

Lenus: Research Repository



Within the Walls: Experiences of Admission to Psychiatric Hospital in Ireland Prior to 2001.

Item Type	Journal Article;Article
Authors	Graham, Clare;Webster, Anthony;Guerin, Suzanne;Gaynor, Keith
DOI	10.1111/inm.70123
Download date	2026-05-20 22:14:19
Item License	https://creativecommons.org/licenses/by/4.0/
Link to Item	https://hdl.handle.net/10147/646894

ORIGINAL ARTICLE OPEN ACCESS

Within the Walls: Experiences of Admission to Psychiatric Hospital in Ireland Prior to 2001

Clare Graham¹ | Anthony Webster² | Suzanne Guerin¹ | Keith Gaynor^{1,3} ¹School on Psychology, University College Dublin, Dublin 4, Ireland | ²Trim Adult Mental Health Service, HSE, Navan, Ireland | ³DETECT, Early Intervention in Psychosis Service, Blackrock, Ireland**Correspondence:** Keith Gaynor (keith.gaynor@ucd.ie)**Received:** 27 February 2025 | **Revised:** 17 July 2025 | **Accepted:** 24 July 2025**Funding:** This study was supported by Health Service Executive.**Keywords:** inpatient | interpretative phenomenological analysis | lived experience | mental health act | serious mental illness

ABSTRACT

There has been a dramatic shortage of patient-focused research in the history of psychiatric inpatient treatment. This study aimed to explore the lived experience of a sample of inpatients of psychiatric hospitals in Ireland before the introduction of the Mental Health Act in 2001. Six adults (aged 40–73 years; $M = 57$) who had been inpatients in Irish psychiatric institutions were interviewed using a semi-structured format. The data were analysed using interpretative phenomenological analysis. The analysis yielded four Group Experiential Themes (GET): Within the Walls, the Treatment of Treatments, Relationship with Self and Identity as Patient, and Relationships and Ruptures. Each GET comprised two subthemes exploring the impact of participants' admission to a psychiatric hospital. Participants described a complex and ambivalent relationship to their psychiatric admission. The findings emphasised the need to understand the individuals' experiences and the societal and cultural context in which the admission occurred. The findings highlighted how historical psychiatric admissions impacted social identity and wellbeing. The findings have direct clinical implications. This cohort is aging and may require inpatient services in the form of nursing home care. For those who have experienced long-term psychiatric institutionalisation, it is important to tailor support for this group whose voices have not been heard until now.

1 | Introduction

A small number of previous publications (Finnane 1981; Kelly 2016; Prior 2017) have considered the history of psychiatric treatment and care in Ireland, typically from an institutional or clinical perspective. Psychiatric institutions and their residents were often kept at a distance, on the outskirts of a town, on the periphery of society (O'Morain et al. 2012), with residents often excluded from family life (Cusack 2021; Prior 2017).

In the 1950s, Ireland had the highest global rate of psychiatric bed utilisation, reaching a peak in 1956 when 0.5% of the population on the island of Ireland (21 720 people) were inpatients (Brennan 2017). In line with the international

de-institutionalisation movement (Fakhoury and Priebe 2002), a key Irish policy reform was the 2001 Mental Health Act (Prior 2017). The Mental Health Act (2001) was tasked with protecting and safeguarding the civil rights of persons who engage with mental health services, with a specific focus on reducing long-term psychiatric admission and increasing treatment in the community.

In this context, little is known about the psychological experiences of patients who spent time in psychiatric institutions prior to the Mental Health Act (2001). A patient's appraisal of their mental health care, including time in inpatient psychiatric care, is recognised as an important outcome in their ongoing recovery. Murphy et al. (2017) conducted a qualitative study of

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial-NoDerivs](https://creativecommons.org/licenses/by-nc-nd/4.0/) License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2025 The Author(s). *International Journal of Mental Health Nursing* published by John Wiley & Sons Australia, Ltd.

participants after their discharge from the hospital after an involuntary admission. While identifying some positive aspects of involuntary admission, participants identified several factors that harmed their psychological well-being, including a sense of 'disempowering and controlling practices', 'feeling uninvolved in decision making', a 'lack of accessible information' and 'emotional support'.

Satisfaction with care has been linked to increased compliance with treatment, and an increased likelihood of completing treatment regimens (Bleich-Cohen et al. 2009; Henderson et al. 1999; Williams and Wilkinson 1995), while dissatisfaction has been found to increase the likelihood of service users disengaging from, and failing to complete, treatment programmes (Henderson et al. 1999). Dissatisfaction is particularly problematic for those who are involuntarily detained (Woodward et al. 2017) and involuntary admission can reduce treatment motivation and the building of positive therapeutic relationships (Fiorillo et al. 2012).

Women's experience is of interest within the wider inpatient population, specifically mothers. Women were admitted for psychiatric care marginally less than men (Daly and Craig 2021; Kelly 2016), but at the same time, women who are psychiatric patients are more likely than their male counterparts to have children (Banerjee et al. 2021). Perinatal mental health issues can have profound negative consequences for the mother, the infant, and the wider family (Huschke et al. 2020). In the UK and Ireland, suicide is the leading cause of maternal death in the first year after pregnancy (Knight et al. 2018), suggesting that mothers living with mental illness require specialist support (Banerjee et al. 2021).

