerlessness and adversity. However, the current findings build on this research and suggest that paranoia may be one such emotional response to this re-traumatisation of powerlessness and adversity. Moreover, participants often viewed paranoia as a valid response to the level of violence, aggression and coercion that they experienced and witnessed on the ward. This is consistent with the existing literature that suggests that the development of paranoid thinking relates to past experiences that foster suspicion of others such as experiences of bullying (Shevlin et al., 2015) or witnessing violent acts (Freeman & Fowler, 2009; Harper & Timmons, 2019).

The findings of the current study suggest that many participants found it difficult to disentangle rational-based fear from paranoia. This speaks to ideas put forward in the cognitive model of paranoia where Freeman and colleagues (2002) argue that all forms of paranoid thinking are built on normal and commonly occurring emotional experiences. The findings of the current study provide support for this model and suggest that paranoia in the context of inpatient admission can result from genuine concern and worry, fear, and anxiety related to feelings of being disbelieved, stigmatised and uncared for, along with feeling confused and unsafe in the ward environment. Interestingly, the participants of the current study reported a range of paranoid thoughts which arguably correspond to distinct levels of the paranoia hierarchy described by Freeman and colleagues (2005) such as social evaluative concerns, persecutory beliefs and beliefs about a conspiracy.

4.2.5. The Importance of Care and Connection in Alleviating Paranoia

Perhaps the most consistent finding of the current study was that moments of care and connection helped to ease feelings of suspicion and paranoia (theme

5). Although distance and disconnection from others were often an initial way of coping, there was an overwhelming sense that being able to build connections with staff and service users allowed participants to let their guard down and move past the paranoia they were experiencing. Importantly, this was a theme that prevailed throughout the experience of the only participant who did not experience paranoia during her inpatient stay. This is consistent with the large body of literature that speaks of the importance of developing trusting therapeutic relationships during admission (Fenton et al., 2014; Secker & Harding, 2002; Stenhouse, 2011). The current findings build on the existing literature by suggesting a possible reason for the importance of positive therapeutic relationships. More specifically, experiencing care and kindness from staff helped to ease participants' paranoia and suspicion about being imprisoned and persecuted by staff, thus enabling a break in the cycle of paranoia and mistrust, and allowing for increased engagement and relationship building. These findings may also relate to existing literature regarding the relationship between attachment and the development of paranoid thinking (e.g., Pearce et al., 2017). However, since attachment was not measured or explored explicitly in the current study, more research is needed.

Existing research has also highlighted that admission to an inpatient ward can lead to a loss of identity and self-worth (Roe & Ronen, 2003). Whilst the current study did not find this, participants perhaps maintained a sense of their identity and normality by building relationships with other service users and maintaining contact with loved ones outside of the ward environment. This perhaps enabled participants to maintain a sense of security and normality in the confusing, threatening and unfamiliar ward environment.

4.3. Critical Review

This section will critically review the current study by considering its limitations, quality assurance principles and strengths, as well as reflexivity.

4.3.1. Limitations of the Study

Taking a critical approach requires acknowledgement of the study's limitations. Although a sample size of eight is in line with other comparable research, it is relatively small. The author attempted to recruit more participants by re-posting the social media advert three times across three months and using snowballing sampling, however, no further participants were identified. Additionally, waiting to reach saturation (Guest et al., 2006) was not possible due to time constraints.

The demographic profile of the current study was limited since a large proportion of participants identify as women. This is consistent with research that suggests women are more willing to participate in health-related research compared to men (Glass et al., 2015). This may have been influenced by researcher characteristics (Newington & Metcalfe, 2014), namely the researcher's name and image on social media which may have implicitly communicated to potential participants that the researcher identifies as a woman.

Moreover, all who participated fall within the White ethnicity category, as defined by the Race Disparity Unit (2021). Specific efforts were made to recruit participants from racialised communities by posting a secondary social media advert that named an interest in speaking with people from racialised backgrounds. However, recruitment through social media, where the researcher was identifiably White, may have compounded these issues, perhaps because of the discrimination and stigma experienced by marginalised and racialised groups, particularly in mental health settings, that can result in a lack of trust for researchers within this field (Lang et al., 2013). Importantly, the toolkit for increasing the participation of racialised groups (National Institute for Health Research, 2018) suggests that access to translation and interpretation can significantly increase the participation of racialised groups. This was not available for the current study but should be considered for future research.

This research asked participants to provide accounts of their inpatient experience and therefore relied on participant recall and memories of events and experiences (Willig, 2017). Critically, recall can be influenced by how interview questions are asked (J. Smith & Noble, 2014) and, although the researcher aimed to ask open questions throughout, one critique of using a semi-structured interview schedule is that it leaves room for flexibility which perhaps influences participant recall (Bryman, 2012). Participants also engaged in retrospective sense-making of their inpatient experiences which may have been impacted by the length of time between inpatient admission period and taking part in the study. Critically, efforts were made to standardise this length of time by recruiting people who had been admitted to an inpatient mental health hospital in the last five years. Additionally, participants had been admitted to inpatient wards between 2017 and 2021, with the majority being admitted in 2020, a year before taking part in the current study.

Finally, as highlighted in Theme 2. (Section 3.4.), although many participants reported confusion and difficulty remembering their inpatient experience, they tended to recall the most emotionally salient experiences with greater ease. This is consistent with a large body of research that reports that the emotional quality of a certain memory can aid recall (e.g., Dolcos et al., 2004). Whilst this is not a limitation as such, it should be noted that this may have influenced the outcome of the current study which has found several themes related to emotionally salient experiences.

4.3.2. Quality Assurance and Methodological Strengths

This study used Spencer and Ritchie's (2011) three guiding principles of contribution, credibility and rigour to assure the quality of the research (see section 2.5.3. and Appendix V)

4.3.2.1. Contribution: this study is relevant given the social-political context presented in the Introduction of this thesis, namely that of increasing detentions under the Mental Health Act (1983, 2007), recent developments in inpatient mental health care, and the increased focus on Trauma-Informed approaches. The current study provides a platform for service users' perspectives and experiences to be heard and captures experiences from service users with a range of mental health diagnoses and therefore maintains representational generalisation, meaning that the findings in relation to the sample can be generalised to the parent population from which the sample came (Lewis & Ritchie, 2003). The author believes that the current study has novel implications for inpatient mental health ward policy, practice, and clinical psychology more generally (see section 4.4) and care has been taken to describe actionable and practical suggestions so they can be implemented effectively. Specific contribution to the existing literature is discussed in section 4.2.

A methodological strength was the nuanced collection of demographic information informed by Cameron & Stinson's (2019) guidelines for respecting gender diversity within research. This allowed for a more in-depth exploration of how identity impacted participants' experiences of paranoia in inpatient mental health wards. Importantly, the sample also included people who identify as non-binary and transgender who are typically underrepresented in research due to 'gender mismeasurement' through binary measurement of gender (Cameron & Stinson, 2019). Consequently, a strength of the study's contribution is that it gives voice to the experiences of people who have typically been underrepresented in research (Holdcroft, 2007).

4.3.2.2. Credibility: to demonstrate credibility, vivid extracts were used in section 3. to link the data with the findings and explanations of these extracts included both explicit and implicit meaning derived from what participants said during the interviews. Additionally, an audit trail in the form of notes, memos and mind-maps can be seen as evidence for the credibility of conclusions drawn from the data (Appendix S and Appendix T). Nuance and examples of variation were actively sought. Section 4.2. discussed how the themes and subthemes fit together into a wider narrative of service users' experiences of paranoia on psychiatric wards. Additionally, the author discussed the findings with the research supervisor and reviewed the findings in relation to the existing body of literature which highlighted consistencies as well as novel findings and advancements.

4.3.2.3. Rigour: rigour calls for auditability, defensibility, and reflexivity throughout the research process (Spencer & Ritchie, 2011). Rigour during analysis was assured by following Braun and Clarke's (2006) six steps of Thematic Analysis. For auditability, NVivo software was used to analyse the qualitative data, allowing for an audit trail to be created. Examples of a coded extract (Appendix Q), initial candidate themes (Appendix R), and a description of how initial themes developed into the final themes (Appendix T) have been provided. Notes, memos and mind maps were also used throughout the analysis (Appendix S). For defensibility, a clear rationale for the critical realist stance, along with a rationale for each part of the methodology has been outlined in section 2.2. To ensure reflexivity, a research journal was kept throughout which detailed thoughts, ideas and decision-making processes about data collection and analysis, for example how the four subthemes of theme 1 relate to one another (see Appendix T for an example). Section 4.3.3. explores the researcher's personal and epistemological reflexivity further.

4.3.3. Personal and Epistemological Reflexivity

Reflexivity can be defined as the researcher's awareness of the influential processes they have on the research and how the research process has impacted them (Gilgun, 2006).

4.3.3.1. How the researcher's position has impacted the research: the author's theoretical background and training inherently understand paranoia to be an emotional response to threat and adversity, as opposed to a symptom of a 'mental illness' (Johnstone & Boyle, 2018). These may have influenced the thesis' topic and research question which positions paranoia as something that can be influenced by a person's context and factors such as those which may exist on an inpatient psychiatric ward. The author's theoretical background and training may also have influenced the development of the semi-structured interview questions which perhaps imply the possibility of environmental causes and contributors to the experience of paranoia. For example, the inclusion of the question 'what made you feel paranoid' (see Appendix N) implies that there may be external factors separate from the person's internal experience that influence suspiciousness and paranoia which may have elicited information about environmental and contextual factors. This is in line with the PTMF approach in asking 'what happened to you' as opposed to 'what is wrong with you' (Johnstone & Boyle, 2018), alongside behavioural, social and systemic approaches to psychological experiences and expression of distress. This may be particularly important when seeking to understand Trauma-Informed Approaches to experiences of paranoia.

Considering their experience of working on a psychiatric ward (see section 1.9.), the researcher was motivated for the implications of this research to have practical relevance to psychiatric ward policy and practice. This may have influenced the researcher to take a critical realist stance which assumes some underlying unobservable mechanisms that may be involved in generating certain outcomes (Leung & Chung, 2019), which could be influenced by changes in policy or practice. This may also have influenced the development of the semi-structured interview schedule which included questions about practical suggestions for what could be done differently to help ease experiences of paranoia.

If the researcher had taken a purely positivist position, this may have influenced the researcher to seek ‘truth’ in the participants' responses (Willig, 2017) or search for corroboration from ward staff of participants’ perceptions and experiences of paranoia. If the researcher had taken a social constructionist position, this may have led to the use of Discourse Analysis to explore how paranoia is ‘talked into being’ on inpatient psychiatric wards (Willig, 2017) which may have limited this research’s ability to make practical suggestions for policy and practice as no underlying causal mechanisms would have been assumed (Willig, 2017).

4.3.3.2. How the research process has influenced the researcher: the researcher found that conducting the interviews and being emersed in the data brought back memories of their time working on inpatient wards. This led to considerable reflections on how the researcher’s past actions or practices may have contributed to service users’ experiences of distress and paranoia. Many participants fed back on how important they believed this research to be, and how motivated they were to participate with the hope of changing policy and practice and influencing inpatient experiences for service users in the future. This has increased the researcher’s motivation to publish this study and disseminate the findings widely to ensure that participants’ voices are heard. However, the findings of this research created some discomfort for the researcher. Although some findings relate specifically to everyday practices and interactions on the ward which could be modified, other findings relate to more systemic issues related to the wider mental health system, the use of the Mental Health Act (1983, 2007), and social stigma towards people experiencing psychological distress. In writing this thesis, the researcher has sometimes felt discouraged by the pervasive and impenetrable nature of these issues. Whilst this research does not aim to rectify these issues, the researcher hopes to continue valuing the experiences and perspectives of people who access mental health services to encourage wider systemic change based on the views and experiences of the people who are at the heart of these services.

4.4. Implications

This study highlights the factors which people consider to influence their experience of paranoia on psychiatric wards. This section outlines the wider implications of the findings as well as implications for policy, practice and clinical psychology. Barriers to implementation will also be discussed.

4.4.1. Implications for Policy

The findings illustrate that paranoia is often an emotional consequence of and response to the environment, experiences, relationships, and practices on psychiatric wards. Consequently, the findings of the current study have implications for Trauma-Informed Care policy development, such as Psychologically Informed Environments policies (e.g., Breedvelt, 2016) and the See Think Act relational security guidance (Royal College of Psychiatrists, 2015) which tend to focus on PTDS responses. It is recommended that Trauma-Informed Care policies on inpatient wards should consider more nuanced and diverse emotional responses to adversity and practice, such as paranoia. Additionally, they should pay particular attention to the influence of systemic operations of power through the use of the Mental Health Act (1983, 2007) and the propensity of the ward environment to mirror past experiences of abuse that may elicit paranoid responses. Particular attention should be paid to senior leadership commitment and staff support and training to ensure that the adoption of these approaches is widespread and sustainable, allowing for a culture shift within inpatient mental health services (Bryson et al., 2017).

The current findings highlight that the process of admission to psychiatric inpatient wards can be highly distressing, and that the ward environment, alongside experiences during admission, can leave service users feeling suspicious, paranoid, stigmatised, and disregarded, believing that the mental health system is designed to control or punish as opposed to supporting their recovery. However, the findings also indicate that feeling listened to, cared about, and connecting with others can ease distress and paranoia, leading to a positive experience of inpatient admission. This has significant implications for current UK mental health policy and provides a rationale for the consideration of alternatives to inpatient admission. This could include non-medical crisis houses, acute day hospitals (Thornicroft & Tansella, 2004), or adopting the Soteria Paradigm (Mosher et al., 2004) which promotes the development of therapeutic communities to support people experiencing psychological distress and has been found to be at least as effective as conventional medication-based approaches (Calton et al., 2008).

4.4.2. Implications for Practice

The findings of the current study suggest that particular attention should be paid to how service users experience being sectioned and detained under the Mental Health Act (1983, 2007). The current study highlights that these individuals may feel trapped and persecuted by both the mental health ‘system’ and the staff caring for them, leading them to feel paranoid, worried, and anxious about their safety. The findings also highlighted how meaningful moments of freedom and autonomy were. Consequently, it is recommended that services be designed to incorporate outside space to allow service users to access a more open environment even when they are detained. Similarly, the findings also suggest that paranoia and psychological distress decreased when participants were allowed to leave the ward. Consequently, these findings should inform therapeutic risk-taking (Felton et al., 2017) in inpatient settings and may help advance practitioners’ understanding of the benefit of giving Section 17 leave when risk can be managed.

Moreover, many of the participants spoke of the benefit of accessing activities on the ward, meaningful interactions with staff and being able to speak to staff about their concerns. This suggests that there should be an increased focus on the provision of age-appropriate activities and a revision of meaningful therapeutic engagement in line with the relevant literature (e.g., McAllister et al., 2019) as this could help to distract service users from the chaos on the ward, allowing them to connect with fellow staff and service users and ease experiences of paranoia.

This study highlights that service users can feel confused during their admission and report a need for more information about their rights while on section, reviewing their section, and what their human rights are while in hospital. This highlights the importance of clear communication with service users about their human rights, rights on section, and a clear pathway detailing how service users can raise concerns if they believe their rights have been breached. Additionally, clear explanations of day-to-day ward practice, routine, and occurrences, such as alarms sounding, and rationale for 1:1 observations, are needed. Since many participants reported gaps in their memory during admission, it is recommended that the information be communicated in written form that can be revisited throughout the admission. This could take the form of a ‘welcome booklet’ that outlines why the admission may have occurred and what they can expect from the admission. Ensuring transparency between service users and staff might reduce the feelings of persecution and help service users to engage more meaningfully with their admission (Ritter, 2014).

Although consistent themes were identified across participants’ accounts, there were still nuanced experiences described. Implications of this suggest the importance of giving service users choices during their admission. This could take the form of a choice of activities to engage with, the choice to be left on their own or to engage in a one-to-one discussion with a nurse, or a choice about who they want to speak to about a certain issue, to name a few. Providing moments of choice may allow service users to feel like they have some agency, thus reducing feelings of paranoia and allowing service users to feel more actively engaged during their admission (Laugharne et al., 2012).

The current study found that human connection, caring interactions, and compassion from staff helped ease experiences of paranoia on the ward. This implies that ward practice should focus on behavioural indicators of care and demonstrable compassion. This could include ‘practical compassion’ which encompasses compassionate interactions such as taking the time to speak with service users and engaging in activities together (B. Brown et al., 2014) alongside staff communication and listening skills (Kneafsey et al., 2016).

Importantly, the current study has significant implications for the work that is already being done to improve the service user experience of inpatient wards.

For example, Star Wards (Bright, 2017), Safewards (2022) and Positive Practice (2022) to name a few, have developed theoretical frameworks and practical resources for enabling greater containment, connection and relational security on inpatient psychiatric wards. It is recommended that psychiatric wards make use of the free and readily available resources to help support service users during what can be a highly distressing and paranoia-inducing experience.

4.4.3. Implications for Clinical Psychology

As discussed in section 1.2.2, the implementation of the Long Term Plan (NHS, 2019) and the reallocation of funding (Ebrahim & Wilkinson, 2021) means that Clinical Psychologists are becoming an integral part of Multi-Disciplinary Teams working on the wards (Penfold et al., 2019) and may be well placed to influence current ward policy and practice. Clinical Psychologists have strengths in formulation, and it has been argued that sound psychological formulation could be used in conjunction with or as an alternative to psychiatric diagnoses (Johnstone, 2018). Some implementation of trauma-informed approaches on inpatient wards has included Power Threat Meaning Framework team formulations, where explicit threat responses are considered (Nikopaschos & Burrell, 2020). The findings of the current study imply that paranoia should be explicitly considered as a threat response, and consideration of what might be increasing paranoia on the ward, and what might help to alleviate this, could be included in trauma-informed formulations.

Clinical Psychologists have an important role in the training and offering of psychological consultation within inpatient settings (Ebrahim & Wilkinson, 2021; The British Psychological Society, 2012). Whilst current Trauma-Informed Care approaches often start by educating and training staff on the impact of PTSD on service users (Chandler, 2008), implications of the current study suggest that training and staff education should also include exploration of paranoia-inducing experiences and the impact of paranoia on service user’s social, relational and personal experiences on the ward.

4.4.4. Barriers to Implementation of Recommendations

Whilst a range of recommendations can be made based on the study’s findings, it is important to acknowledge the potential barriers to change. As discussed in the Introduction, the dominance of the medical model has limited mental health professionals' understanding of paranoia as influenced by a person's environmental context and a response to trauma and adversity (Moskowitz, 2011). This has arguably been a barrier to the implementation of Trauma-Informed approaches more generally (Sweeney et al., 2016). Consequently, to implement the changes implicated by the current study's findings, a considerable culture shift may be required. More specifically, TIC will need to be viewed as the gold standard and best practice and paranoia should be viewed as something which can be initiated and perpetuated in certain contexts and physical and relational environments.

Over the years, public services in the United Kingdom have been continuously changing because of austerity, reduced budgets and increasing demand which can make the implementation of new policies and practices challenging (Sweeney et al., 2016). Additionally, scarcer resources such as real term pay cuts for inpatient mental health staff as a result of inflation (The Health Foundation, 2022) and lower morale mean that inpatient staff may find it hard to engage with new ways of working or suggested changes in practice (Sweeney et al., 2016). Moreover, it has been suggested that a lack of staff access to regular supervision is a barrier to the implementation of TIC more generally (Sweeney et al., 2016), which may also be a barrier to the implementation of changes in practice that recognise and respond to paranoia in a Trauma-Informed way.

Whilst these barriers may be significant and pervasive, there are ways in which policymakers and service managers can increase the likelihood that necessary changes will be implemented. For example, Fallot and Harris (2015) recommend organisations develop a strategy for TIC-related organisational change emphasising three key elements: planning; providing adequate training for staff; and monitoring change in both the short- and long-term.

4.5. Future Research

Considering the limited amount of research about the service user experience of paranoia on inpatient wards, further research is necessary. Replication of the current study with a larger and more diverse sample would allow for further development of the findings and could aim to develop a well-established model which could be used to influence policy and practice further. Additionally, whilst the current study explored the general adult ward experience, future research could focus on how certain characteristics of different types of wards (e.g., acute wards, rehabilitation wards, forensic wards) may influence service users' experiences of paranoia. This may highlight ward-specific implications and help to develop context-specific safeguards and interventions to help ease paranoia within different inpatient settings. Whilst the current study gives voice to service users of psychiatric wards, future research could explore the views and experiences of staff to understand more about how staff views might impact on service users' experiences of paranoia and how the relational dynamics between staff and service users might exacerbate or ease experiences of paranoia. Finally, future research could explore what mediates the interaction between paranoia and the ward environment, for example, further exploration of service user attachment styles as discussed in section 1.4.4.

4.6. Conclusions

This research aimed to explore what service users perceive to influence their experience of paranoia on psychiatric wards. The findings indicate that experiences of epistemic injustice, being sectioned and experiencing judgement and stigma can all lead to paranoia and suspicion, particularly when there are limited activities on the wards. A lack of information can lead to confusion and may mean that service users make sense of the unknowns of the inpatient context in a paranoid way which highlights a need for clear and open communication throughout the admission. A perceived lack of safety on the ward was an important precursor to paranoia; feeling physically unsafe and being paranoid about who to trust, in conjunction with feeling violated by common ward practices, often left service users feeling vulnerable and highly vigilant. Importantly, paranoia was often seen by participants as a valid way of coping with the uncertain and unsafe ward environment, and common ward occurrences had the propensity to remind people of past experiences of abuse or exacerbate suspicion that was founded in past abuse or trauma. Finally, although disengagement and relational distance were initial ways of dealing with paranoia-inducing experiences on the ward, moments of care and connection with others helped ease feelings of paranoia by building a sense of care and mutual trust.

These findings are consistent with and build upon the existing literature and have implications for policy, practice, and clinical psychology. They highlight a need to recognise the impact of paranoia-inducing experiences and incorporate paranoia-reducing practices into Trauma-Informed Care approaches implemented on inpatient psychiatric wards.

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APPENDICES

Appendix A: Relevant Mental Health Act (1983, 2007) Sections

A person may be detained in psychiatric hospital if they are deemed to have a ‘mental disorder’, if there is a risk to their safety or the safety of others, and if treatment is only possible if they are detained in hospital (Mind, 2020b). Once detained, the section can be lifted and the person can be discharged from hospital by: the responsible clinician; the hospital manager; their nearest relative; applying to a Mental Health Tribunal to be discharged (Mind, 2020b).

Table outlining relevant Sections of the Mental Health Act (1983, 2007), informed by Mind (2020b).

Section	**Details**
Section 2	Can be detained for up to 28 days for assessment and possible treatment
Section 3	Can be detained for up to six months (can be renewed after the first time for another six months, and then 12 months at a time). Section 3 can be renewed an unlimited number of times.
Section 17	Gives the responsible clinician power to grant leave from the ward and hospital for a specified time. Only applies to involuntary patients.
Section 37	Can be detained in psychiatric hospital for up to six months initially, and then renewed for a further six months, and then for one year at a time after that. Applies after you have been convicted of a crime punishable by a prison sentence and medical treatment for a ‘mental disorder’ is available, appropriate, and detention in hospital is the most appropriate option.

Section 41	This is a restriction order that applies if you are section under Section 37. Discharge, transfer, or section 17 leave can only happen with the permission of the Ministry of Justice.
Section 47	Can be detained for up to six months initially, and then renewed for a further six months, and then for one year at a time after that. Applies if the Ministry of Justice orders you to be transferred from prison to hospital for mental health treatment.
Section 49	This is a restriction order that applies if you are detained under Section 47. This means that you can only be discharged, transferred, or given section 17 leave with the permission of the Secretary of State for Justice.
Section 136	Can be taken to a place of safety for up to 24 hours (can be extended to 36 hours in some circumstances) for a mental health assessment by a doctor and applies if a police officer suspects you have a ‘mental disorder’ and need ‘immediate care or control’.

Appendix B: Literature Review Strategy

Systematic Literature Review

Date Conducted: June/July 2021

Key search terms in title or abstract

("service user experience" OR "client experience" OR "patient experience" OR "subjective experience")

AND "inpatient"

AND ("psychiatric ward" OR "psychiatric hospital" OR "psychiatric unit" OR "psychiatric care")

Databases Searched/Information Sources

EBSCO: Academic Search Complete, CINAHL Plus with Full Text, APA PsycArticles, APA PsycInfo

Science Direct

SCOPUS

CORE

Inclusion Criteria

(1) were readable in English (2) had a primary aim of exploring service user experiences of a psychiatric inpatient admission; (3) examined adult inpatient psychiatric services (4) had separate analysis for service user perspective if they included other groups such as staff or carers.

Exclusion Criteria

(1) related to child/adolescent/older adult only, (2) related to medical/physical health condition only, (3) if staff perception only (4) if related to specific intervention e.g. sensory room or DBT (5) if about the development of a scale to measure service user satisfaction (6) if only looking at coercive experiences e.g. seclusion and restraint without exploring broader experiences of psychiatric admission (7) related to a specialist service e.g. forensic services which

involved higher restrictions and alternative practices related to the Ministry of Justice.

Bidirectional Citation Searching

Bidirectional citation searching (checking references and citations) was used on the final 30 articles and appropriateness for inclusion was based on: title i.e. service user/patient AND inpatient AND mental health AND experience. One more paper was identified however this was a review paper and was excluded at the next stage.

Objective: to collate and synthesise evidence related to the experience of being a service user of inpatient mental health services.

Review papers were then excluded, and a meta-synthesis was conducted.

Meta-Synthesis of Review Papers

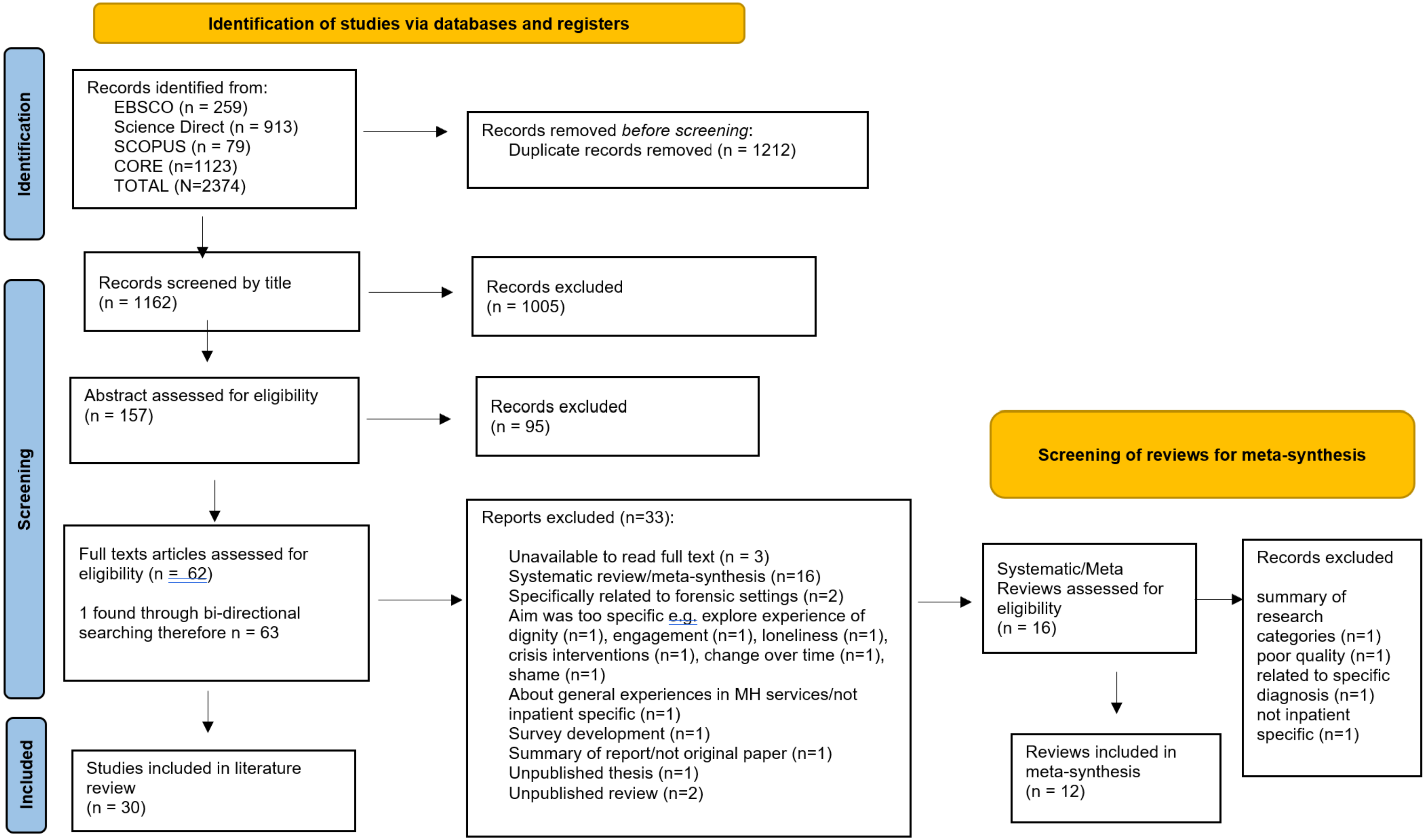
Inclusion Criteria

(1) Were a review paper (2) were readable in English (3) had a primary aim of exploring service user experiences of psychiatric inpatient admission (4) examined adult inpatient psychiatric services (5) had separate analysis for service user perspective if they included other groups such as staff or carers

Exclusion Criteria

(1) was a summary of research categories (2) related to specific experience of people with diagnosis of Borderline Personality Disorder (3) not inpatient specific (4) poor/quality of methodological description

Appendix C: PRISMA Diagram



Records identified from:
EBSCO (n = 259)
Science Direct (n = 913)
SCOPUS (n = 79)
CORE (n=1123)
TOTAL (N=2374)

Records removed *before screening*:
Duplicate records removed (n = 1212)

Records screened by title
(n = 1162)

Records excluded
(n = 1005)

Abstract assessed for eligibility
(n = 157)

Records excluded
(n = 95)

Full texts articles assessed for eligibility (n = 62)

1 found through bi-directional searching therefore n = 63

Reports excluded (n=33):

- Unavailable to read full text (n = 3)
- Systematic review/meta-synthesis (n=16)
- Specifically related to forensic settings (n=2)
- Aim was too specific e.g. explore experience of dignity (n=1), engagement (n=1), loneliness (n=1), crisis interventions (n=1), change over time (n=1), shame (n=1)
- About general experiences in MH services/not inpatient specific (n=1)
- Survey development (n=1)
- Summary of report/not original paper (n=1)
- Unpublished thesis (n=1)
- Unpublished review (n=2)

Studies included in literature review
(n = 30)

Systematic/Meta Reviews assessed for eligibility
(n = 16)

Records excluded

- summary of research categories (n=1)
- poor quality (n=1)
- related to specific diagnosis (n=1)
- not inpatient specific (n=1)

Reviews included in meta-synthesis
(n = 12)

Appendix D: Description of Literature Included in the Systematic Literature Review

Author(s)	Country	Aim(s)	Participant Demographics	Study Design	Major Findings
Ådnanes et al. (2018)	Romania, Austria, Slovenia, Finland, Italy, and Norway.	To explore service users' experiences of psychiatric re-hospitalisation across six countries in Europe.	N=55 from 6 different countries Gender: 40% male, 60% female Age (yrs): range = 26–65 Ethnicity not reported Diagnoses: 42% psychotic disorders, 38% bipolar disorder, 22% depressive disorder, 13% anxiety disorder (multiple reported per participant)	Qualitative Semi-structured focus groups Analysed using Systematic Text Condensation	Themes included: rehospitalisation as less traumatic than the first time; rehospitalisation seen as necessary and a relief; rehospitalisation seen as an inevitable and part of the recovery process.
Andreasson & Skärsäter (2012)	Sweden	To describe patients' beliefs and experiences of care in compulsory	N=12 Gender: 58% male, 42% female Age (yrs): range = 18–65	Qualitative Semi-structured interviews	Compulsory treatment was seen as a positive experience if: good care was given; if shelter was given; and if they are given help with understanding what was happening. Importance of

		treatment for acute onset of psychosis.	Ethnicity not reported Diagnoses: schizophrenia, delusional disorder, schizoaffective disorder, and unspecified non-organic psychosis	Analysed using Phenomenographic Analysis	autonomy, participation and using patients’ own resources to allow service users to feel respected and to prevent traumatisation during compulsory treatment.
Care Quality Commission (2009)	UK	CQC inpatient survey to explore service users' experiences of inpatient psychiatric care.	N=approx. 7,800 (28% response rate) Excluded secure and specialist units. Gender: 45% male, 55% female Age (yrs): 26% 16-35, 43% 36-50, 31% 51-65. Ethnicity: 83% white, 17% black and minority ethnic background Diagnoses not reported	Quantitative Survey	The survey showed that 45% of patients ‘always’ felt safe on the ward, while 39% ‘sometimes’ felt safe and 16% did not feel safe at all. Other outcomes included: mostly positive relationships with staff, a lack of activities available, limited access to talking therapies, shortcomings in information giving, physical health checks and a lack of explanation about the side effects of medication.

Chambers et al. (2014)	England	To explore the service user experience of being detained with a focus on dignity and care.	N=19 Gender: 63% male, 37% female Age (yrs): range = 19–53, mean = 35 Ethnicity: 36% Black British, 52% White British and 12% of other ethnic origins. Diagnosis not reported	Qualitative Semi-structured interviews Analysed using Inductive Thematic Approach	Service users considered their dignity and respect compromised by 1) not feeling listened to by staff, 2) a lack of participation in decision-making 3) a lack of information about their treatment 4) lack of access to talking therapies and 5) lack of activities to relieve their boredom
Eldal, Natvik, et al. (2019)*	Norway	To explore how service users experience current inpatient treatment	N=14 Age (yrs): range = 20s-60s Gender: 50% male, 50% female Ethnicity and diagnosis not reported	Qualitative Semi-structured interview Analysed using IPA	Two themes were identified: (1) a need to have one‘s self-identity recognised and maintained, and (2) ambivalence between wanting closeness and distance. Findings highlighted the importance of being recognised as a whole person, and the therapeutic relationship.

Eldal, Veseth, et al. (2019)*	Norway	To explore conflicting experiences of safety and shame in inpatient treatment	N = 14 Age (yrs): range = 20s-60s, Gender: 50% male, 50% female Ethnicity and diagnosis not reported	Qualitative Semi-structured interview Analysed using IPA	Hospitalisation was a contradictory experience for patients. Participants experienced the hospital as a place where they could be vulnerable, while others experienced it as stigmatising and depersonalising.
Emrich et al. (2021)	England	To explore the service user experience of recovery from psychosis in the context of acute mental health inpatient care	N=10 Excluded participants with active psychosis Age (yrs): range = 21-57 Gender: 90% male, 10% female, Ethnicity: 90% White British, 10% Indian Diagnosis: 20% Bipolar Affective Disorder type II, 20% Bipolar,	Qualitative Semi-structured interview Analysed using IPA	Themes included: the struggle of living with a mental illness; traumatic experiences of being in hospital; a journey towards reaching an understanding; recovery requiring help from others. The ward was experienced as traumatic or distressing by all participants.