1.1 | The Present Study

Published works on psychiatric care in Ireland before 2001 have focused on the memories or perspectives of medical staff (Finnane 1981; Kelly 2016; Prior 2017). Kelly (2016) highlighted a dearth of patients' voices, describing this perspective as 'astonishingly distant and frequently inaudible to today's historians' (p. 7). This exploratory study seeks to understand the lived experience of people who spent time in a psychiatric institution in Ireland prior to the Mental Health Act (2001).

A core theoretical framework for the study is social identity theory (SIT, Tajfel 1978; Tajfel and Turner 1986), which considers individual behaviour and how it is influenced by group membership. This is of crucial importance to inpatients in a psychiatric setting as they find themselves in an environment where many elements of their identities, their membership of family, community, teams and organisations, are outside of the hospital. Critically, in conditions of threat or conflict, social identity becomes more salient than personal identity, resulting in behaviour where people evaluate the situation to maximise inter-group connection (Hogg and Terry 2000).

The present study aims to develop an understanding of the experience of being an inpatient in a psychiatric hospital by asking the question: What were participants' experiences of admission to a psychiatric hospital in Ireland prior to 2001, with a particular interest in identity and social context?

2 | Method

2.1 | Research Design

As there is little research on patients' accounts of time spent in psychiatric hospitals before 2001, an exploratory, qualitative approach was chosen for the current study. An interpretative phenomenological approach (IPA) was chosen to capture the participants' lived experience in the psychiatric hospital. IPA focuses on lived experience and how individuals make meaning of their personal and social world, drawing upon fundamental principles of phenomenology, hermeneutics and idiography (Pietkiewicz and Smith 2014). It aims to generate rich and detailed descriptions of an individual's subjective experience of the phenomena under investigation.

In developing and implementing the research, while there was no specific public patient involvement (PPI) element to the research, the researchers drew on prior qualitative research on lived experience in institutional settings and the clinical experience that research team members have had over several decades working with individuals who had these lived experiences.

2.2 | Participants & Recruitment

The study aimed to recruit people who had spent time as inpatients in psychiatric institutions in Ireland prior to the MHA (2001), with the additional inclusion criterion that they were currently receiving mental health treatment from the community mental health team. A purposive sampling approach was used, with recruitment supported by community mental health teams and advertisement of the study in health settings. Individuals who expressed an interest and were deemed clinically suitable by the treating team were provided information on the study and invited to contact the research team. Clinical suitability required that individuals were not in an acute mental health crisis and were emotionally and behaviourally stable enough to engage with the research process. Individuals also needed to demonstrate the capacity to provide informed consent, which included a clear understanding of the study's aims, procedures, potential risks, and their right to withdraw at any time. Informed consent was obtained from all participants prior to conducting the interview.

Participants were a mixed-gender sample of six former patients of psychiatric hospitals (M=2, F=4), ranging in age from 40 to 73 years (Mean = 58). All the participants had spent time in psychiatric hospitals prior to 2001, with a minimum of three admissions per participant. Three participants were unsure of their number of admissions; therefore, the mean could not be calculated. Table 1 reports key characteristics of participants, including pseudonyms used in reporting the findings.

2.3 | Data Collection

Smith et al. (2009) recommend that semi-structured interviews be used to conduct phenomenological studies, focusing on eliciting rich and detailed first-person accounts of participants' experiences in a psychiatric hospital. A semi-structured interview schedule (see [Supporting Information](#)) was devised

TABLE 1 | Characteristics of participants.

Participant pseudonym	Gender	Age at interview	Approx. age at first admission	Approx. no of admissions to psychiatric hospital
Casey	F	74	17 years	At least 5
Ger	F	53	27 years	3 or 4
Alex	F	62	19 years	3
Sam	F	39	17 years	4
Frankie	M	66	25 years	Unsure, 4?
Jo	M	59	22/23 years	Unsure, 5?

based on previous literature, questions of interest to the current project, and consultation with the community mental health treatment team. Interviews were conducted at the community mental health site or in participants' homes and ranged from 30 to 69 min. Upon conclusion of each interview, participants were debriefed. The researcher conducted each of the six interviews, which were audio recorded and then transcribed verbatim. Each of the six participants was offered the opportunity to review their transcripts.

2.4 | Data Analysis

Data were analysed according to the principles of IPA across three broad stages in line with Smith et al. (2009). The first stage involved multiple readings of the raw data, documenting notes on descriptive and linguistic aspects of the content, and detailing initial interpretative comments. The second stage involved moving toward an increased level of conceptualisation to transform notes into emergent themes. Each interview was analysed in isolation to allow for impartiality in developing themes. The final stage was characterised by the collation of group experiential themes (GET) and subthemes, and involved looking for connections across themes and clustering them together according to conceptual similarities. Finally, each cluster was assigned a descriptive label which captured the core meaning of the included GETS and subthemes. Although not a part of classical IPA, GETS have been used in IPA methods in group settings. They typically refer to higher-order themes developed after analysing individual cases to organise cross-case analysis, helping to reflect shared experiences while still honouring individual nuance.