			20% Schizophrenia, 30% paranoid schizophrenia, 10% Schizoaffective Disorder		
Fenton et al. (2014)	UK	To explore the inpatient experience of young people with psychosis.	N=6 Age (yrs): range = 18-33 Gender: 83% male, 17% female Ethnicity: 67% White British, 17% White European, 16% White African Caribbean Diagnosis: not specified but specific population with psychosis	Qualitative Semi-structured interview Analysed using IPA	Four themes were identified: (1) confusion and uncertainty due to lack of information (2) feeling safe in the hospital environment but experiencing the ward environment as chaotic and unsafe (3) maintaining identity (4) the importance of meaningful relationships
Gilburt et al. (2008)	England	To explore the service users’ experiences of admission to acute	N=19 Gender: 53% male, 47% female. Age(yrs): range = 25-60+	Qualitative Mixture of focus group and individual	Relationships formed a central part of service users' experiences which could be conceptualised by themes of communication, safety, trust,

		psychiatric hospital	Ethnicity: 68% White British, 5% White European, 16% Black British, 11% Asian British Diagnosis not reported	unstructured interviews Analysed using Thematic Analysis	coercion, and cultural competency. The experience of treatment, a lack of freedom and a poor physical environment negatively impacted service user experiences.
Goodwin et al. (1999)	England	To examine the views of patients of adult in-patient psychiatric services	N=110 Gender: 51% male, 49% female Age not reported Ethnicity not reported Diagnosis not reported	Mixed methods Analysed using Grounded Theory	Themes included the tangible and intangible environment, institutionalisation, power and control, procedures and policies, talking, counselling and listening, respect, hospital as a prison, information, care and compassion, medication, relaxation and activities, and practical support.
Hughes et al. (2009)	England	To explore service user perspectives of involuntary	N=12, people previously admitted to psychiatric hospital Gender: 42% male, 58% female	Qualitative	Experiencing care and support from staff led service users to feel less impacted by the inpatient stay. However,

		inpatient care, with a focus on the impact on the self, relationships and recovery.	Age (yrs): range = 19-62, mean = 39 Ethnicity: not reported Diagnosis: 50% Bipolar, 17% Borderline Personality Disorder, 17% schizophrenia, 16% depression	Semi-structured interviews Analysed using Thematic Analysis	coercive and punitive experiences with staff often led to a negative self-concept and a loss of identity.
Johansson & Lundman (2002)	Sweden	To gain a deeper understanding of the service user experience of involuntary psychiatric care	N=5 Gender: 40 % male, 60% female Age(yrs): range = 27- 49 Ethnicity: not reported Diagnosis not reported	Qualitative Unstructured narrative style interviews Analysed using Phenomenological Hermeneutic Methods	Results highlighted experiences of both support and violation and the inpatient experience was interpreted as a difficult balance between positive opportunities and significant losses

Johansson et al. (2009)	Sweden	To understand more about how service users experience care on a locked acute psychiatric ward.	N=10 Gender: 80% male, 20% female Age (yrs): range = 18-55 Ethnicity not reported Diagnosis: 60% Bipolar, 20% major depression, 10% Anxiety, 10% Anorexia Nervosa	Qualitative Semi-structured interviews Analysed using Content Analysis	Themes included (1) getting relief from suffering (2) being supported/strengthened (3) experiencing it as a place for refuge (4) being exposed to stress through being reliant and trapped.
Jones et al. (2010)	UK	To explore the experiences of service users on acute inpatient psychiatric wards, focusing on their feelings of safety and security.	N = 60 Gender: 60% male, 40% female Age (yrs): range = 19–81, mean = 43 Ethnicity: 67% White, 18% Black/Black British, 10% Asian/Asian British, 5% Other ethnic groups	Qualitative Semi-structured interviews Analysed using Thematic Analysis	Safety and support from staff and other patients was felt by many. Threats to a sense of safety included aggression, bullying, theft, racism and the use of intoxicating substances on the ward.

			Diagnoses not reported		
Koivisto et al. (2004)	Finland	To describe patients' experiences of being helped during inpatient admission.	N=9 Participant demographics not reported	Qualitative Open ended interviews Analysed using Giorgi's Phenomenological methods	Themes included: feeling a need to be protected from vulnerability through feeling safe, feeling understood, respected and trusted; the importance of maintaining integrity; experiencing coercion which increased fear, helplessness and vulnerability; and a lack of information causing confusion and feelings of worthlessness
Lilja & Hellzén (2008)	Sweden	To explore former psychiatric inpatients' experience of admission to a psychiatric inpatients unit	N=10 Gender: 30% male, 70% female Age (yrs): range = 32-64 Ethnicity not reported Diagnosis not reported	Qualitative Semi-structured interviews Analysed using Content Analysis	Themes included: (1) being seen as a disease (2) striving for a sense of control in a lonely and scary environment (3) giving in to oppressive care (4) "meeting an omniscient master" (5) care as a something hopeful in the darkness.

Loft & Lavender (2016)	UK	To explore experiences and impact of compulsory admissions on the psychological functioning of adults with psychosis	N=17 (8 service users, 9 psychiatrists) Gender (of service users): 75% male, 25% female Age (yrs): range = 16-65 Ethnicity not reported Diagnosis: formal diagnosis of psychosis	Qualitative Semi-structured interviews Analysed using Grounded Theory	Themes associated with service user experience included: (1) worsening mental health (2) professionals removing service users' freedom (3) managing psychological distress on the ward (4) regaining liberty (5) recovery in the community.
Mcguinness et al. (2013)	Ireland	To gain an understanding of what it means to have an involuntary hospital admission	N=6 Gender: 67% male, 33% female Age (yrs): range = 20-66 Ethnicity not reported Diagnosis: <17% acute psychotic episode, 33% brief	Qualitative Semi-structured interviews Analysed using IPA	Findings illustrated both positive and negative experiences. Participants described now knowing what was going on because of a lack of information or explanations. Participants also described a need to 'move on' while in hospital, however this was impacted by stigma, and they described a range of

			psychotic episode,<17% relapse Bipolar affective disorder, <17% Bipolar affective disorder manic, <17% Bipolar affective disorder manic with psychosis		emotions that they felt during admission such as anger and anxiety.
Mind (2004)	England and Wales	Survey to explore the experience of service users of inpatient mental health services	N = 335 Gender: 30% male, 51% female, 19% did not answer Age (yrs): range = 18-85+ Ethnicity: 3% Black/Black British, 1% White Irish, 2% Mixed Heritage (2%), 1% Asian/Asian British, 81% White British, 3% Other White, <1% Other ethnic group, 7% Did not answer Diagnosis not reported	Mixed Methods Questionnaire and 2 focus groups Analysis method not specified	The finding revealed two extremes of hospital conditions: For some, the hospital environment aids mental health recovery. For others, the experience was experiences as negative, harmful, and inhumane due to poor accommodation and security, issues of safety, inadequate levels of staffing and boredom.

Molin et al. (2016)	Sweden	To explore the service user experience of daily life in psychiatric inpatient care.	N=16 Gender: 22% male, 88% female Age (yrs): range = 20-51 Ethnicity not reported Diagnosis: borderline personality disorder, depression, bipolar syndrome, PTSD, eating disorder, dissociative syndrome, anxiety, burnout, and Tourette’s syndrome, unknown.	Qualitative Semi-structured interviews Analysed using Grounded Theory	Three key themes: (1) staff make the difference (2) seeking shelter in a stigmatising environment (3) and feeling confused by care processes.

Murphy et al., (2017)	Ireland	To explore the service user experience of being admitted to psychiatric hospital involuntarily	N=50 Gender: 58% male, 42% female Age (yrs): range = 18 – 65+ Ethnicity: not reported Diagnosis: 52% nonaffective psychotic disorder, 32% Affective psychotic disorder, 6% Alcohol use disorder, 4% Other, 4% No diagnosed disorder, 2% Diagnosis not available	Qualitative Semi-structured interviews Analysed using Inductive Thematic Process	Themes included (1) feeling confined and coerced (2) lack of information and emotional support (3) admission-induced trauma (4) person-centred encounters.

Nolan et al. (2011)	UK	To elicit service users beliefs about being cared for in acute psychiatric settings.	N=44 Gender: 42% male, 58% female Age (yrs): range = 18-71 Ethnicity not recorded Diagnosis not recorded	Qualitative Semi-structured interviews Analysis not specified	Results highlighted that some service users saw admission as an experience to be tolerated that included stigmatisation and loss of self-worth. Others saw it as a relieving experience where they could seek care and treatment and provided respite for their families.
Pejlert et al. (1995)	Sweden	To illustrate experiences of being a patient in a hospital ward with a diagnosis of schizophrenia	N=10 Gender: 40% male, 60% female Age (yrs): range = 30-66, median = 40 Ethnicity not reported Diagnosis: schizophrenia	Qualitative narrative interviews analysed using Phenomenological Hermeneutic Methods	Themes highlighted that service users were preoccupied with an inner dialogue, trying to solve problems on their own. Relational difficulties occurred on the ward because they both longed for and feared contact with others, and did not feel like themselves when they were around others.

Roe & Ronen (2003)	USA	To investigate the experience of service users regarding the difficult aspects of inpatient psychiatric admission.	N=43 Gender: 58% male, 42% female Age (yrs): range = 20-39, mean = 28 Ethnicity: 81% White, 19% Black Diagnosis: 51% Schizophrenia, 30% schizoaffective disorder, 19% major affective disorder	Qualitative Individual interviews Analysed by reporting a Narrative summary and open-ended coding	Key themes included: (1) passivity (2) confrontation with the personal meaning of hospitalisation (3) loss (of self, of the previous perception by others, of the ease to meet the demands of the environment) (4) the importance of safety (5) being with others who have had similar experiences.
Secker & Harding (2002)	UK	To explore the inpatient experiences of a sample of African and African Caribbean people	N=26 Gender: 62% male, 38% female Age (yrs): range = 25-44 Ethnicity: 30% African, 70% African Caribbean Diagnosis: 62% schizophrenia	Qualitative Semi-structured interviews Analysed using Content Analysis	Findings highlighted participants experienced a sense of loss of control and experienced of explicit and indirect racism. These experiences were underpinned by unhelpful service user–staff relationships.

Stenhouse (2011)**	Scotland	To explore the experience of being a patient on an acute inpatient psychiatric ward	N=13 Gender: 46% male, 64% female Age (yrs): range = 18-65 Ethnicity and diagnosis not reported	Qualitative Unstructured interviews Analysed using Holistic Analysis	Findings specifically related to experiences of 'help': participants expected to receive help through the development of relationships with staff, but often found that staff were too busy. In response, service users sought support from each other.
Stenhouse (2013)**	Scotland	To understand more about the experience of being a patient on an acute psychiatric inpatient ward.	N=13 Gender: 46% male, 64% female Age (yrs): range = 18-65 Ethnicity and diagnosis not reported	Qualitative Unstructured interviews Analysed using Narrative Analysis	Findings specifically related to 'safety': Initially, participants experienced a sense of safety from the external world, however they often felt vulnerable due to a lack of knowledge of their fellow patients, and a key issue was the perception of threat from other service users on the ward.

Thibeault et al. (2010)	Canada	To understand the world of people with mental illness who had been hospitalised	N=6 Gender: 67% male, 33% female Age (yrs): range = 20-75 Ethnicity not reported Diagnosis: Major depression, bipolar, delusional disorder, schizophrenia	Qualitative semi-structured interviews Analysed using an Interpretative Phenomenological Approach	Key findings included patients describing a controlling, rule-bound and oppressive milieu, alongside experiences of healing and health through connection.
Thomas et al. (2002)	USA	To explore the phenomenological world and experience of psychiatric patients	N=8 Gender: 63% male, 37% female Age (yrs): range = 23-58 Ethnicity and diagnosis not reported	Qualitative Phenomenological interviewing analysed using Phenomenological Analysis	Key findings included seeing the inpatient environment as a refuge from self-destructiveness. Three interrelated themes came through: like me/not like me, possibilities/no possibilities, connection/disconnection.

D. Wood & Pistrang (2004)	UK	To provide a detailed description of the experience of being an inpatient on a mental health ward, specifically with regard to feelings of safety and threat.	N=9 service users, 12 staff Gender (of service users): 56% male, 44% female Age (yrs): range = 26-61 Ethnicity: 67% White, 11% Black-Caribbean, 11% Black African, 11% Chinese Diagnosis: 33% Bipolar Affective Disorder, 33% Depression, 22% Schizophrenia, 11% Borderline Personality Disorder	Qualitative Semi-structured interviews Analysed using Thematic Analysis	Patients' accounts were characterised by an overwhelming sense of vulnerability and helplessness. Key themes that impacted on their sense of safety and threat included: (1) interactions between patients (2) the behaviour and attitudes of staff (3) non-consensual treatment.

*/**Studies using the same sample

Appendix E: Description of Reviews Included in Meta-Synthesis

Author	Review Type	Aim	Inclusion and Exclusion Criteria	Methodology	Findings
Akther et al. (2019)	Systematic Review and Meta-synthesis	To review qualitative evidence on service user experiences of assessment and detention under mental health legislation	N=56 Inclusion: qualitative, included patient experiences of assessment or detention under mental health legislation; adult sample; published in peer-reviewed journals. Exclusion: studies had a mixed sample and did not include specific analysis for involuntary service users; non-adult sample only or no separate analysis for adults; data collected using surveys, questionnaires or case studies; not peer-reviewed	Thematic Synthesis	Key themes included the importance of knowledge of and participation in treatment/care, the ward environment and therapeutic relationship, as well as detention negatively impacting emotional experiences and self-worth.

Berry et al. (2013)	Narrative Review	To review studies investigating the prevalence and development of PTSD induced because of experiences of psychosis and hospitalisation	N=28 Inclusion: empirical research published between 1980-2011; written in English; included sample with a diagnosis of psychosis or other severe and enduring mental health difficulties, measures of PTSD symptoms or psychological distress in response to mental health experiences or hospitalisation. Exclusion: thesis abstracts, editorials, review papers or opinion pieces.	Narrative Review	A consistent finding was that experiences of psychosis and hospitalisation are highly distressing and many service users meet criteria for PTSD in relation to their experiences. Distressing experiences related to treatment, threats or actual physical and sexual violence, involuntary admission, isolation from family members, lack of choice and understanding, lack of fairness, respect, empathy and support from staff, and the physical environment.

Cutcliffe et al. (2015)	Narrative Review	To review published mental health service evaluations.	Number of studies included not specified Drew on the published appraisals of psychiatric care, written by service user groups, practitioners and/or academics, originating from the United Kingdom, Portugal, Canada, Switzerland, Germany and Australia	Narrative Review	Themes included experiences that lack therapeutic relationships, respectful communications, information or choice about medication or psychological therapies. Conclusions found that inpatient experiences are dominated by coercion, disinterest, inhumane practices, and controlling interactions with staff.
Lindgren et al. (2019)	Systematic Review	To explore patients' experiences of isolation in psychiatric inpatient hospitals	N=15 Inclusion: qualitative design, published between 2000-2016, adult sample, focused on inpatient experiences of isolation, locked doors, and seclusion Exclusion: published pre-2000, sample of children and adolescents.	Meta-ethnographic synthesis	Themes included (1) feeling imprisoned e.g. feeling restricted, stripped of one's rights, unsupported and abandoned (2) having access to shelter and feeling safe and regaining a sense of control

Modini et al. (2021)	Meta-Review	Aimed to establish and synthesise the factors that inpatients self-report influence their perception of inpatient hospitals.	N=12 Inclusion: written in English, related to adult sample admitted to an inpatient psychiatric hospital, peer reviewed Exclusion: if they only explored adolescents, staff or carer's/family member's perception, had mixed sample and did not have separate analysis for inpatients, if the setting was a specialist inpatient setting e.g. forensic ward	Thematic Synthesis	Key themes included: (1) relationships on the ward (2) the ward environment (3) coercive practice (4) legal status (5) independence (6) feeling worthy of care (7) expectations of care at the beginning and end of admission.
Plunkett & Kelly (2021)	Systematic Review	To synthesise the existing literature on service user experience of dignity in inpatient	N=9 Inclusion: included psychiatric inpatients; considered service users' personal experience of inpatient mental health care, and refer to detained patients.	Thematic synthesis	Key themes included: (1) coercion (2) powerlessness (3) care environment (4) relationships with staff (5) long term impact of involuntary treatment (6) paradoxes.

		psychiatric care.	Exclusion: related to family or carers only; did not involve detained service users; was a single case-study or case-report, or were not accessible in English.		
Prebble et al. (2015)	Mixed Method Review	To explore how voluntary service users experience acute inpatient psychiatric units.	N=46 Inclusion: published in English after 1993, focused on voluntary service user experience of acute adult psychiatric facilities. Exclusion: focused on specialist/ community settings; quantitative studies about patient satisfaction only; if they had a mixed sample and didn’t have separate analysis for involuntary patients.	Thematic Analysis	Key themes included the experience of coercion, lack of informed consent and a limited knowledge of their rights.

Scholes et al. (2021)	Systematic Review	To synthesise staff experiences and women service users' experiences of inpatient mental health services	N=18 Inclusion: qualitative/qualitative component of mixed-methodology study, aimed to explore the inpatient experience of women service user sample, staff with current or previous experience of providing care to women service users Exclusion: quantitative methodology, considered non-adult, specialist or non-inpatient psychiatric settings, focused on an intervention, had a mixed sample and did not use separate analysis for female experiences or for service user perspectives, were not published in English, were not peer-reviewed, were review papers	Thematic Synthesis	Themes related to service user experience included: (1) Safe haven relating to relational security (2) Broken system referred to being fearful of the inpatient environment, having inadequate knowledge and information, acknowledgement of historical abuse and coercion and the system being under-resourced. The therapeutic milieu was an important mediator between these two themes.