To ensure transparency and plausibility of the analysis, a second researcher reviewed the process from the interview schedule to the write-up. The two researchers engaged in a joint reflective dialogue throughout the process to ensure this was applied in a systematic manner, adhering to IPA's commitment to ensure the trustworthiness of the interpretative account (Smith et al. 2021). Participants' names and other identifying information were changed to protect confidentiality.

2.5 | Reflexivity and Rigour

The role of the researcher plays a significant part in the entire process of IPA. Throughout this research project, the researcher

engaged in self-reflection through journaling and used space in supervision to debrief following interviews. When considering personal characteristics (age, gender, educational status), the primary researcher had differences from the majority of the participants. She is of a similar age to one participant. The researcher was aware that being positioned as a clinical training psychologist may have led to preconceptions by the participants that her role may have been as a team clinical psychologist, and she endeavoured to address and clarify her research role. Prior to this, her training in clinical psychology and humanistic psychotherapy likely influenced how she engaged with participants throughout the interviews, likely with a more therapeutic stance than if a nonclinical researcher had conducted the interviews. However, she has never spent time in a psychiatric institution, nor have any of her direct family members. Psychiatric institutions have received much media attention over the last decade, and she was aware of the potential for interpretation of the data to be influenced by this wider narrative.

2.6 | Ethics Statement

Ethical approval was awarded by Louth/Meath HSE and University College Dublin Regional Ethics Committees. Before indicating their intent to participate, interested individuals were afforded appropriate time and opportunity to make an informed decision regarding participation. Due to the potential for distress in recounting their experiences, a distress protocol was designed with support from members of the community mental health team.

3 | Results

The analysis of participant interviews yielded four GET, each with two subthemes presented in Table 2.

3.1 | GET 1: Within the Walls

The theme within the walls describes how it felt to live in an environment looking out at the walls and the experience of each participant trying to make meaning and find purpose in each day spent in the institution. The theme also looks at the interaction of societal and cultural norms throughout this time. The experiences of living within the walls of the psychiatric institution permeate each of the subthemes identified.

TABLE 2 | Table of GETs and subthemes.

Group experiential theme	Subtheme
Within the walls	The walls – confining or containing?
	Finding meaning and purpose in each day
The treatment of treatments	Medication: This will clear your mind
	Electroshock treatment
Relationship to self and identity as patient	Loneliness and connection
	Why am I here?
Relationships and ruptures	My family and me
	The loss of the act of mothering

Reflecting the subtheme The walls—confining or containing?, Sam and Frankie viewed the institution as an environment they wanted to escape. For example, Frankie reported, ‘I broke out three times ... it was the Guards [police] who brought me back ... I thought I’d never get out’. While neither spoke of being against their admission, or at least did not report any objection to it at the time, they both saw the institution as a place they sought to escape. How this was approached and dealt with was illustrated in the following quote from Sam:

I was constantly trying to run out. I didn’t want to stay. I was just trying to go, go, go...constantly trying to escape...they just grab you back in if you were pushing and pushing too much, they’d put you back in isolation... You’re not allowed out because you’re being unreasonable.

In contrast, Alex and Jo describe the walls in a different way, viewing the walls and the institution as a place they needed to be, a place that was containing for them at that time in their lives. While Alex did not want to leave (‘I did not want to leave... did not want to open that door and go... [even for] a cup of coffee with my mother, no, I didn’t want to leave there’), Jo’s desire to remain seemed linked to fear of relapse, saying:

I knew in my own mind I won’t go now ‘cause I could get a relapse. I’ll stay now ... And I don’t want to come out with anything bothering ya. I was getting a rest. Doing too much. It was nice going in... Ah no, but I was looked after very well.

It was noticeable to the researcher that across participants there appeared to be no understanding of duration of admission. The silence around the duration of admission may be an important factor in feeling contained.

Further illustrating the GET, the subtheme Finding meaning and purpose in each day reflected the impact of the institutional structure, or lack thereof, each day. Frankie and Casey

reported being given some jobs to do. In Frankie’s case these jobs did not seem to be offered in a structured or predictable routine, however Casey reported a role as part of a routine that was done daily, saying ‘You got up and you had to make all the beds in the whole place. Those would have been 100 beds, but we had to make them all’. Other participants reporting the lack of activities, ‘you would see a doctor and they go through things with you a couple of times a week, and then it was just... moped around... There wasn’t really anything’ – Alex. Each participant highlighted their time on their own and recollections of activities, including OT and physical therapy, which varied across each participant, admission and institution. What was consistent was that the lack of structure in each admission may have contributed to difficulty in re-integrating into relationships, work and life outside of the institution.

3.2 | GET 2: The Treatment of Treatments

All participants spoke of their experience of receiving medication, which is central to psychiatric care. The participants’ relationship with treatment in psychiatric hospitals was a complex one. Similar to the confining or containing subtheme above, there were differing views of how treatments received are now framed.