Seed et al. (2016)	Narrative Review	To further understanding of how service users experience involuntary psychiatric detention	N=15 Inclusion: considered the experiences of involuntary patients in acute general psychiatric wards, used a qualitative methodology, published in English Exclusion: used mixed sample of detained and voluntary service users with no separate analysis, focused on community settings, specialist wards or treatments without looking at the overall experience, or were not empirical research studies	Narrative synthesis	Themes included: (1) sanctuary, (2) loss of normality and perceived autonomy (3) feeling terrified and fluctuating emotions (4) varying person-centred practice and disempowerment (5) intra-psychic coping as an internal factor.
Staniszewska et al. (2019)	Systematic Review	To identify key themes for improving experiences of inpatient psychiatric care	N=72 Inclusion: considered experiences of current or former psychiatric facilities, reported empirical research, peer-reviewed and published in English between January 2000-2016.	Thematic synthesis	Themes included: (1) the significance of relationships (2) avoiding adverse experiences of coercion (3) a healthy, safe and empowering physical setting and ward atmosphere

			Exclusion: not primary studies, published pre-2000 data, had sample of children and/or adolescents		(4) genuine experiences of patient-centred care
Sugiura et al. (2020)	Systematic review and meta-synthesis	To describe the experiences of service users, informal carers, and professionals in involuntary psychiatric admission decision-making and throughout the subsequent involuntary admission.	N=37, n=24 focusing on service users Inclusion: qualitative or mixed methods (with a focus on the qualitative results) studies, adult participants, explored experiences of involuntary admission to inpatient mental health services. Exclusion: relate to non-inpatient psychiatric environments, had mixed sample include separating analysis for involuntary participants; focused only on single coercive procedures	Thematic Analysis	Service user specific themes related to admission: useful, distressing and disempowering. Service users expressed difficulties around the ward atmosphere/context and relationship with staff. They were also distressed by certain experiences such as coercion in the form of forced medication

L. Wood & Alsawy (2016)	Systematic Review	Aimed to examine patients' experiences of psychiatric inpatient care	N=11 Inclusion: peer-reviewed; had a primary aim of exploring patients' experiences of a psychiatric inpatient admission; adult sample; used a qualitative methodology, majority of participants were service users, conducted in a European country. Exclusion: examined specific events related to inpatient admission, e.g. of being sectioned, or being discharged; explored non-adult experiences e.g. child/older adult, examined long-term rehabilitation wards; and examined the perceptions of other groups.	Thematic synthesis	Main themes included: (1) collaborative and inclusive care (2) positive relationships (3) safe and therapeutic hospital environment. Experiences included receiving inadequate and inappropriate treatment, feeling unsupported or dismissed, feeling isolated from others and feeling unsafe. Positive qualities of care facilitated the journey of recovery were also identified.

Appendix F: Meta-Synthesis of Review Studies

The Preferred Reporting Items of Systematic Review and Meta-Analysis Protocol (PRISMA-P: Shamseer et al., 2015) and Enhancing Transparency in Reporting the Synthesis of Qualitative Research guidelines (ENTREQ: Tong et al., 2012) have been followed. Reviews were included based on having the primary aim of considering the adult service user experience of mental health inpatient wards, were available in English, and had separate analyses for service user perspective if they included other groups such as staff or carers. They were excluded if there were methodological concerns, for example, no information about methodology or search strategy, if they related to the specific experience of people with a diagnosis of Borderline Personality Disorder, or if they were not specific to the inpatient experience.

This meta-synthesis also follows the recommendations by Shaw's (2011) regarding the phases of synthesising qualitative literature which included reading and re-reading of the original review papers and drawing out themes. Seven key themes were identified and are described below.

Summary of Themes

Dehumanised and stigmatised: a key theme was that of service users feeling dehumanised (Akther et al., 2019; Seed et al., 2016; Sugiura et al., 2020) through their experience of certain coercive interventions such as being in seclusion (Akther et al., 2019) which was found to impact service users' self-worth and dignity (Plunkett & Kelly, 2021). The literature also highlighted the ongoing stigma and prejudice that service users felt both within hospital (Akther et al., 2019) and after admission, perhaps through the impact of admission on their social roles (Scholes et al., 2021) and the feeling that they would be labelled after being discharged (Sugiura et al., 2020). Importantly, it was reported that service users felt the stigma would be long-lasting (Plunkett & Kelly, 2021). In contrast, there was some research which highlighted that service users did not feel judged, however, this was a small proportion of service users and related to positive interactions with staff (L. Wood & Alsawy, 2016).

Coercion, Control and Powerlessness: another theme was that of the distressing and negative impact of coercive interventions (Modini et al., 2021; Scholes et al., 2021; Sugiura et al., 2020) which were often a reminder of traumatic experiences in the past (Akther et al., 2019), and incited feelings of powerlessness from previous abuse (Seed et al., 2016). The literature highlights that coercive interventions tend to be seen as inhumane and custodial (Cutcliffe et al., 2015) which impacts service users' dignity (Plunkett & Kelly, 2021) and lead to feelings of being controlled and powerlessness (Lindgren et al., 2019). One review reported that much of the service user experience is characterised by trying to avoid the negative consequences of coercion (Staniszewska et al., 2019). In a study which considered the experience of voluntary admission, as opposed to involuntary admission, Prebble and colleagues (2015) found that coercion incited fear of being sectioned. L. Wood and Alsawy (2016) found that service users can feel powerless as a result of a lack of involvement in their care which leads to increased distress. Importantly, Modini and colleagues (2021) talk about the positive impact of coercive treatments such as creating a sense of safety, if administered under conditions of clear communication, explanation and good relationship with staff.

Boredom: lack of activities and boredom were highlighted in many reviews (Akther et al., 2019; Modini et al., 2021; Staniszewska et al., 2019; L. Wood & Alsawy, 2016), highlighting the need for more structure to provide relief and distraction (Akther et al., 2019). Experiences of boredom have been linked to increased levels of distress, worsening symptoms and instances of violence on the ward (Staniszewska et al., 2019).

Lack of, and importance of, information: another theme was the importance of clear information (Akther et al., 2019; Scholes et al., 2021) and the general lack of information (Cutcliffe et al., 2015; Sugiura et al., 2020) about things such as informed consent, service users rights (Prebble et al., 2015) and medication (Cutcliffe et al., 2015). A lack of information about admission and treatment can lead to feelings of disempowerment (Akther et al., 2019) and an increase in distress (Berry et al., 2013), whilst being provided with clear information could decrease distress (Cutcliffe et al., 2015) and help service users to feel safer (Akther et al., 2019). Suguira and colleagues (2020) highlight the importance of staff repeatedly explaining information to service users as some service users were unable to take in or retain the information when it was given right at the beginning of their admission, perhaps due to their level of stress.

Fear, lack of safety and distress: another key theme was fear and distress related to hospital experiences (Berry et al., 2013) where service users regularly described feeling fearful for their personal safety and reported experiences of violence and sexual harassment (Akther et al., 2019). Furthermore, a systematic review considering the experience of women service users in both mixed-sex and all-female wards found that many service users reported feeling fearful of the ward environment because of the risk of assault, drug use and theft (Scholes et al., 2021). Other reviews also identified that aggressive behaviour on the ward led service users to feel unsafe around other service users and reported that the ward environment felt uncaring which lead to an increase in distress and an experienced lack of safety (L. Wood & Alsawy, 2016) which worsened their mental health difficulties (Sugiura et al., 2020).

Feeling of safety: in contrast to the theme described above, another prevalent theme was that of some service users feeling that the ward provided a sense of safety. More specifically, some reviews highlighted that service users felt grateful for being in a safe environment (Lindgren et al., 2019), seeing hospital as a safe haven due to the supervision by staff (Scholes et al., 2021). Additionally, they saw the experience of admission as a sanctuary which was keeping them safe from self-desrtuctive behaivours (Seed et al., 2016). Importantly, an increased sense of safety was found to occur when service users felt able to approach staff for help when aggression occurred on the ward (L. Wood & Alsawy, 2016)

*The therapeutic relationship: a*nother theme was the importance of relationships with staff (Akther et al., 2019; Modini et al., 2021; Staniszewska et al., 2019). Importantly, service users often experience a lack of warmth from staff (Cutcliffe et al., 2015) and can feel abandoned and uncared for (Lindgren et al., 2019). The quality of therapeutic relationships was seen as highly influential on the service user experience, with positive relationships having a helpful impact on the service user experience (L. Wood & Alsawy, 2016), allowing them to feel valued (Modini et al., 2021). Positive therapeutic relationships could also lead to a reduction in experiences of fear and the need for coercive measures such as seclusion or restraint (Modini et al., 2021). It was also found that negative interactions with staff impacted the service users' dignity (Plunkett & Kelly, 2021). This also incorporates the concept of the therapeutic milieu on the ward as being a mediator between service users' experiences being deemed safe and helpful or unsafe and coercive (Scholes et al., 2021; Staniszewska et al., 2019).

Critique of Existing Reviews

It should be noted that whilst many of the empirical studies in the current systematic review (section 1.6. in the main body of text and Appendix D) are included in the reviews part of the meta-synthesis, the focus of many of these reviews was very specific, for example, looking specifically at shame or experiences of seclusion. Consequently, many of the empirical studies included in other reviews were excluded from the current systematic review since they did not fit the inclusion criteria. Considering this, it could be argued that the systematic review presented in section 1.6.1. provides a more comprehensive overview of the literature specifically relating to 'the overall service user experience' in inpatient mental health settings than existing reviews. Additionally, it can be seen to advance the existing literature in that it finds an explicit theme of 'the inpatient experience as traumatising', and presents a comprehensive conceptualisation of experiences, namely that of negative experiences, emotional experiences, and more positive experiences which can help to reduce the distress that is so often felt within inpatient settings. Importantly, the similarity in themes across the current systematic review (see section 1.6.1) and the meta-synthesis highlights some consistent findings throughout the literature and provide considerable support for the validity of the systematic review presented in section 1.6.1.

Critique of the Meta-synthesis

Importantly, the different epistemological positions and methodologies employed within and between reviews can make the synthesising process challenging (Shaw, 2011). However, it should be noted that the majority of the reviews included in the meta-synthesis employed a qualitative thematic synthesis methodology, thus allowing for a more consistent synthesis of themes. Additionally, although some of the epistemological positions may differ, Yardley and Bishop (2008) suggest taking a pragmatic approach, which moves away from a positivist positioning of knowledge, toward a position where science and common sense can contribute to valid knowledge (Yardley & Bishop, 2008).

Considering the interpretative nature of a meta-synthesis, the author must be aware of their own positioning and pre-conceptions (Shaw, 2011). Considering that the meta-synthesis was carried out alongside a systematic review of the empirical literature, pre-conceived themes may have been present in the mind of the author. However, the author engaged in a reflexive process throughout to minimise the risk of bias, and the generation of new themes, such as ‘boredom’, highlights the author's openness to novel themes within the literature.

Appendix G: SPREC Ethics Application

UNIVERSITY OF EAST LONDON

School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

(Updated October 2019)

FOR BSc RESEARCH

FOR MSc/MA RESEARCH

FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

1. Completing the application

1.1 Before completing this application please familiarise yourself with the British Psychological Society's Code of Ethics and Conduct (2018) and the UEL Code of Practice for Research Ethics (2015-16). Please tick to confirm that you have read and understood these codes: ☑

1.2 Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will then look over your application.

1.3 When your application demonstrates sound ethical protocol, your supervisor will submit it for review. By submitting the application, the supervisor is confirming that they have reviewed all parts of this application, and consider it of sufficient quality for submission to the SREC committee for review. It is the responsibility of students to check that the supervisor has checked the application and sent it for review.

1.4 Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (see section 8).

1.5 Please tick to confirm that the following appendices have been completed. Note: templates for these are included at the end of the form.

- The participant invitation letter ☑
- The participant consent form ☑
- The participant debrief letter ☑

1.6 The following attachments should be included if appropriate. In each case, please tick to either confirm that you have included the relevant attachment, or confirm that it is not required for this application.

- A participant advert, i.e., any text (e.g., email) or document (e.g., poster) designed to recruit potential participants.

  Included ☑ or

  Not required (because no participation adverts will be used) ☐

- A general risk assessment form for research conducted off campus (see section 6).

  Included ☑ or

  Not required (because the research takes place solely on campus or online) ☐

- A country-specific risk assessment form for research conducted abroad (see section 6).

  Included ☐ or

  Not required (because the researcher will be based solely in the UK) ☑

- A Disclosure and Barring Service (DBS) certificate (see section 7).

  Included ☑ or

Not required (because the research does not involve children aged 16 or under or vulnerable adults) ☐

- Ethical clearance or permission from an external organisation (see section 8).

  Included ☐ or

  Not required (because no external organisations are involved in the research)

- Original and/or pre-existing questionnaire(s) and test(s) you intend to use.

  Included ☐ or

  Not required (because you are not using pre-existing questionnaires or tests)

- Interview questions for qualitative studies.

  Included ☑ or

  Not required (because you are not conducting qualitative interviews) ☐

- Visual material(s) you intend showing participants.

  Included ☐ or

  Not required (because you are not using any visual materials) ☑

2. Your details

2.1 Your name: **Georgina Cox**

2.2 Your supervisor's name: **David Harper**

2.3 Title of your programme: **Doctorate of Clinical Psychology**

2.4 UEL assignment submission date (stating both the initial date and the resit date): **May 2022**

3. Your research

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and details of your proposed research.

3.1 The title of your study: Service Users' Experiences of "Paranoia" on Psychiatric Wards

3.2 Your research question: What do service users perceive to be the factors which influence their experience of paranoia?

3.3 Design of the research: Qualitative

3.4 Participants:

This study aims to recruit approximately 12 participants from the general population.

Inclusion and Exclusion Criteria:

Participants must be aged 18-65yrs and have been an inpatient in a psychiatric hospital in the UK within the last five years.

3.5 Recruitment:

Participants will be recruited through posting an advertisement on social media e.g. Twitter, specifically sharing it on service user network pages to access individuals who may be interested in participating in the study. See Appendix A for the social media advert.

3.6 Measures, materials or equipment:

Semi-structured interview schedule (see Appendix D).

3.7 Data collection:

Interviews will take place over Microsoft Teams and will be recorded using the same programme. This will be stored on a password protected computer in the UEL One drive for business. Further data management processes are outlined in the data management plan.

The researcher will read out the information sheet which will outline the purpose of the research. Participants will also have been emailed the information sheet in advance and before commencing the interview, will be invited to read the information sheet themselves and will be asked if they have any questions. Any questions they have will be addressed. They will then be given the consent form (via email) to read and sign if they still wish to proceed (can be signed and returned via email). They will also be reminded of their right to withdraw at any time before, during, or after the interview.

3.8 Data analysis:
The recordings of the interviews will be transcribed, at which point any identifiable information will be removed or altered to ensure anonymity. These transcripts will be analysed using a Thematic Analysis using data management software e.g. NVivo.

4. Confidentiality and security

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

4.1 Will participants data be gathered anonymously?
No, I will know participants' names.

4.2 If not (e.g., in qualitative interviews), what steps will you take to ensure their anonymity in the subsequent steps (e.g., data analysis and dissemination)?
The data will be completely anonymised during the transcription process and only anonymised extracts will be used in the write up of the thesis.

4.3 How will you ensure participants details will be kept confidential?
Contact details such as email addresses will be needed in order to interview participants. These will be kept in a password protected word file on the UEL OneDrive for Business which is secure and encrypted. These will be deleted once they are no longer needed e.g. after successful passing of the viva or after outcomes of the research have been communicated to the participants if they consented to this on the participant consent form.

Signed consent forms will be retained for the duration of the research by the researcher, and for up to 1 year after publication by the research supervisor to ensure explicit consent to publish is available.

Interviews will be conducted via Microsoft Teams (MS Teams) which has been approved by the University of East London as a secure way of conducting individual interviews. The recordings will be initially stored on Microsoft stream, which is password protected, on a personal laptop which is also password protected. A copy of the recordings will then be transferred to the researcher’s personal UEL OneDrive for Business which is encrypted and secure and the original copy will be deleted/destroyed. Each audio file will be named with participant initials and the date of the interview. Anonymised transcripts of the interview will be stored in a password protected word file on UEL OneDrive separate from the identifiable interview recording data. These files will be named using the given participant number e.g. Participant 1. No list will be kept of participant numbers linked to person identifying information.

The data gathered will only be discussed between the researcher and their research supervisor.

4.4 How will the data be securely stored?
For the duration of the research period, the data will be stored in password protected files which will be stored on the UEL OneDrive which is secure and encrypted. The data will be backed up using the UEL H: drive which is also password protected. Full details can be found in the data management plan.

4.5 Who will have access to the data?
The researcher and their supervisor will be the only people with access to the data.
Since the thesis is being examined, examiners may need access to anonymised data. This is outlined in the participant consent forms.