The subtheme Medication – ‘This will clear your mind’ represents a metaphor used between doctors and patients in describing medication’s impact on psychiatric illness (Rhodes 1984) and reflects participants’ relationship to medication and treatment. The participants captured this as a complex relationship. Alex described how staff ‘drugged me to the eyeballs’, while Sam spoke about medication as something that was ‘needed’:

When you’re first in hospital, they just throw medication at you because you need to be ... because you’re confined in an institution ... So they do need to heavily medicate you for you to first get out of the cycle of being unwell. The being erratically unwell.

Casey described not questioning the medications, saying ‘I never complained or anything else’, while Jo described an evolving relationship with treatments, and particularly with medication: ‘I was put on tablets and I wouldn’t take them (prior to admission)...and [then in hospital they] put me on medication, tablets which were hard to get used to that time’. While there seemed to be some consensus among participants that medication was a very necessary part of their recovery, there were differing views of the role of medication in their present-day lives. This may speak to their reflections on how they were offered or told what the right treatment was for them.

Perhaps the subtheme with the most consistent narrative is that of electroconvulsive therapy (ECT), or electroshock treatment, as participants labelled it. Three of the six participants interviewed received ECT, which was discussed with one other but never carried out. The descriptions of all three participants are of a difficult experience, as captured in a quote by Casey:

Then they put me down for electric shock treatment. And they gave me one shock. And I remember waking up, I didn't know where I was. I didn't know who I was. I didn't know a thing. So, they didn't give me any more of that either.

Reflecting on all treatment options available, Jo holds a strong belief that it should not be part of any psychiatric treatment:

They shouldn't have got the shock, they should have went on tablets ... nearly a year to get it out of your system after it...you can't bring back when it's done ... If I'd to do it again I would destroy them before they gave it to me, I would.

Finally, Alex described ECT as the most frightening aspect of psychiatric treatment, needing to have the support of a family member in the treatment decision:

I said, I do not want electric shock treatment. Do not do it to me. So, I got Mammy, a grown woman, because my voice wasn't being heard, and I got Mammy to write a letter saying and stating that I did not want electric shock treatment. And as the guardian, she wouldn't agree to it. That was the only way around that one. And that way I felt safe then.

The fear that Alex captures in response to being offered ECT echoed that of other participants. The disjointed nature with which people spoke about it was striking throughout the interviews when ECT came up. Sentences would trail off, or thoughts about it would return later. Jo also struggled to talk about ECT clearly or calmly, but thoughts on ECT came out throughout the interview. The researcher noticed a reluctance in participants to speak in detail about ECT, which may relate to very difficult memories of this experience or a lack of memory about the process.

3.3 | GET 3: Relationship With Self and Identity as a Patient

Participants described experiencing solitude, isolation and difficulty in trying to see and understand themselves as psychiatric patients. The weight of this and the challenge of making sense of this part of their lives in the development of their relationships to others and themselves was apparent throughout each interview. This theme explores participants' sense of their relationship with themselves while in psychiatric care, as well as their understanding.

The subtheme Loneliness and connection explores participants' individual experiences of being in psychiatric hospitals. All participants had multiple admissions, all were in open wards during these times and some reported being, at least sporadically, part of groups for occupational therapy, physical therapy or jobs within institutions. Some participants spoke quite explicitly about the loneliness they felt while in psychiatric institutions, as

illustrated by Ger's comment: 'It was quite lonely, actually. Yeah, it was quite lonely. A lot of the days I sat at the table'. Later on, Ger also referred to other patients and the lack of relationship with them, saying 'They were there, but they weren't really people that I associated being in'. Frankie shared that, while alone most of the time, there were others there with whom he felt a sense of similarity, but despite 'playing pool sometimes' he never formed any connections: 'I was on my own a lot of the time. A lot of people like me'.

Alex spoke of loneliness also and developed this by referencing how she viewed herself as a psychiatric inpatient, even in a situation with many others in a psychiatric institution saying, 'we kind of kept to ourselves ... I was terribly embarrassed, and I felt like a failure because I was in a psychiatric hospital ... And then there was the stigma, "she's in a psychiatric hospital"'. All participants highlighted the barriers to forming connections with other patients while in psychiatric care. The feeling that this is a group of which the participants did not want to be a part is made evident in Ger's quote, 'they weren't people that I associated being in'. When Alex speaks of the stigma she felt of being in a psychiatric institution and how she may be viewed, it offers insight into how she or any of the participants may have carried this stigma.

Reflecting a further element of this GET, the second subtheme asked why am I here? Each participant expressed some level of uncertainty as to why they were in a psychiatric institution. Two participants reported not knowing exactly what it is they were being treated for, while one reported they received a diagnosis many years ago. However, it had changed based on a private psychiatric assessment. There remains a broad variance in each participant's engagement with their diagnosis or understanding of their need for psychiatric admission. What was apparent across participants was the adoption of the role of a patient who does not question the system's authority over whom they are treated or how their diagnoses are explained to them. Ger described how 'it got hard to figure out what exactly was wrong...he (treating psychiatrist) said there was a form of psychosis'. Alex reported feeling as if she had been labelled while in psychiatric care, saying 'I just got tagged and that was it. And you just take these tablets. That's it', going on to say, on reflection, she was unsure and lacked confidence as to how to ask these; 'You didn't really have a voice. Yeah. You didn't have a voice'.

A sense of not understanding what is happening to your mind and body during psychiatric difficulty, coupled with a sense of not understanding the treatments being offered, was pervasive throughout the development of this theme. The identity of the patient seems to be intertwined with an experience of not being able to question, challenge, or truly reach an understanding of what will support everyone's recovery.

3.4 | GET 4: Relationships and Ruptures

As part of the final GET in this analysis, all participants spoke about their family of origin and their family's understanding of mental illness. The importance of these relationships, whether they were viewed as positive or negative, supportive or not by

participants, was paramount. In discussing familial relationships, participants did so in a societal and cultural context.

As part of the subtheme *My family and me*, Frankie and Casey both described the ruptures experienced within their respective families as a result of having a family member admitted to a psychiatric institution. Frankie shared that the same year he was first admitted to a psychiatric institution, he had a brother who had committed suicide and also recalled that after each bout of ECT he received, 'I wake up, my mother and father would be there, my family'. Besides these times, Frankie reported his family did not visit. This may have been reflective of how his family approached, discussed and processed mental health difficulties throughout the years. Casey described her mother and father as seemingly being at odds about her treatment. When Casey once fled the psychiatric institution and made her way home, her father accepted her home. However, after a visit from the priest who Casey remembered as not stating she had to return, Casey said 'the strangest thing, mammy put me out on the road that night in the pitch dark to go back, so I had to thumb a lift back in the dark'. Casey's description speaks to a common occurrence among patients of psychiatric institutions in the 20th century; once admitted, families frequently did not accept their children or family members home (Kelly 2016). Each of the participants' experience of mental health difficulty in a family context speak to a lack of a shared and safe language to begin to process and repair the significant impact on familial relationships.

Four participants spoke about their experiences of being mothers; specifically, being a mother and simultaneously an inpatient, leading to the subtheme *The loss of the act of mothering*. Each of them spoke of a profound sense of loss, both in the literal sense of losing access to their children for various periods and in the very difficult sense of grief and sadness for what could have been during their children's early lives. Casey spoke of receiving medication when pregnant, saying 'I was expecting the third child when this started [...] The doctor, she gave me an injection and it was that size...And I can always see that injection ... and I don't know what it did'. Later, she reiterated, '[The doctor] never said what it was or anything. And back then, you trust the doctors and what they were doing was the right thing, you know?'

The impact of treatment on mothering went beyond concerns about the impact of medication. Sam had adhered to her pathway of care and medication for a long time and had been without an admission for over five years. However, the uncertainty during the time surrounding going into labour had resulted in her missing her medication:

I relapsed in hospital hours after I had [child's name] and that was my worst relapse and that's when I ended up in [institution]. And that was the worst experience of my life really. I was there for three months. I missed out on [name] for [three] months ... My first baby. I was in there for Mother's Day, and I never realised that at the time.

Highlighting the significant impact of psychiatric care, Ger reported that two of her children went into state care as a result of her psychiatric admissions. Speaking about her daughter, she

described, 'The neighbours took her for the first three months and then the second or third time I went in, she went into care. So, she went into care then. She's been in care ever since'. Despite this experience, Ger described having a positive relationship with her children while in care and since she has been home and treated in the community.

Finally, Alex's feelings around lost time were the most striking aspect of her story. She shared early on in her interview that 'I so desperately wanted a baby and was so excited ... And this was just taken from me'. Alex was admitted to a psychiatric institution when her firstborn child was very young and was there for nearly a year. She stated that throughout that time, 'we talked about everything else, but not the baby' with her mother and the medical staff. In discussing the layers of loss she experienced, Alex shared, 'It was a bereavement because I couldn't have my baby. I loved him so much and yet I couldn't mind him'. Alex was admitted to hospital again shortly after the birth of her second child and in speaking of her recovery as her children grew older Alex described the deep sadness that remains, saying 'I'd lost these two babies. I didn't have these two babies to nurture and love and care for and protect. So, there was such a loss. I lost a child. Literally, I lost my child'.

The experience of being in a psychiatric institution while also holding the role of mother appears to have led to a profound conflict and sadness within each of the participants, one which was not addressed while an inpatient.

4 | Discussion

This exploratory study sought to provide an in-depth understanding of the lived experience of a person who had spent time in a psychiatric institution prior to de-institutionalisation. This phenomenon was examined in the context of a familial and societal culture of Ireland throughout the second half of the twentieth century, and data analysis yielded four GET, each comprised of two subthemes.