4.6 How long will data be retained for?
Contact details for participants will be deleted one they are no longer needed e.g. after the viva or after feedback on the outcomes of the project has been communicated to participants. The interview recordings will be destroyed once they are no longer needed for University approval (October 2022). Transcripts and analysis data will be retained on the research supervisor’s UEL OneDrive for business for up to 5 years as the researcher may wish to submit the research for publication. Consent forms will also be retained on the research supervisor’s UEL OneDrive for Business for up to 1 year after publication as they may need to be evidenced for publication purposes. This identifiable data (e.g. consent forms) will be stored separately from anonymised data (e.g. transcripts and analysis data)

5. Informing participants

Please confirm that your information letter includes the following details:

☑

5.1 Your research title:

5.2 Your research question: ☑

5.3 The purpose of the research: ☑

5.4 The exact nature of their participation. This includes location, duration, and the tasks etc. involv ☑

5.5 That participation is strictly voluntary: ☑

5.6 What are the potential risks to taking part: ☑

5.7 What are the potential advantages to taking part: ☑

5.8 Their right to withdraw participation (i.e., to withdraw involvement at any point, no questions asked): ☑

5.9 Their right to withdraw data (usually within a three-week window from the time of their participation): ☑

5.10 How long their data will be retained for: ☑

5.11 How their information will be kept confidential: ☑

5.12 How their data will be securely stored: ☑

5.13 What will happen to the results/analysis: ☑

5.14 Your UEL contact details: ☑

5.15 The UEL contact details of your supervisor: ☑

Please also confirm whether:

5.16 Are you engaging in deception? If so, what will participants be told about the nature of the research, and how will you inform them about its real nature.

NO

5.17 Will the data be gathered anonymously? If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

NO. The recording of interviews will not be anonymous however any identifiable data will be anonymised during the transcription of interviews. Any Identifiable data that could be linked to anonymised data will be stored separately, in password protected files.

5.18 Will participants be paid or reimbursed? If so, this must be in the form of redeemable vouchers, not cash. If yes, why is it necessary and how much will it be worth?

NO

6. Risk Assessment

Please note: If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

6.1 Are there any potential physical or psychological risks to participants related to taking part? If so, what are these, and how can they be minimised?

No physical risks to participants since the interview will be taking place remotely via MS Teams.

Potential psychological risk - The interview schedule will ask participants to reflect on and recount potentially distressing experiences therefore this research requires sensitive data collection and analysis.

This risk will be minimised through the inclusion of a debrief sheet and debrief at the end of the interview, along with contact details of supporting charities and services. Additionally, the experience of hospitalisation, especially on section, involves considerable power imbalances and sometimes abuses of power. Consequently, the implications of the researcher being a trainee psychologist and in a position of power must be carefully considered throughout the interview process and will be mediated by ensuring informed consent, offering breaks or stopping of the interview in case of distress and the right to withdraw from the study.

6.2 Are there any potential physical or psychological risks to you as a researcher? If so, what are these, and how can they be minimised?

No physical risks to the researcher since the interview is taking place remotely via MS Teams.

Potential low level psychological risk to researcher – the interview schedule will be asking participants to reflect on potentially traumatic and distressing events. In turn, it may be distressing for the researcher to hear such events. The researcher will speak to their supervisor if they are concerned about their wellbeing.

6.3 Have appropriate support services been identified in the debrief letter? If so, what are these, and why are they relevant?
Yes – services included in the debrief letter are as follows:

- MIND UK
- Samaritants UK
- Sane
- Rethink Mental Illness

These supporting services have been identified since they aim to support individuals who are struggling with distress and their mental health. They offer free and confidential support and some provide support 24 hours a day, 365 days a year.

6.4 Does the research take place outside the UEL campus? If so, where?
YES – via Microsoft teams

If so, a ‘general risk assessment form’ must be completed. This is included bel☑s appendix F. Note: if the research is on campus, or is online only (e.g., a Qualtrix survey), then a risk assessment form is not needed, and this appendix can be deleted. If a general risk assessment form is required for this research, please tick to confirm that this has been completed:

6.5 Does the research take place outside the UK? If so, where?
NO

If so, in addition to the 'general risk assessment form', a 'country-specific risk assessment form' must be also completed (available in the Ethics folder in the Psychology Noticeboard), and included as an appendix. [Please note: a country-specific risk assessment form is not needed if the research is online only (e.g., a Qualtrix survey), regardless of the location of the researcher or the participants.] If a 'country-sp☐c risk assessment form' *is* needed, please tick to confirm that this has been included:

However, please also note:

- For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance.
- For *on campus* students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Head of School (who may escalate it up to the Vice Chancellor).
- For *distance learning* students conducting research abroad in the country where they currently reside, a risk assessment must be also carried out. To minimise risk, it is recommended that such students only conduct data collection on-line. If the project is deemed low risk, then it is not necessary for the risk assessments to be signed by the Head of School. However, if not deemed low risk, it must be signed by the Head of School (or potentially the Vice Chancellor).
- Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

7. Disclosure and Barring Service (DBS) certificates

7.1 Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?
YES / NO

7.2 If so, you will need a current DBS certificate (i.e., not older than six months), and to include this as an appendix. Please tick to confirm that you have included this: ☐

Alternatively, if necessary for reasons of confidentiality, you may ☐

email a copy directly to the Chair of the School Research Ethics

Committee. Please tick if you have done this instead:

Also alternatively, if you have an Enhanced DBS clearance (one

you pay a monthly fee to maintain) then the number of your ☑

Enhanced DBS clearance will suffice. Please tick if you have

included this instead: **001540457330**

7.3 If participants are under 16, you need 2 separate information letters, consent form, and debrief form (one for the participant, and one for ☐

their parent/guardian). Please tick to confirm that you have included

these:

7.4 If participants are under 16, their information letters consent form, and debrief form need to be written in age-appropriate language. ☐

Please tick to confirm that you have done this:

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) ‘vulnerable’ people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children click here.

8. Other permissions

8. Is HRA approval (through IRAS) for research involving the NHS required? Note: HRA/IRAS approval is required for research that involves patients or Service Users of the NHS, their relatives or carers as well as those in receipt of services provided under contract to the NHS.

YES / **<u>NO</u>**   If yes, please note:

- You DO NOT need to apply to the School of Psychology for ethical clearance if ethical approval is sought via HRA/IRAS (please see further details here).
- However, the school *strongly discourages* BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
- If you work for an NHS Trust and plan to recruit colleagues from the Trust, permission from an appropriate manager at the Trust must be sought, and HRA approval will probably be needed (and hence is likewise strongly discouraged). If the manager happens to not require HRA approval, their written letter of approval must be included as an appendix.
- IRAS approval is not required for NHS staff even if they are recruited via the NHS (UEL ethical approval is acceptable). However, an application will still need to be submitted to the HRA in order to obtain R&D approval. This is in addition to a separate approval via the R&D department of the NHS Trust involved in the research.
- IRAS approval is not required for research involving NHS employees when data collection will take place off NHS premises, and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

8.1 Will the research involve NHS employees who will not be directly recruited through the NHS, and where data from NHS employees will not be collected on NHS premises?

YES **<u>/ NO</u>**

8.2 If you work for an NHS Trust and plan to recruit colleagues from the Trust, will permission from an appropriate member of staff at the Trust be sought, and will HRA be sought, and a copy of this permission (e.g., an email from the Trust) attached to this application?

YES / **NO**

8.3 Does the research involve other organisations (e.g. a school, charity, workplace, local authority, care home etc.)? If so, please give their details here. **NO**

Furthermore, written permission is needed from such organisations if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation. If that is the case, please tick here to confirm that you have included this written permission as an appendix: ☐

In addition, before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation,' or with the title of the organisation. This organisational consent form must be signed before the research can commence.

Finally, please note that even if the organisation has their own ethics committee and review process, a School of Psychology SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

9. Declarations

Declaration by student: I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name (typed name acts as a signature): **Georgina Cox**

Student's number: **1945435** Date: **31/03/2021**

As a supervisor, by submitting this application, I confirm that I have reviewed all parts of this application, and I consider it of sufficient quality for submission to the SREC committee.

NOTE: Appendices for the SPREC Ethics application included the social media advert, participant information sheet, consent form, interview schedule, participant debrief sheet and risk assessment form. For continuity of appendices included in this thesis, the social media advert, consent form, interview schedule and participants debrief sheet have been removed. They can be viewed in the relevant appendices in the thesis (Appendix I, Appendix J, Appendix L, Appendix N and Appendix O respectively). The risk assessment can be seen on the next page.

UEL Risk Assessment Form

UEL Risk Assessment Form

Name of Assessor:	**Georgina Cox**	**Date of Assessment**	**11/03/2021**
Activity title:	**Service users' experiences of "paranoia" on psychiatric wards**	**Location of activity:**	**MS Teams**
Signed off by Manager (Print Name)	**Dr David Harper**	**Date and time (if applicable)**	**20/03/2021**

Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc)
If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:

Individual interviews will take place via Microsoft Teams. This study aims to recruit approximately 12 participants from the general population between the ages of 18 and 65. This is part of data collection for a thesis as part of the Professional Doctorate in Clinical Psychology. Interviews will ask participants to reflect on their time spent as an inpatient on a psychiatric ward and consider experiences that made them feel unsafe, threatened and/or "paranoid".

Overview of FIELD TRIP or EVENT:

n/a

Guide to risk ratings:

a) Likelihood of Risk	**b) Hazard Severity**	**c) Risk Rating (a x b = c)**
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Further control measures essential)

Hazards attached to the activity

Hazards identified	Who is at risk?	Existing Controls	Likelihood	Severity	Residual Risk Rating (Likelihood x Severity)	Additional control measures required (if any)	Final risk rating
Potential Psychological risk from talking about distressing events	Participant/ interviewee	Participants will be provided with an information sheet prior to consenting to taking part. This will outline the general aim of the interview and any risks associated with taking part. They will also be given a debrief which will outline key contacts if they wish to discuss any difficulties further e.g. mental health charities.	1	1	1	The associated risk is deemed to be low. However, attention will be paid to interviewees during the interview process and the interviewer will check in with the individual if they appear distressed and offer a break or the option to stop the interview	1
Potential Psychological risk from hearing participants talking about distressing events	Interviewer/ researcher	Regular supervision. The researcher is also experienced in working with people describing distressing events	1	1	1	n/a	1

Review Date: 31/03/2021

A comprehensive guide to risk assessments and health and safety in general can be found in UEL's Health & Safety handbook at http://www.uel.ac.uk/hrservices/hs/handbook/ and a comprehensive guide to risk assessment is available on the Health & Safety Executive's web site at http://www.hse.gov.uk/risk/casestudies/index.htm. An example risk assessment is also included below.

Appendix H: SPREC Ethical Approval Confirmation Letter

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Hanna Kampman

SUPERVISOR: David Harper

STUDENT: Georgina Cox

Course: Prof Doc in Clinical Psychology

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

APPROVED

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):* Georgina Cox

Student number: u1945435

Date: 10/06/2021

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☑ LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: Hanna Kampman

Date: 09.06.2021

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

Appendix I: Social Media Advert

University of
East London

PARTICIPANTS NEEDED

Have you been admitted to an adult Psychiatric Hospital in the UK in the last 5 years?

- I am looking to participants to speak to me about their experiences as a service user in psychiatric hospital.
- I am particularly interested in experiences on the ward that might have made you feel “paranoid”, threatened, or unsafe.
- Take part in a one-hour online interview for a new study to discuss your experiences.

If you would like more information or want to take part, please email u1945435@uel.ac.uk

Appendix J: Information Sheet

PARTICIPANT INVITATION LETTER

Study Title: Service Users' Experiences of "Paranoia" on Psychiatric Wards

You are being invited to participate in a research study. Before you agree, it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a Trainee Clinical Psychologist at the University of East London and am studying for a Doctorate in Clinical Psychology. As part of my studies, I am conducting the research you are being invited to participate in.

What is the research?

I am conducting research into what makes people feel "paranoid," suspicious, or unsafe on psychiatric wards with the aim of understanding what we could be doing differently.

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate in my research as someone who fits the kind of people I am looking for to help me explore my research topic. I am looking to involve adults between the ages of 18 and 65 who have had an experience of being an inpatient in a psychiatric hospital within the last 5 years. I am not looking for 'experts' on the topic, and I am really interested to hear your thoughts and experiences. You will not be judged or personally analysed in any way and you will be treated with respect.

Do you have to take part?

You do not have to take part in this study and should not feel under any obligation to. If you decide to participate, you will be able to withdraw up to 3 weeks after the interview takes place and you won't have to say why.

What will your participation involve?

If you agree to participate you will be asked to take part in a one-off individual interview with myself which will last somewhere between 30 and 60 minutes. Whilst I will have a few key questions to ask, I hope this will feel as relaxed and informal as possible since this is a chance for you to share your experience. It will take place over Microsoft Teams to ensure that we can stay safe during covid-19 and to make sure the connection is safe and secure. I will not be able to pay you for participating in this study, but your participation would be very valuable in helping to develop knowledge and understanding of my research topic.

Will taking part be safe and confidential?

In general, yes. Your privacy and safety will be respected at all times. You will be offered a chance to ask any questions before the start of the interview. It is important that you know you do not have to answer all the questions I ask, and you can stop the interview or have a break at any time. You will also be offered time at the end of the interview to ask any questions you may have.

If I am worried about your safety or the safety of someone else, it is my responsibility to tell someone who may be able to help or who may need to know. I will discuss this with you first, if possible.

What will happen to the information that you provide?

In order to meet with you (virtually) I will need an email address contact. This will be stored on the UEL OneDrive which is secure and encrypted. No information will be stored on my phone.

The interview will be recorded (so that I do not miss anything you say) and then I will transcribe it (i.e. type it up). However, in the transcript you will be given a pseudonym (i.e. a fictitious name) to protect your identity and no identifying information (your name, other potentially identifying details etc) will be included.

The electronic recording and the transcripts will be securely stored in password-protected files on a UEL OneDrive which is secure and encrypted. No-one other than my supervisor and I will have access to these.

When I write up my thesis, I may use quotes from your interview, but you will only be referred to by a pseudonym and nothing that might identify you will be included. The thesis will be publicly accessible in the University of East London's Institutional Repository (ROAR) but this will not include any information which might identify you.

I will delete the interview recordings once they are no longer needed for University approval (approximately October 2022). At this point, I will also delete your contact information unless you wish to be updated about the progress of the study.

My research supervisor will keep the anonymised transcripts of the interviews for up to 5 years as I may wish to publish the findings of this research. They will also keep the signed consent form for up to 1 year after publication for this purpose. The data gathered for this study will be retained in accordance with the University's Data Protection Policy.

Are there any risks?

I hope that taking part will be a fulfilling experience where you can share your experiences and I appreciate that this can be difficult at times. I would like you to consider some of the difficulties that may come up. Thinking and talking about your experiences on a psychiatric ward might bring up some difficult thoughts, feelings and memories, maybe about your own experience or what you may have seen. Here are a few suggestions of how I can support you:

- Please let me know if you do experience difficulties before, during or after the interview.

- If I notice that you are becoming distressed or upset during the interview, I might check in with you and ask if you would like a break.
- I am not able to offer direct counselling, but I can direct you to several services and charities who will be able to support you further.

Are there any benefits?

Although there are no specific benefits, it is hoped the study may help to increase our understanding of this topic. In addition, many people find it interesting to talk about their views and experiences and I hope that taking part in this research will allow you and your experience to feel heard.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage, or consequence. Separately, you may also request to withdraw your data even after you have participated, provided that this request is made within **3 weeks** of the interview. After this time, I will have begun to analyse the data and withdrawal will not be possible.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Georgina Cox – [researcher's uel email address]

If you have any questions or concerns about how the research has been conducted please contact the research supervisor David Harper. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: [research supervisor's email address]

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Appendix K: Example Confirmation Email Sent to Participants

Dear [redacted]

I hope you are well and have had a good week. I am getting in touch to organise a day and time that works well for you to do the interview with me for my research. As a starting point, I thought I would put out some dates to see if they work for you:

Thursday 21st October: any time during the day or after 5:30pm.

Saturday 23rd October: any time before 2pm

Wednesday 27th October: after 5:30pm

Please let me know if any of these are convenient for you. If not, then we can definitely come up with other dates and times.

I am also still hoping to find more people who are interested in taking part, so if you know anyone (men in particular since I have had mostly women come forward so far) who would be interested in taking part, please feel free to pass on the study information and my email address so they can get in contact.

I have attached another copy of the participant information sheet for you to re-read and keep. I have also attached a copy of the consent form. Please do have a read through it, and if you are happy to proceed, tick, sign and email it back to me when you can. I will also read through the consent form with you before we start the interview so if you have any questions or concerns, please feel free to leave it unsigned and we can talk through it more at the time.

Thanks and I look forward to hearing from you.

Best Wishes,

Georgina Cox

Trainee Clinical Psychologist

Appendix L: Consent Form

UNIVERSITY OF EAST LONDON

Consent to participate in the research study:

Service Users’ Experiences of “Paranoia” on Psychiatric Wards

I confirm that I have read the information sheet dated 01/10/2021 (version 1) for the above study and that I have been given a copy to keep. ☐

I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation in the study is voluntary and that I may withdraw at any time, without providing a reason for doing so. ☐

I understand that if I withdraw from the study, my data will not be used. ☐

I understand that I have 3 weeks from the date of the interview to withdraw my data from the study. ☐

I understand that the interview will be recorded using Microsoft Teams ☐

I understand that my interview data will be transcribed from the recording and anonymised to protect my identity. ☐

I understand that my personal information and data, including audio recordings from the research will be securely stored and remain strictly confidential. Only the research team will have access to this information, to which I give my permission. ☐

It has been explained to me what will happen to the data once the research has been completed. ☐

I understand that short, anonymised quotes from my interview may be used in the thesis and that these will not personally identify me. ☐

I understand that the thesis will be publicly accessible in the University of East London’s Institutional Repository (ROAR). ☐

I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in professional and academic journals resulting from the study and that these will not personally identify me. ☐

I understand that a digital copy of the consent form will be stored on the university's secured drive until a year after publication and that these forms will be stored separately from the anonymised transcripts. ☐

I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to. ☐

I agree to take part in the above study.

Participant’s Name (BLOCK CAPITALS)

……………………………………………………………………………………….

Participant’s Signature

………………………………………………………………………………………..

Researcher’s Name (BLOCK CAPITALS)

………………………………………………………………………………………..