The theme 'within the walls' described participants' experiences living in an environment where they looked out on walls each day. Psychiatric hospitals were typically on large campuses, inside large walls on the outskirts of towns. Participants reported the desire to escape, which echoes previous research in an Irish context throughout the 21st century. Murphy et al. (2017) found that two-thirds of people who had been admitted to a psychiatric hospital felt they had been confined, with some reporting that the Gardaí (police) were involved in their admission. A Ugandan study of people in psychiatric care reported similar findings (Kaggwa et al. 2021). Reflecting the subtheme of the lack of meaning and purpose in their day, Kaggwa et al. also found that participants were motivated to flee from the hospital as they were without routine, meaning or purpose. In contrast, the finding that some people recognised the 'need' to be in the institution is supported by McGuinness et al. (2013), who found that some participants reported a feeling of relief during their time in hospital (McGuinness et al. 2013).

The second theme explored participants' thoughts on treatments, with medication the principal treatment reported. This is

supported by Murphy et al. (2017), where almost 50% of participants reported medication was the principal treatment offered and reported they felt they needed to comply with medications to be discharged, echoed by McGuinness et al. (2013). A recent systematic review by Staniszewska et al. (2019) reported that participants spoke of perceived overmedication, lack of communication and lack of consent concerning medication. Participants in this study reported uniformly negative feelings about their experiences of ECT. Espinoza and Kellner (2022) notes the reclassification of ECT by the US Food and Drug Administration in America from 'high risk' to 'moderate risk, requiring special controls', reporting refinements in technique had reduced but not eradicated all side-effects (Espinoza and Kellner 2022).

The findings of this study also highlighted participants' sense of their own identity while in a psychiatric institution. Participants' psychiatric care was a time of loneliness and isolation, where connecting to other patients was difficult. This is supported by two recent systematic reviews on the topic (Akther et al. 2019; Staniszewska et al. 2019). Chambers et al. (2014) reported that participants found isolation and seclusion to be disempowering, while Kaggwa et al. (2021) found that the experience of being in a psychiatric hospital was compounded by the fact that social connections were difficult to form. The identity as a patient and the perceived lack of autonomy are supported by many studies (McGuinness et al. 2013; Murphy et al. 2017). Since many of these studies worked with participants who had psychiatric admissions after de-congregation, it is noticeable how similar some of the experiences described were. Research of this type is typically atheoretical or based on grounded theory. However, a SIT perspective illuminates the social meaning of many of the participants' experiences. In GET 1 and GET 3, it is noticeable that participants often resisted the categorisation of identity as 'psychiatric patients' by literally escaping from the hospital or not associating with other patients. This is in contrast to Hogg and Terry (2000) who proposed that in conditions of threat or conflict, people evaluate the situation to maximise intergroup connection and increase social identity rather than personal identity. Because social identity in a psychiatric institution is associated with societal stigma, participants described avoiding social connection. This social avoidance may have preserved their sense of identity but increased their loneliness. Participants discussed the external labels of 'diagnosis' or 'psychiatric patient' and the internalised stigma they felt related to the threat to their social value. Participants discussed role conflict, especially around motherhood, where the identity as 'patient' undermined other valued roles. Through the 4 GETS, participants identified difficulties with agency as the institutional setting often reinforced a passive identity through a lack of structure and activity. These findings highlight the value of a SIT-based methodology in admission-focused research for two reasons: (i) it supports generalisation, as many of the social challenges associated with long-term inpatient admission identified historically by the participants are also true today and (ii) it highlights the function of contradictory behaviour: loneliness and social avoidance. Many of the participant descriptions reflect the challenge to identity of the institutional social context, and that many of the participant behaviours can be understood in this context.

The final theme explored participants' experiences with their families, including with their children. Participants appeared to

find it difficult to talk about their families, mirroring the theme of an individual's isolation and social exclusion when in hospital (Kelly 2016; O'Morain et al. 2012). Koschorke et al. (2017) found that people living with mental illness can face criticism, stigma and abuse from within their own family. Family members' reactions to mental illness may also be influenced by coping style, cultural-ethnic perceptions of mental illness, and beliefs about mental illness (Weller et al. 2015). A family narrative at this time likely was to either not speak of, or cast out mental illness (O'Morain et al. 2012). Those who were mothers spoke about the cross-section of motherhood and their mental health difficulties, with each having admissions very early on in their infants' lives. They reported feeling alone and isolated both in the hospital and outside the walls of the hospital. Approximately 50% of women with schizophrenia who are mothers lose custody of their children, either temporarily or permanently (Seeman 2012). There was a significant sense of loss for each of the women as they spoke about this aspect of their admissions, and they described not only missing out on the act of mothering but experiencing a silence around their role as a mother while in the hospital.

5 | Strengths and Limitations

The use of a phenomenological design presents several strengths and limitations. In terms of sample size, the small sample in the present study allowed for an in-depth exploration of the experience of family relationships, which prioritised the voice of participants in the study, in line with the idiographic commitment of IPA (Smith et al. 2009). The interpretative element must be approached with caution when completing IPA research. An interpretative focus is central to IPA, accounting for the richness of the data; although interpretation is susceptible to bias when it is not monitored closely. The lead researcher kept a reflective diary throughout the project and sought guidance before conducting interviews to support the process of interviewing a population with whom she had little experience. The recruitment of participants via purposive sampling is recognised as a potential limitation due to the potential for bias and the potentially limited diversity of perspectives. The small sample size is also a limitation. Participants represented a cohort of specific psychiatric inpatients with experiences of a particular culture at a particular time. Therefore, findings must be extrapolated with caution when applying them to other psychiatric inpatient cohorts. However, important insights remain from the study, given the lack of research presenting the individual's voice with experience in inpatient care.

6 | Conclusion

The present study explored the lived experiences of being an inpatient of a psychiatric institution prior to the introduction of de-institutionalisation. The findings emphasise the need for an understanding not only of the individuals' experiences, but also of the societal and cultural context in which this cohort experienced inpatient psychiatric care—developing supports that engender a trusting, therapeutic relationship, allowing former inpatients to continue to make sense of and find meaning in their experience as an inpatient is paramount. This is a cohort of aging people who may require inpatient admission again in the

future. The clinical implications of this study are important to tailor supports for this group whose voices have not been heard until now.

7 | Relevance to Clinical Practice

Findings from this study have several important implications for clinical practice. The cohort of people who experienced psychiatric admission pre- and post-mental health act are likely to engage in ongoing physical health, mental health and geriatric care. Nurses are often the primary point of contact for patients in these settings. The current study describes how participants make sense of the social context of hospital and how this may impact their sense of identity and sense of agency. For example, participants may find future admission *confining* or *containing*, depending on their historical experiences, highlighting the need for individualised care approaches. Nurses in geriatric or community settings may encounter patients with histories of institutionalisation and unresolved trauma. It can guide reflective practice, particularly in understanding the historical context of psychiatric care and present-day patient mistrust or disengagement. From a SIT perspective, the internalised stigma and reduced social value associated with being a mental health patient may remain. Within a congregated hospital or nursing home setting, supporting someone to maintain their social identity or to form a positive in-group identity with other patients may be an important protective process. The role of the mother and ruptures in the relationship with children are of particular relevance. Recent research highlights that a mother's bond with her baby is an important aspect of her own mental health outcomes and something clinicians should incorporate in inpatient and community services (Taylor et al. 2022). Literature suggests that psychoeducation and psychosocial interventions delivered in mental health centres benefit both the development of children and parenting skills. In addition to psychoeducation, these centres could also offer social support to expectant and new mothers, their partners and families.

The results of this study outline several important avenues for future research to enhance public and professional understandings of the experience of people who were treated in psychiatric institutions prior to de-institutionalisation. Results highlighted a need to understand further the cumulative effect of multiple admissions throughout adulthood on significant relationships with family and peers and the development of therapeutic relationships. Future research is also needed to develop further an understanding of what it means to personal identity to be an inpatient of psychiatric hospitals: how people viewed themselves alongside that social context and experience. PPI-led research has indicated how experiences of mental illness can be positive and deeply meaningful (O'Keeffe et al. 2021) but also how it can negatively impact social identities (Jackson et al. 2009). The data from the current study tell a story of uncertainty and, apart from medication, participants did not speak of any intervention offered. Greater understanding is needed of what treatments are offered during psychiatric admission, how treatments are offered, and how that treatment plan is communicated to patients.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

References

- Akther, S. F., E. Molyneaux, R. Stuart, S. Johnson, A. Simpson, and S. Oram. 2019. "Patients' Experiences of Assessment and Detention Under Mental Health Legislation: Systematic Review and Qualitative Meta-Synthesis." *BJPsych Open* 5, no. 3: e37.
- Banerjee, D., R. Arasappa, P. S. Chandra, and G. Desai. 2021. "Narratives of Mothering": Lived Experiences of Child-Rearing in Mothers With Severe Mental Illness." *World Social Psychiatry* 3, no. 3: 189–194.
- Bleich-Cohen, M., T. Hendler, M. Kotler, and R. D. Strous. 2009. "Reduced Language Lateralization in First-Episode Schizophrenia: An fMRI Index of Functional Asymmetry." *Psychiatry Research: Neuroimaging* 171, no. 2: 82–93.
- Brennan, D. 2017. "Theoretical Exploration of Institution-Based Mental Health Care in Ireland." In *Asylums, Mental Health Care and the Irish: 1800–2010*, edited by P. Prior. Irish Academic Press.
- Chambers, M., A. Gallagher, R. Borschmann, S. Gillard, K. Turner, and X. Kantaris. 2014. "The Experiences of Detained Mental Health Service Users: Issues of Dignity in Care." *BMC Medical Ethics* 15, no. 1: 1–8.
- Cusack, E. 2021. "A Narrative History of Psychiatric/Mental Health Nursing in the Asylum/Mental Hospital System in Ireland from 1940 to 1970. 'Always Remember They are Some Mother's Child'." Doctoral diss., Dublin City University.
- Daly, A., and S. Craig. 2021. "Annual Report on the Activities of Irish Psychiatric Units and Hospitals 2020." *Health Research Board: Dublin, Ireland*.
- Espinoza, R. T., and C. H. Kellner. 2022. "Electroconvulsive Therapy." *New England Journal of Medicine* 386, no. 7: 667–672.
- Fakhoury, W., and S. Priebe. 2002. "The Process of Deinstitutionalization: An International Overview." *Current Opinion in Psychiatry* 15, no. 2: 187–192.
- Finnane, M. 1981. *Insanity and the Insane in Post-Famine Ireland*. Croom Helm.
- Fiorillo, A., D. Giacco, C. De Rosa, et al. 2012. "Patient Characteristics and Symptoms Associated With Perceived Coercion During Hospital Treatment." *Acta Psychiatrica Scandinavica* 125, no. 6: 460–467.
- Henderson, C., M. Phelan, L. Loftus, R. Dall'Agnola, and M. Ruggeri. 1999. "Comparison of Patient Satisfaction With Community-Based vs. Hospital Psychiatric Services." *Acta Psychiatrica Scandinavica* 99, no. 3: 188–195.
- Hogg, M. A., and D. I. Terry. 2000. "Social Identity and Self-Categorization Processes in Organizational Contexts." *Academy of Management Review* 25, no. 1: 121–140.
- Huschke, S., S. Murphy-Tighe, and M. Barry. 2020. "Perinatal Mental Health in Ireland: A Scoping Review." *Midwifery* 89: 102763.
- Jackson, L., J. A. Tudway, D. Giles, and J. Smith. 2009. "An Exploration of the Social Identity of Mental Health Inpatient Service Users." *Journal of Psychiatric and Mental Health Nursing* 16, no. 2: 167–176.