Researcher’s Signature

…………………………………………………………………………………………

Date: ……………

Appendix M: Demographics Questionnaire

The following information will only be used to describe the group of people that are included in this study. This information will not be linked with your name, your data or used for any other purpose

1. How old are you?...

2. Which of the following most accurately describes you (choose as many as you like)?

☐Female ☐Male ☐Non-binary ☐ Transgender

☐Intersex

☐If none of the above, please describe ……………………………………….

3. How would you describe your ethnicity? ……………………………………………

4. How many times have you been admitted to a mental health hospital in the last 5 years?......................

5. Roughly how long was/were the admission/s……………………………………

6. Were you admitted under section or was the admission voluntary? ....

7. Have you ever been given a mental health diagnosis?

If yes, please describe……………………………………………………………………………

8. Are you

☐Working (full or part-time)

☐At college or university

☐In training

☐Unemployed

☐Not working due to long term physical or mental health difficulties

☐Retired

☐If none of the above, please describe……………………………………………….

Appendix N: Interview Schedule

Question 1: Tell me about your experience of being on a psychiatric ward

- Probe: When were you in hospital? Why were you admitted?
- Probe: Context questions e.g. ethnicity, age, gender, social class… tell me about how aspects of yourself impacted your experience?
- Probe: individual, situations, relational experiences

Question 2: Did you ever experience/feel unsafe/threatened on the ward?

- Probe: Sometimes people feel suspicious/”paranoid” on psychiatric wards, did this happen for you?
- Probe: Can you give me an example of that – what happened?
- Probe: Did you ever feel “paranoid” before being admitted? Was it part of the reason you were admitted?

Question 3: Can you tell me about what made you suspicious or “paranoid” on the ward?

- Probe: What happened/what was the situation? E.g. patient interaction, staff interaction, ward round, special observations, seclusion, mealtime, handover?
- Probe: What did you do?
- Probe: What did others do?
- Probe: Why did this make you feel “paranoid”/threatened/unsafe?

Question 4: Can you tell me about how other people responded to you?

- Probe: Threat situation change?
- Probe: People’s behaviour?

Question 5: Can you tell about what was helpful in dealing with these feelings?

- Probe: What did you do?
- Probe: What did others do?
- Probe: Why did these help?

Appendix O: Participant Debrief Sheet

University of East London

PARTICIPANT DEBRIEF LETTER

Thank you for participating in my research study on what makes people feel “paranoid”, suspicious or unsafe on psychiatric wards. This letter offers information that may be relevant since you have now taken part.

What will happen to the information that you have provided?

The following steps will be taken to ensure the confidentiality and integrity of the data you have provided.

- The interview have be recorded so that I can listen to it again and make sense of the experiences you have shared while writing up the research project.
- I will be writing up the content of the interview. When I do this, I will change any identifying information e.g. your name, name of the inpatient unit, to protect your identity.
- Extracts of the write up will be used as part of a thesis which will be publicly accessible in the University of East London’s Institutional Repository (ROAR).
- Since this is a University project, I have a supervisor who is overseeing the project. I will be discussing the information from the interviews with them but I will not use your real name. This project will also be examined, so examiners will have access to the final writeup and may ask for access to the anonymised transcripts.
- The interviews and written documents will be password protected and be stored on a secure and encrypted university system (UEL OneDrive).
- I will delete the interview recordings once they are no longer needed for University approval (approximately October 2022). At this point, I will also delete your contact information unless you wish to be updated about the progress of the study.

- I plan to keep the anonymised transcripts of the interviews for 5 years as I may wish to publish the findings of this research. I also plan to keep the signed consent form (will be kept separate from anonymised transcripts) for this purpose. Both of these will be kept by my research supervisor in their UEL OneDrive for Business which is secure and encrypted and will be deleted once they are no longer needed.
- You may wish to withdraw your data even after you have participated, provided that this request is made within **3 weeks** of the interview (after which point the data analysis will begin with anonymised data, and withdrawal will not be possible).

What if you have been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways you may find the following resources/services helpful in relation to obtaining information and support:

MIND UK

Promotes the views and needs of people with mental health difficulties.

- Phone: **0300 123 3393** (Monday to Friday, 9am-5pm)
- Website: www.mind.org.uk

Samaritans UK

Confidential support for people experiencing distress or despair

- Phone: **116 123** for free 24 hours a day, 365 days a year
- Website: www.samaritans.org

Sane

Emotional support, information and guidance for people affected by mental health difficulties, their families and carers.

- Textcare: comfort and care via text message, sent when the person needs it the most www.sane.org.uk/textcare

- Peer support forum: www.sane.org.uk/supportforum
- Website: www.sane.org.uk/support

Rethink Mental Illness
Support and advice for people living with mental health difficulties

- Phone: **0300 5000 927** (Monday to Friday, 9:30am to 4pm)
- Website: www.rethink.org

You are also very welcome to contact me or my supervisor if you have specific questions or concerns.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Georgina Cox – [researcher's uel email address]

If you have any questions or concerns about how the research has been conducted please contact the research supervisor David Harper. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: [research supervisor's email address]

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

Appendix P: Data Storage and Management Plan

UEL Data Management Plan: Full

For review and feedback please send to:
researchdata@uel.ac.uk

If you are bidding for funding from an external body, complete the Data Management Plan required by the funder (if specified).

Research data is defined as information or material captured or created during the course of research, and which underpins, tests, or validates the content of the final research output. The nature of it can vary greatly according to discipline. It is often empirical or statistical, but also includes material such as drafts, prototypes, and multimedia objects that underpin creative or 'non-traditional' outputs. Research data is often digital, but includes a wide range of paper-based and other physical objects.

Administrative Data	
PI/Researcher	Georgina Cox
PI/Researcher ID (e.g. ORCiD)	0000-0003-1435-5403
PI/Researcher email	U1945435@uel.ac.uk
Research Title	Service users' experiences of "paranoia" on psychiatric wards
Project ID	
Research Duration	1.5 yrs, start date 03/2021 until 10/2022

Research Description	The proposed research aims to explore service users' experiences of psychiatric hospital admission with a specific focus on exploring what experiences contribute to experiences of paranoia, sense of threat, and lack of safety. Data will be collected via individual interview using MS Teams and will be analysed using the appropriate software e.g. NVivo.
Funder	n/a
Grant Reference Number (Post-award)	n/a
Date of first version (of DMP)	22/01/2021
Date of last update (of DMP)	15/03/2021 v.2 - This version to reflect change to retention period of data
Related Policies	UEL's Research Data Management Policy
Does this research follow on from previous research? If so, provide details	no
Data Collection	
What data will you collect or create?	Minimum of 5 and maximum of 12, 1hour recordings will be generated and stored. Anonymised transcription data will then be created from the interview. This will be stored as a word file which will be password protected. Each participant will be given a participant number and all identifiable information e.g. hospital name, location, will be anonymised in the transcripts. The data will be exported to NVivo in a word file format and analysed as appropriate.

	Thematic analysis will be used to analyse the data, and will be written up into a final report (word document) Participant consent forms will also be created (pdf) which will contain person data (names). Prior to interview, email addresses or contact information e.g. telephone number, will be collected prior to interview for the purpose of arranging interviews via the researcher UEL email address.
How will the data be collected or created?	I will collect interview data from individual participants. This will be done via MS Teams and will be recorded and stored in a video/audio format. Consent will be gathered in the form of electronically signed consent forms (pdf) that will be emailed to the researcher by participants. These will be moved and saved on the UEL H:drive, and documents will be password protected. The email containing the consent form will then be deleted. Consent will also be gained verbally at the start of the interview process. Attempts will be made to use the MS Teams transcription ad-in, however this will also be reviewed and corrected by hand where needed and will be stored as a word document.
Documentation and Metadata	
What documentation and metadata will accompany the data?	Through NVivo, codes and themes will be made and stored in NVivo. A blank consent form (pdf), participant information sheet (pdf), guide interview questions (word doc), debriefing sheet (pdf), and file naming convention document (word document) will also accompany the data. Demographic data about participants gathered in the interview will also accompany the data, and this will be kept in a separate document and file to the anonymised transcription data.

Ethics and Intellectual Property	
How will you manage any ethical issues?	Participants will be informed of the data management plan, plans for analysis, write up and possible publication of the final report prior to consenting to participate in the research. They will also be informed that the data may be retained for up to 5 years should the researcher wish to publish the research. They will also be informed of their right to withdraw and the limit of this (e.g. approximately 3 weeks after the interview has taken place, after which point analysis will have begun, the data will be anonymous, and it will not be possible to remove their individual data). They will be given the researcher's contact details should they wish to withdraw their consent. If a participant decides to withdraw from the study within this 3 week time period, they will be informed that their contribution (e.g. interview recording and transcript) will be removed and confidentially destroyed. Confidentiality of the data will be ensured at the transcription stage where the data will be anonymised by changing names and any identifiable information e.g. location of hospital. Transcription will be undertaken only by the researcher to protect confidentiality of the participant. Information regarding the sharing of data with the research supervisor and information regarding the dissemination of the research data in the form of a thesis will be outlined in the participant information sheet and consent form. The information sheet and consent form will also outline that the anonymised data (e.g. transcripts), and metadata related to this e.g. consent forms and analysis documents, may be securely retained by the research supervisor for a duration of up to 5 years in case the researcher wishes to publish the findings. They will also be informed that this

	data will be destroyed after the 5 years period.
How will you manage copyright and Intellectual Property Rights issues?	The interview schedule used to collect that data is original. Therefore, there are no issues of copyright.
Storage and Backup	
How will the data be stored and backed up during the research?	Recordings of interviews will initially be stored on the researcher’s password protected on Microsoft Stream Library. The laptop is a personal, non-networked, with a password known only by the researcher. To ensure security, the researcher will then download a copy to upload to UEL OneDrive for Business which is secure and encrypted. The local copy will be deleted from the Microsoft stream library and the download folder once successfully uploaded. Each audio file will be named with participant initials and the date of the interview. Anonymised transcripts of the interview will be stored in a password protected word file separate from the identifiable interview recording data. These files will be named using the given participant number e.g. Participant 1. No list will be kept of participant numbers linked to person identifying information. The completed consent form documents (pdf) will be stored in a separate place (the UEL H: drive) away from the identifiable data, in a separate password protected file. The coding document (password protected word document) will also be stored in a separate file away from identifiable data. All of the data detailed above will be stored on the UEL OneDrive for Business which is

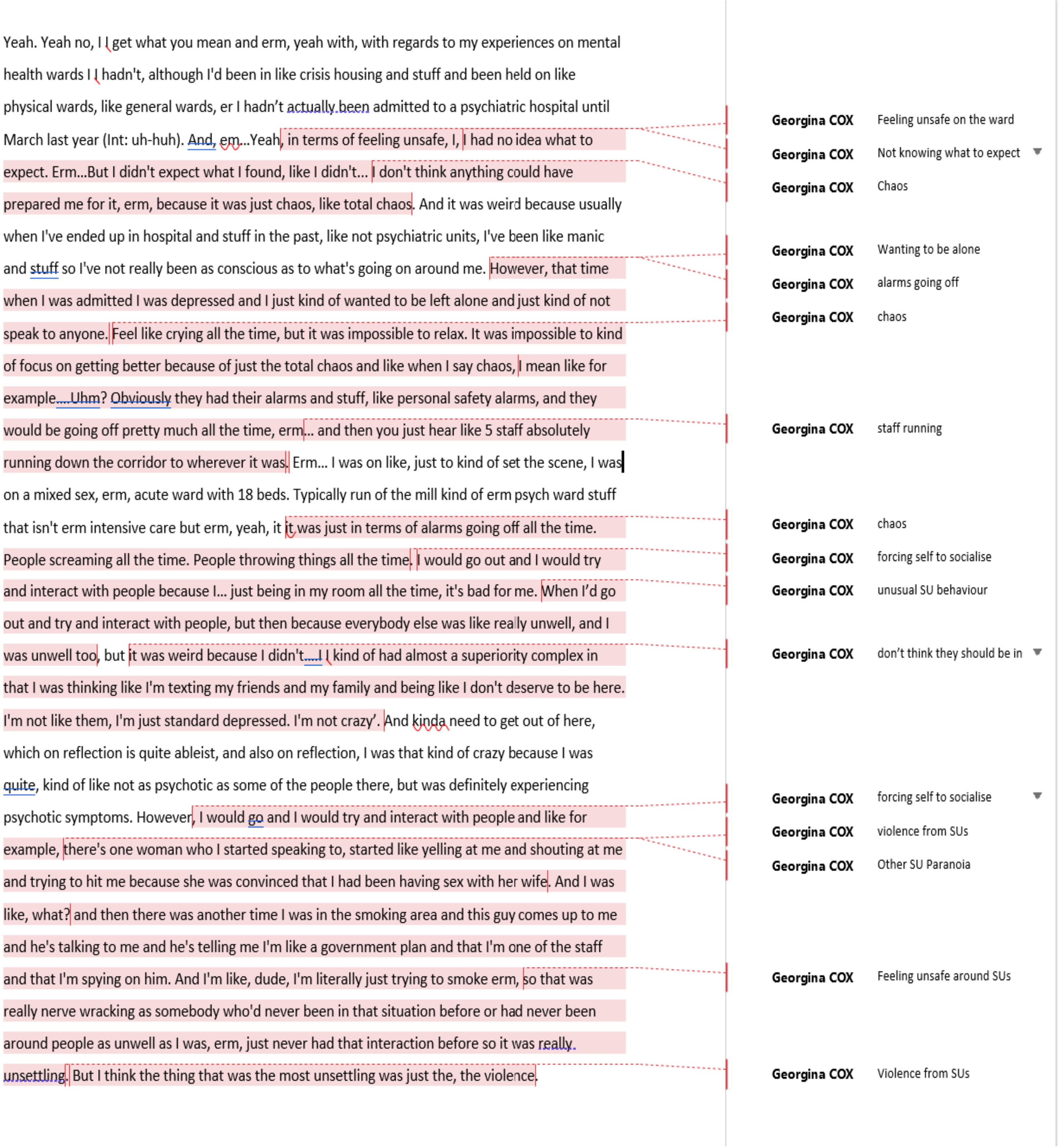
	encrypted and secure, and will be backed up using the UEL H Drive which is also password protected.
How will you manage access and security?	Anonymised data (e.g. transcripts) will be stored separately from data that could reidentify someone (e.g. recordings of interview). They will be stored in separatee files on the researcher's UEL OneDrive for Business which is secure and encrypted. Security will also be ensured by password protecting all documents and storing the data and meta data on UEL's OneDrive for Business which is secure and encrypted. During the research period, anonymised transcript data may be shared with the researcher's supervisor. If the data is to be shared, it will be shared via UEL's OneDrive for Business and file names will also be anonymous e.g. Participant 1.
Data Sharing	
How will you share the data?	The transcripts and data will not be shared via the UEL data repository since the information gathered may be too sensitive even if anonymised. Extracts from the anonymised transcript will be written up into a thesis which will be deposited and shared via the UEL repository via the UEL research open access repository (ROAR). Identifiable data will not be included in these extracts. The information sheet and consent form will also outline that the anonymised data (transcripts), and metadata related to this e.g. analysis documents, and consent forms, may be securely retained for a duration of up to 5 years by the research supervisor in case the researcher wishes to publish the findings. Any identifiable data (e.g. consent forms) will be stored separately from the anonymised data.

	Participants will also be informed that this data will be destroyed after the 5 years period.
Are any restrictions on data sharing required?	
Selection and Preservation	
Which data are of long-term value and should be retained, shared, and/or preserved?	The MS Teams recordings will be destroyed once they are no longer needed for University approval (e.g. by October 2022). Participant contact information will also be deleted after it is no longer needed e.g. after successful completion of the viva or after a summary of the research findings has been fed back to them (if they selected this option on the consent form). Participant consent forms will be deleted once they are no longer needed for publication purposes (e.g. up to 1 year after publication) as this data may be required if the thesis is to be reviewed for publication. A thesis will be written up using extracts of transcripts and this thesis will be stored in the research open access repository (as outlined in the UEL Research Data Management Policy). Transcripts and analysis data will be retained for up to 5 years by the research supervisor as the researcher may wish to submit the research for publication.
What is the long-term preservation plan for the data?	The MS Teams recordings will be destroyed once they are no longer needed for University approval (e.g. by October 2022). The thesis will be stored and deposited in the research open access repository (as outlined

	in the UEL Research Data Management Policy). Anonymised data (e.g. transcripts) and metadata (e.g. consent forms, analysis data) will be moved and deleted from the researcher's UEL OneDrive for Business and UEL H Drive by Oct 2022 since the researcher will no longer have access to these UEL storage facilities as their course will have finished. From that point on, data and metadata will instead be stored on the research supervisor's UEL OneDrive for business for up to 5 years as this data may be required if the thesis is to be reviewed for publication. Identifiable data e.g. consent forms will be stored separately from anonymised data (e.g. transcripts) and again, will be password protected and be stored in encrypted files. After 5 years, all the anonymised data and all meta data will be deleted.
Responsibilities and Resources	
Who will be responsible for data management?	The researcher (Georgina Cox) After thesis completion and marking, the research supervisor will be responsible for managing the data.
What resources will you require to deliver your plan?	A Laptop, MS Teams access, UEL email account, and UEL OneDrive for Business, UEL H Drive, research supervisor's OneDrive for Business.
Review	
Date: 12/03/2021	**Reviewer name: Penny Jackson**

Appendix Q: Example of coded extract

NVivo was used to code the interview data. Gaining a comprehensive coded extract was not possible using this software therefore an example of a coded extract has been attached.



Yeah. Yeah no, I I get what you mean and erm, yeah with, with regards to my experiences on mental health wards I I hadn't, although I'd been in like crisis housing and stuff and been held on like physical wards, like general wards, er I hadn't actually been admitted to a psychiatric hospital until March last year (Int: uh-huh). And, em...Yeah, in terms of feeling unsafe, I, I had no idea what to expect. Erm...But I didn't expect what I found, like I didn't... I don't think anything could have prepared me for it, erm, because it was just chaos, like total chaos. And it was weird because usually when I've ended up in hospital and stuff in the past, like not psychiatric units, I've been like manic and stuff so I've not really been as conscious as to what's going on around me. However, that time when I was admitted I was depressed and I just kind of wanted to be left alone and just kind of not speak to anyone. Feel like crying all the time, but it was impossible to relax. It was impossible to kind of focus on getting better because of just the total chaos and like when I say chaos, I mean like for example....Uhm? Obviously they had their alarms and stuff, like personal safety alarms, and they would be going off pretty much all the time, erm... and then you just hear like 5 staff absolutely running down the corridor to wherever it was. Erm... I was on like, just to kind of set the scene, I was on a mixed sex, erm, acute ward with 18 beds. Typically run of the mill kind of erm psych ward stuff that isn't erm intensive care but erm, yeah, it it was just in terms of alarms going off all the time. People screaming all the time. People throwing things all the time. I would go out and I would try and interact with people because I... just being in my room all the time, it's bad for me. When I'd go out and try and interact with people, but then because everybody else was like really unwell, and I was unwell too, but it was weird because I didn't....I I kind of had almost a superiority complex in that I was thinking like I'm texting my friends and my family and being like I don't deserve to be here. I'm not like them, I'm just standard depressed. I'm not crazy'. And kinda need to get out of here, which on reflection is quite ableist, and also on reflection, I was that kind of crazy because I was quite, kind of like not as psychotic as some of the people there, but was definitely experiencing psychotic symptoms. However, I would go and I would try and interact with people and like for example, there's one woman who I started speaking to, started like yelling at me and shouting at me and trying to hit me because she was convinced that I had been having sex with her wife. And I was like, what? and then there was another time I was in the smoking area and this guy comes up to me and he's talking to me and he's telling me I'm like a government plan and that I'm one of the staff and that I'm spying on him. And I'm like, dude, I'm literally just trying to smoke erm, so that was really nerve wracking as somebody who'd never been in that situation before or had never been around people as unwell as I was, erm, just never had that interaction before so it was really. unsettling. But I think the thing that was the most unsettling was just the, the violence.

Appendix R: Initial Candidate Themes Example

Table of Initial Candidate Themes Created from Initial Codes

Name of Theme (number of participants' experiences included in the theme)	**Codes**	**Number of Ps included**
Not believed / epistemic injustice (8)	Not believed or trusted	7
	Epistemic injustice *renamed I'm not mad*	5
	Being believed helped	2
Feeling Persecuted and Trapped (8)	Trapped and Locked up	8
	Persecuted	7
	Controlled and complying	6
	Helpful - Freedom helps to reduce paranoia	4
	Making sense of admission in a paranoid way	4
Not knowing (8)	Lack of Communication	8
	Feeling confused	6
	Questioning reality	4
	Unsure of who people were	4
	Helpful - the previous admission helped with understanding	2
Lack of Relational Safety (8)	Can't trust staff	7
	I don't trust sus	5
	I don't trust the system	5
	Staff don't know	5
	Unsure of who you can trust	5
Lack of Care (7)	Feeling dismissed and ignored	7
	Staff don't care or want to help	7
	Judged by staff	6

Lack of physical safety (7)	Sus are dangerous	7
	Feeling unsafe on the ward	6
	Unsafe practice	6
	I am unsafe because of my identity	3
	Staff are Dangerous	3
Distance and Disconnect to Cope (7)	Keeping distance	5
	Disengaging to cope	4
	Kept suspicious thoughts to myself	4
	Wanting to be alone	3
	Wanting to lock self in room	2
	Wanting to move away from sus	2
	Locking door giving peace of mind	1
A Suspicious Mind (6)	Paranoia before admission	4
	Naturally on edge or mistrusting	3
	The paranoid mind	3
	Description of paranoia	1
Unusual Interactions (6)	Unusual SU behaviour	5
	Other SU paranoia	4
Left to sit in own illness (6)	Nothing to do	6
	Nothing to do - overthinking	4
	Routine and structure- helpful	3
	Lack of routine	2
Under skilled and Understaffed (6)	Understaffed	4
	Underskilled staff	3
Building Connection (6)	Connecting with Staff	5
	Connecting with sus Forcing self to socialise	4
Staff Care (6)	Staff attitude- kind and caring	6
	Staff taking an interest	6

Feeling intruded on by practice (5)	No privacy	4
	Observations feeling intrusive	3
	Feeling observed begin terrifying	1
	Staff coming into room when vulnerable	1
	Staff outside door feeling threatening	1
Paranoia linked to past trauma (5)		5
seeking support from friends and family (5)		5
Paranoia Valid (5)	Seeing notes	1
	Suspicion and paranoia valid	2
	Suspicion and paranoia validated	2
	Hard to disentangle paranoia vs rational fear	1
Having to rely on staff (2)	Having to ask staff for help	2
	Having to wait	2
	Having to trust staff	1
	Staff will protect me	1
A cold environment (2)	Cosy environment - helpful	2
	Clinical environment	1
Staff open communication – helpful (1)	Staff being honest - helpful	1
	Staff being transparent - helpful	1
	Staff communicating - helpful	1

*Previously named epistemic injustice node was renamed ‘I’m not mad’ since it seemed to be describing how people didn’t feel like they need to be in hospital and felt like everyone was seeing them as mad, when they felt like they were fine and didn’t need to be there.

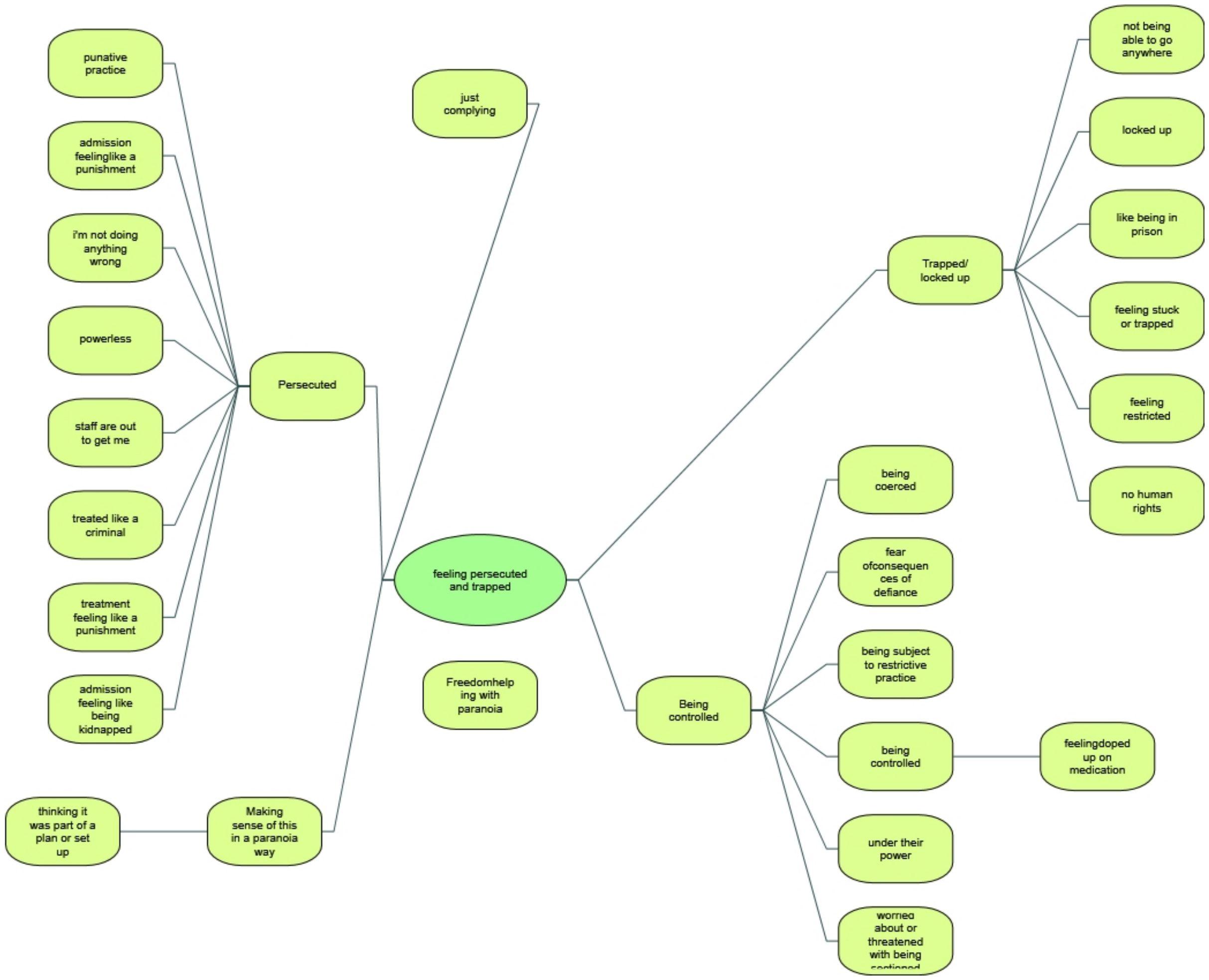
Appendix S: Example of Memos and Mind Maps Regarding Structuring of Themes and subthemes

Feeling trapped, controlled and persecuted (subtheme)

Here, I am putting ideas together about how the participants felt trapped, controlled and locked up, like they were in a prison, and also that it felt like they were being persecuted like it was intentional and like they were being punished

I wondered if being in seclusion should go into this theme, but, on reviewing the extracts, those related to seclusion seem to be talking about how there was nothing to do and they were left on their own, rather than seclusion feeling punitive or like a punishment

I thought about putting restrictive practice in here but when I look at the extracts, they are more talking about how that broke the relational safety of the ward environment, seeing that happen to other patients.



Appendix T: Excerpt from Reflective Research Journal: how candidate themes developed into main themes and subtheme

How 20 initial candidate themes became 5 main themes with 19 subthemes

The following themes were removed because they were not well represented across participants

- Having to rely on staff
- A cold environment

“Disbelieved, disregarded, and discarded” theme created with four sub-themes

1. Not believed and epistemic injustice
2. Feeling trapped and persecuted
3. Lack of care
4. Left to sit in own illness

“I don’t know what is happening” theme was created with three subthemes

1. Unusual interactions
2. Not knowing
    - ‘Staff open communication - helpful’ was added to ‘lack of communication’ within the ‘not knowing’ theme because it was evidence that this theme of not knowing leads to paranoia, and having open communication helped SUs to feel like they knew what was going on, and therefore felt less paranoid.
3. Questioning reality (this was separated out from the general not knowing theme as it seemed like a consequence of not knowing, and was important to the development of paranoid thinking)

“Lack of safety” theme was created with four subthemes

1. Lack of physical safety
2. Lack of relational safety

3. Feeling intruded on by practice
4. Underkilled and understaffed

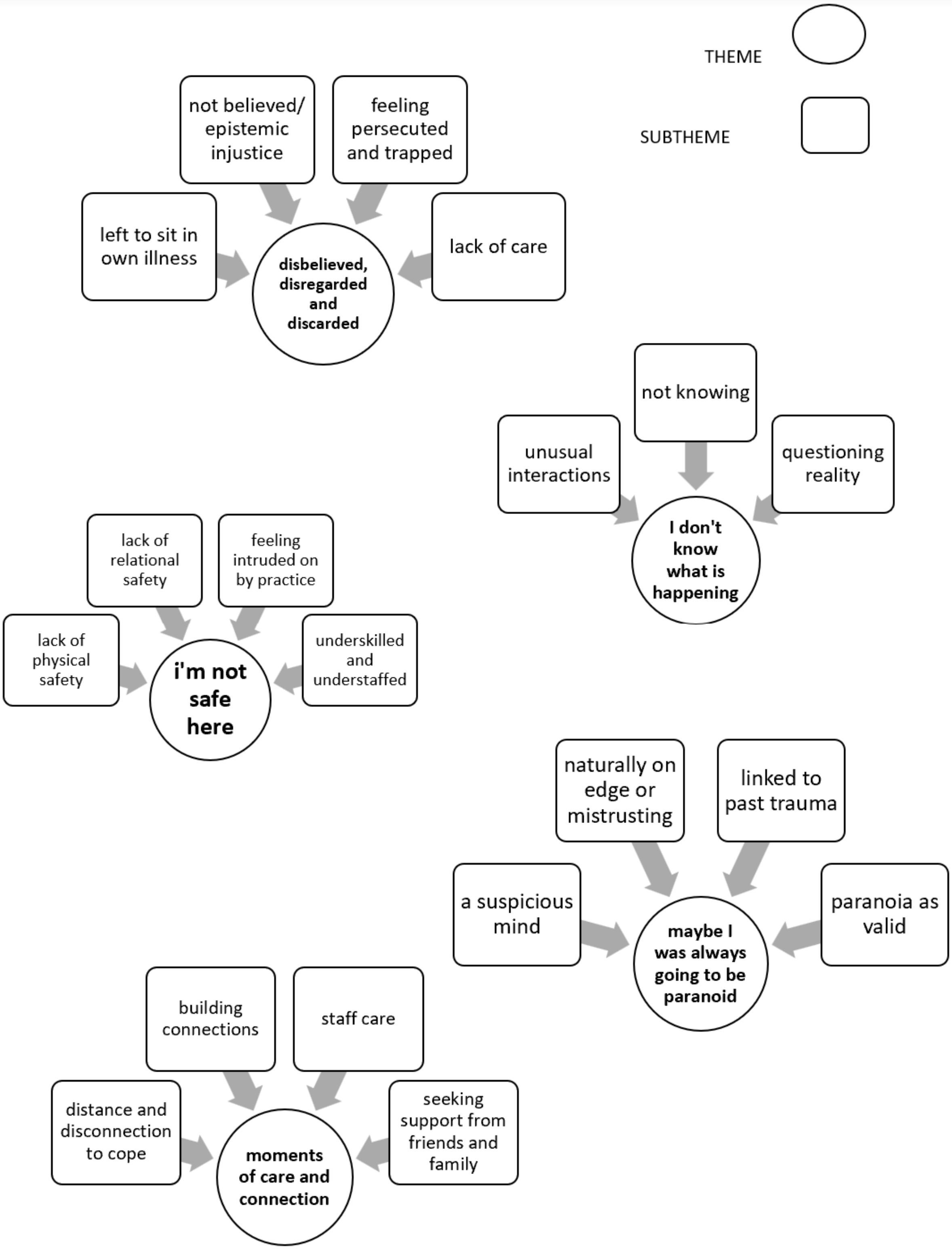
“Maybe I was always going to be paranoid” theme created with four subthemes

1. Paranoia linked to trauma
2. Naturally on edge or mistrusting
    - Naturally on edge needed to stand alone because of its explicit link to past experiences of abuse. It was then combined with paranoia linked to past trauma because people tended to feel naturally on edge as a result of past trauma.
3. Paranoia valid
4. A suspicious mind

“Moments of care and connection” theme was created with four subthemes

1. Disconnecting to cope
2. Connecting with staff and service users
3. Staff as kind and caring
4. Seeking support from friends and family

Illustration of initial 5 themes and 19 subthemes



How 5 themes with 19 sub-themes become 5 themes with 15 subthemes

Theme 1:

Disbelieved, disregarded and discarded – changed name to disbelieved, persecuted, stigmatised and discarded.

- Not believed/epistemic injustice – name changed to Not Feeling Believed: Epistemic Injustice
- Feeling trapped and persecuted – name changed to Feeling Trapped, Controlled and Persecuted
- Lack of care – name changed to Experiencing Staff as Judgemental and Uncaring
- Left to sit in own illness – name changed to Lack of Routine and Feeling Like There is Nothing to Do

I don't know what is happening – name changed to feeling unsure of what is going on.

- Unusual interactions – name changed to Paranoia-Inducing Interactions with other Service Users
- Not knowing and questioning reality merged (because questioning reality is a consequence of feeling confused and not knowing)– renamed Feeling Confused, Unsure and Questioning Reality

I'm not safe here – name changed to Experiencing the ward as an unsafe place to be

- Underskilled and understaffed removed because it was given as an explanation for why staff often didn't respond to risk issues, rather than being a reason for paranoia in its own right
- Feeling intruded on by practice – name changed to Feeling Violated by Ward Practices
- Lack of physical safety – name changed to Experiencing a Lack of Physical Safety
- Lack of relational safety – name changed to Experiencing a Lack of Relational Safety

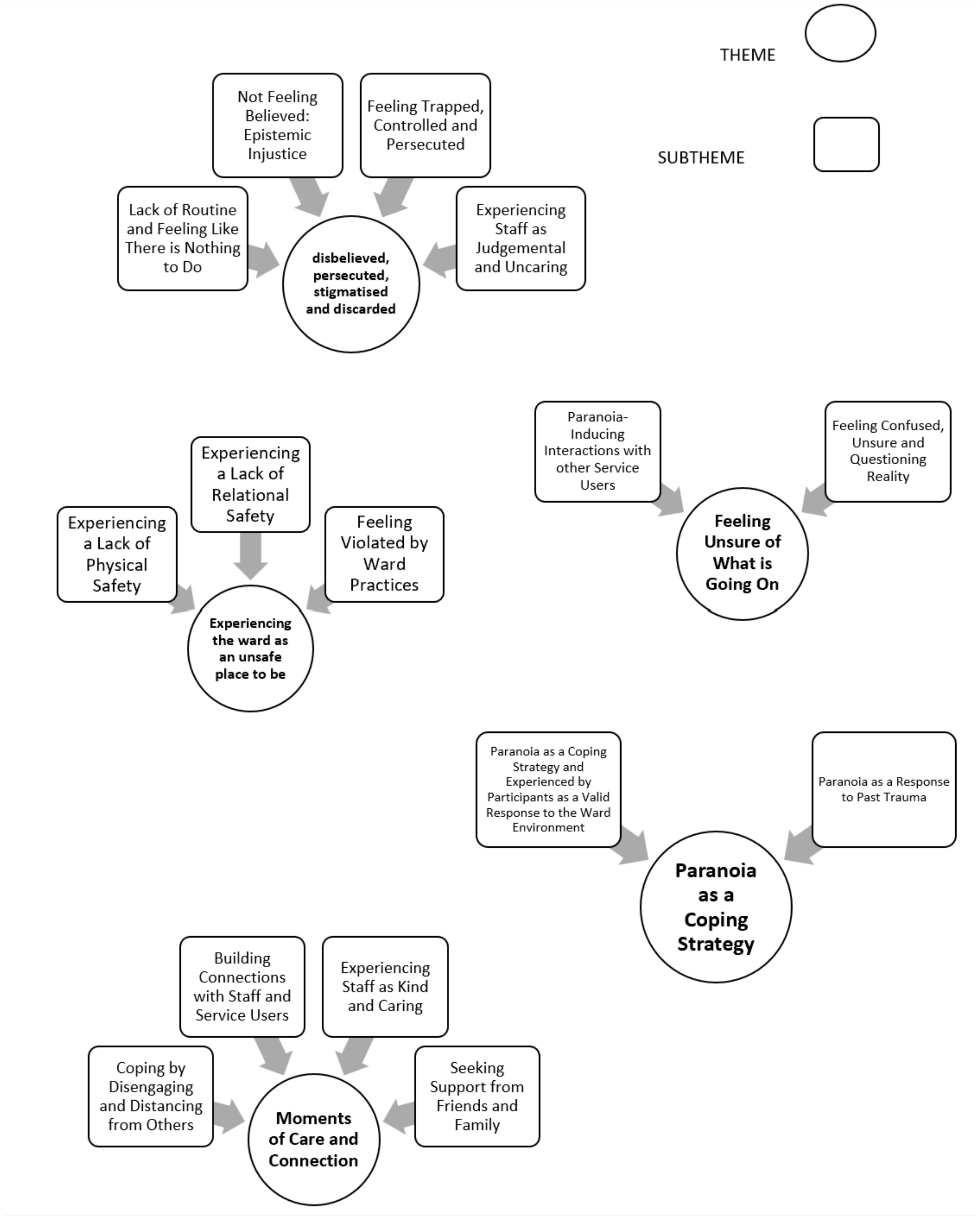
Maybe I was always going to be paranoia – name changed to Paranoia as a Coping Strategy

- A suspicious mind, and paranoia as valid merged into one new sub-theme called Paranoia as a Coping Strategy and Experienced by Participants as a Valid Response to the Ward Environment
- Linked to past trauma (incorporating naturally on edge) – name changed to Paranoia as a Response to Past Trauma

Moments of care and connection

- Distance and Disconnection to cope - name changed to Coping by Disengaging and Distancing from Other
- Building connections – name changed to Building Connections with Staff and Service Users
- Staff care – name changed to Experiencing Staff as Kind and Caring
- Seeking support from friends and family – thought about excluding this as it was not specifically related to the ward, however it felt important to illustrate that people's external worlds were still important within the context of the ward.

Illustration of final 5 themes and 15 subthemes



Example of reflection on the development of themes:

DISBELIEVED, PERSECUTED, STIGMATISED and DISCARDED

Incorporates the following subthemes:

- not believed and epistemic injustice
- feeling persecuted and trapped
- lack of care
- left to sit in own illness

I got a very strong sense that many people didn't feel like they needed to be in hospital, and this also set the scene for them to feel like they were not being believed by the ward staff. It feels like not being believed, which is also linked to epistemic injustice (being labelled as delusional when talking about their life experiences), leads people to feel trapped and persecuted. Many Ps spoke about the admission feeling like a punishment, and spoke of suspicion and paranoia related to being controlled and punished by staff and by the mental health system more generally. This is maybe compounded by the fact that people perceive judgements and a lack of care from staff. Many participants spoke about how 'the staff don't care', and felt like the staff were not there to help them but were instead there to control them. Originally, the 'lack of care' code was a stand-alone theme, however on reviving the extracts, it felt like the paranoia-inducing aspect of the 'lack of care' was related to experiences of feeling judged, punished, controlled and disbelieved by staff.

I decided to bring in the code of 'left to sit in own illness' because many Ps spoke about the impact of limited engagement from staff and limited activities meant that they tended to overthink things in a very paranoid way, and make sense of the lack of care they experienced or their admission in a suspicious and persecutory way.

The theme was originally named 'disbelieved, disregarded, and discarded' however this doesn't quite capture the subthemes because it misses out the experience of feeling judged by staff and perceiving the lack of care from staff. Decided to change the name to Feeling Disbelieved, Persecuted, Stigmatised and Discarded.

Development of PARANOIA AS A COPING MECHANISM

Originally incorporated the following sub-themes

- A suspicious mind
- Naturally on edge or mistrusting
- paranoia as a response to past trauma
- paranoia as a valid response to the ward environment

On reviewing this theme and the subthemes, it needed to be restructured in order to fully describe the data. It was talking about suspicion and paranoia before admission, and also about how people tended to enter into the environment already feeling on edge, and this was often linked to previous abuse and trauma they had experienced and was also used to cope with the uncertain environment.

Had previously decided that naturally on edge needed to stand alone because of its explicit link to past experiences of abuse. It was then combined with paranoia linked to past trauma because people tended to feel naturally on edge as a result of past trauma.

Some participants also got access to their notes after they were discharged and this meant that they saw what staff had been writing about them, which made them feel like the paranoid thoughts they had been having were correct, and they felt validated in some way. It felt important to incorporate this into the theme because in that sense, paranoia was viewed as a valid coping mechanism to deal with the chaotic and unsafe environment.

On writing up the analysis, I decided that ‘a suspicious mind’ did not quite work as its own subtheme, and the name was not reflective of the data – A suspicious mind was then pulled together with paranoia being seen as valid since participants were talking about how the context was feeding into suspicion they already had, and how the inpatient environment is always going to create paranoia because of the context and practices that occur there. This was then renamed into a subtheme of ‘paranoia as a coping strategy and seen as valid within the ward environment’.

This overarching theme was originally called ‘maybe I was always going to be paranoid’ because there was the sense that people might have already felt paranoid when they came into hospital, or felt like they were typically on edge and mistrusting and that contributed to them feeling suspicious and paranoid. Here, a lot of people made sense of the paranoia they may have already felt as being exacerbated by the ward environment. They often explained paranoia as a way of coping with the ward environment. However, they also noted that they already tended to be quite suspicious and on edge, and the environment made it worse. on looking at the data, it appeared that the context exacerbated any suspiciousness people already experienced, and therefore this was re-names as ‘paranoia as a coping mechanism’.

In the end, this theme only has two subthemes.

- paranoia as a response to past trauma
- paranoia as a coping strategy and a valid response to the ward environment

Appendix U: Table and Description of Themes and Subthemes

Table X. Table of Themes and Subthemes

Theme	Subtheme	No. of participants represented
"The whole system is sort of geared towards making people paranoid": Feeling Disbelieved, Persecuted, Stigmatised and Discarded		
	Not Feeling Believed: Epistemic Injustice	8
	Feeling Trapped, Controlled and Persecuted	8
	Experiencing Staff as Judgemental and Uncaring	7
	"Being Left to Sit in Your Own Illness": Lack of Routine and Feeling Like There is Nothing to Do	6
"It was just so confusing": Feeling Unsure of What Was Going On		
	Feeling Confused, Unsure and Questioning Reality	8
	Paranoia Inducing Interactions with other Service Users	6
"I felt completely unsafe": Experiencing the Ward as an Unsafe Place to Be		
	Experiencing a Lack of Physical Safety	7
	Feeling Violated by Ward Practices	5
	Experiencing a Lack of Relational Safety	8
"It's like a survival mechanism going a bit haywire": Paranoia as a Coping Strategy		
	Paranoia as a Response to Past Trauma	5
	Paranoia as a Coping Strategy and Experienced by Participants as a Valid Response to the Ward Environment	8
"We're All Human and We All Need That Sort of Connection": Moments of Care and Connection		
	Coping by Disengaging and Distancing from Others	7
	Building Connections with Staff and Service Users	6
	Experiencing Staff as Kind and Caring	6
	Seeking Support from Friends and Family	5

“The whole system is sort of geared towards making people paranoid”: Feeling Disbelieved, Persecuted, Stigmatised and Discarded (theme)

This theme describes the relationship between being sectioned against one’s will, not being believed and the impact of epistemic injustice and feeling trapped, persecuted and controlled, all leading to suspicion and paranoia about staff intentions and the reason for admission. The theme also encompasses how perceiving staff to be making judgements about them and being uncaring left participants feeling like they were locked up and forgotten about with nothing to do but ruminate on their experiences which increased paranoid thinking.

Not Feeling Believed: Epistemic Injustice (subtheme)

Participants who were on section and in hospital against their will generally didn’t believe that they should have been in hospital at the time and felt mistrusted or not believed by staff. This was often felt in relation to ‘epistemic injustice’, and more specifically testimonial injustice, where they were not believed simply because they were deemed untrustworthy due to their position as a patient on the ward. The result of this meant that they often felt like they could not trust staff and felt paranoid about the potential for abuse. This subtheme also includes how being believed helped one participant to feel safe and helped her not feel paranoid within the inpatient environment.

Feeling Trapped, Controlled and Persecuted (subtheme)

This subtheme described how the participants who didn’t believe they should be in hospital often felt trapped and imprisoned which put them on guard and led them to feel paranoid and persecuted by staff and the mental health system more generally. They often made sense of their admission in a paranoid way which led them to believe that the purpose of admission was to control and/or punish them. This subtheme also includes how moments of freedom helped to lessen experiences of paranoia.

Experiencing Staff as Judgemental and Uncaring (subtheme)

Participants often felt that staff were passing judgements about them, seeing them as ‘attention seeking’ or ‘dangerous’. This also encompassed experiencing staff as uncaring, with many perceiving that staff did not want to talk to service users which often led participants to feel like the staff members did not want to help them. This often led participants to feel dismissed or ignored, and therefore could not trust staff and felt paranoid and suspicious of their intentions.

“Being Left to Sit in Your Own Illness”: Lack of Routine and Feeling Like There is Nothing to Do (subtheme)

This sub-theme describes how many participants reported that there was nothing to do on the ward and with limited care and engagement from staff, they felt like they were simply left to their own thoughts and started to over-analyse and ruminate about what was going on around them in a paranoid way.

“It was just so confusing”: Feeling Unsure of What Was Going On (theme)

This theme describes how participants tended to feel paranoid in response to feeling confused, unsure of what was going on and having unusual and paranoia-inducing interactions with other service users.

Feeling Confused, Unsure and Questioning Reality (subtheme)

This subtheme incorporates all of the ways in which participants felt confused and unsure about what was going on around them. This related to ‘finding it hard to remember’ perhaps because of high levels of distress they were experiencing or because they were highly medication. It also relates to a perceived lack of communication from staff about ward practices such as medication and side effects, the rationale for observations, when ward round would be, and how long their admission would last. This confusion sometimes led participants to question the reality of what was happening because their experiences and perceptions sometimes did not feel real and, as a consequence, they started to question their own credibility and memory. Participants tended to make sense of the unknowns in a paranoid way, perhaps because they already felt trapped and persecuted in the ward environment.

Paranoia-Inducing Interactions with other Service Users (subtheme)

This subtheme describes how paranoia-inducing interactions with service users, such as other service users sharing paranoid thoughts, led to experiences of suspicion and paranoia. These unusual interactions often led participants to feel confused and suspicious about what was happening. Additionally, participants were often left feeling paranoid after these interactions because the paranoid ideas of others tended to instigate suspicious ideas for the participants.

“I felt completely unsafe”: Experiencing the ward as an unsafe place to be (theme)

This theme illustrates the common experience of feeling unsafe on the ward which led participants to feel paranoid about staff and other service users. The lack of safety was spoken about in multiple ways and was conceptualised in terms of experiencing a lack of physical safety, feeling violated, and a lack of relational safety.

Experiencing a Lack of Physical Safety (subtheme)

This subtheme describes the lack of physical safety on the ward. This includes viewing staff as unsafe due to experiences of staff aggression, witnessing chaos on the ward, and seeing other service users subjected to coercive practices such as forced medication and restraint. This also encompassed feeling vulnerable to physical attack due to aspects of their identity such as gender, age and ability. This lack of physical safety was often compounded by being the victim of violence from other service users, all of which led participants to feel wary and paranoid about their physical safety.

Feeling Violated by Ward Practices (subtheme)

This subtheme relates to how participants experienced common ward practices, such as 1:1 observations, as intrusive and often felt like there was a lack of privacy and felt violated as a result. Participants often described feeling watched and studied. This also included how staff coming into a participant's room led to feelings of vulnerability.

Experiencing a Lack of Relational Safety (subtheme)

This subtheme describes how participants often experienced a lack of relational safety, defined as not knowing who they could trust, and finding it difficult to trust other people. Often, participants felt like they could not trust staff because of unusual and paranoia-inducing interactions with staff which made them feel like the staff did not want to help them. This also speaks to the common reports of participants believing that staff were lying about occurrences that happened on the ward and the difficulty that participants had in trusting what staff were saying about them to other members of staff or the psychiatrist. This subtheme also describes the experience of finding it hard to know which fellow service users they could trust, often because they did not know the background or history of new service users. Overall, there was a sense that there was mutual distrust, leading to high levels of paranoia and suspicion.

“It’s like a survival mechanism going a bit haywire”: Paranoia as a Coping Strategy (theme)

This theme describes how participants often felt like the paranoia they felt was a way of coping with the unusual and unsafe environment. Participants spoke about how their past experiences of past abuse meant that they were perhaps more mistrusting on admission, and the ward environment tended to exacerbate this and lead to paranoia, which was often seen as a valid response to what was happening on the ward

Paranoia as a Response to Past Trauma (subtheme)

This sub-theme related to how participants often made sense of their experience of paranoia. Experiences of past trauma often meant that participants were more on edge and wary of the ward environment. Additionally, paranoia was exacerbated paranoia in the context of the ward environment because they were reminded of past abuse and trauma. The paranoia-inducing experiences on the ward often led participants to feel similar to when they were being abused and mistreated in the past or as children, leading them to feel increasingly mistrustful of the ward environment and staff who were there to help.

Paranoia as a Coping Strategy and Experienced by Participants as a Valid Response to the Ward Environment (subtheme)

This subtheme describes how paranoia was often a coping mechanism used to deal with the uncertainty and lack of safety on the ward and relates to how hard it was for some participants to disentangle what was paranoia and what was rational fear. Some participants requested access to their notes after discharge and, once they received their notes, they felt like their suspicions and paranoia had been correct. This subtheme also speaks to the fact that many service users felt like the paranoia they felt was valid within the ward environment that they perceived as dangerous and unsafe.

"We're All Human and We All Need That Sort of Connection": Moments of Care and Connection (theme)

This theme explores how participants managed experiences of paranoia on the inpatient ward and aspects of the ward environment that helped to prevent, counter or reduce feelings of paranoia. Many participants described initially wanting to disengage from the staff and service users around them and keep to themselves. However, a key factor that allowed participants to feel safer, less suspicious and less paranoid were moments of care and connection with staff and fellow service users. This theme also encompasses how a connection with their external support networks such as friends and family allowed participants to feel grounded and supported during their admission.

Coping by Disengaging and Distancing from Others (subtheme)

Many participants spoke of wanting to lock themselves in their room and described coping with paranoid experiences by withdrawing and limiting interaction with staff and service users. Despite this, there was also the sense that participants knew that this was somewhat detrimental to their mental health and I often meant that participants did not tell about the paranoia they were experiencing.

Building Connections with Staff and Service Users (subtheme)

There was a strong sense that participants' paranoia decreased over the time of the admission and many participants described meaningful moments of connection which helped to ease distressing and paranoid experiences. These included things such as getting to know staff members, doing activities with other service users, and making friends, which allowed them to let their guard down and start to build trust and a sense of community with staff and fellow service users.

Experiencing Staff as Kind and Caring (subtheme)

This subtheme describes how, when participants experienced staff as showing a level of care and interest towards them and other service users, they felt less paranoid, and generally felt safer and looked after. This included feeling understood, feeling heard and listened to, staff being attentive and taking the time to talk.

Seeking Support from Friends and Family (subtheme)

Feelings of paranoia and suspicion about the ward environment often meant that participants sought support from outside of the hospital environment. While some participants spoke of wanting to keep their family at a distance during the admission, many spoke about how maintaining connection with friends and family helped them to feel less paranoid and connect with ‘normality’ and have their feelings validated by people who care about them. Additionally, participants spoke about how speaking with trusted friends and family helped encourage them that the admission could be for the best.

Appendix V: Description of Spencer and Ritchie's (2011) Quality Assurance Guiding Principles

Contribution

this principle relates to how the study has contributed to the relevant literature, for example how current knowledge has been extended, wider inference and discussion of the wider contribution to policy, practice and research.

Credibility

This principle relates to how believable and well-founded the findings are, such as how the qualitative evidence in the form of quotes supports the conclusions of the analysis, the plausibility of the findings, and what form of validation has been attempted.

Rigour

This principle is related to the transparency of the research process and defensibility, for example through a well-documented and reflexive analysis process, adoption of appropriate methodology and discussion of ethical issues.