- Kaggwa, M. M., A. Acai, G. Z. Rukundo, S. Harms, and S. Ashaba. 2021. "Patients' Perspectives on the Experience of Absconding From a Psychiatric Hospital: A Qualitative Study." *BMC Psychiatry* 21, no. 1: 1–9.
- Kelly, B. 2016. *Hearing Voices: The History of Psychiatry in Ireland*. Irish Academic Press.
- Knight, M., K. Bunch, D. Tuffnell, et al. 2018. "Saving Lives, Improving Mothers' Care—Lessons Learned to Inform Maternity Care From the UK and Ireland Confidential Enquiries Into Maternal Deaths and Morbidity 2014–16."
- Koschorke, M., R. Padmavati, S. Kumar, et al. 2017. "Experiences of Stigma and Discrimination Faced by Family Caregivers of People With Schizophrenia in India." *Social Science & Medicine* 178: 66–77.
- McGuinness, D., M. Dowling, and T. Trimble. 2013. "Experiences of Involuntary Admission in an Approved Mental Health Centre." *Journal of Psychiatric and Mental Health Nursing* 20, no. 8: 726–734.
- Mental Health Act. 2001. "Dublin: Irish Statute Book." <http://hdl.handle.net/10147/42819>.
- Murphy, R., D. McGuinness, E. Bainbridge, et al. 2017. "Service Users' Experiences of Involuntary Hospital Admission Under the Mental Health Act 2001 in the Republic of Ireland." *Psychiatric Services* 68, no. 11: 1127–1135.
- O'Keeffe, D., B. Keogh, and A. Higgins. 2021. "Meaning in Life in Long-Term Recovery in First-Episode Psychosis: An Interpretative Phenomenological Analysis." *Frontiers in Psychiatry* 12: 676593.
- O'Morain, P., G. J. McAuliffe, K. Conroy, J. M. Johnson, and R. E. Michel. 2012. "Counseling in Ireland." *Journal of Counseling & Development* 90, no. 3: 367–372.
- Pietkiewicz, I., and J. A. Smith. 2014. "A Practical Guide to Using Interpretative Phenomenological Analysis in Qualitative Research Psychology." *Psychological Journal* 20, no. 1: 7–14.
- Prior, P. M., ed. 2017. *Asylums, Mental Health Care and the Irish: 1800–2010*. Irish Academic Press.
- Rhodes, L. A. 1984. "This Will Clear Your Mind: The Use of Metaphors for Medication in Psychiatric Settings." *Culture, Medicine and Psychiatry* 8, no. 1: 49–70.
- Seeman, M. V. 2012. "Intervention to Prevent Child Custody Loss in Mothers With Schizophrenia." *Schizophrenia Research and Treatment* 2012: 1–6.
- Smith, J. A., P. Flowers, and M. Larkin. 2009. *Interpretative Phenomenological Analysis: Theory, Method and Research*. Sage.
- Smith, J. A., P. Flowers, and M. Larkin. 2021. *Interpretative Phenomenological Analysis: Theory, Method and Research*. 2nd ed. Sage.
- Staniszewska, S., C. Mockford, G. Chadburn, et al. 2019. "Experiences of In-Patient Mental Health Services: Systematic Review." *British Journal of Psychiatry* 214, no. 6: 329–338.
- Tajfel, H., and J. C. Turner. 1986. *The Social Identity Theory of Inter-Group Behavior*. Nelson-Hall.
- Tajfel, H. E. 1978. *Differentiation Between Social Groups: Studies in the Social Psychology of Intergroup Relations*. Academic Press.
- Taylor, B. L., A. Sweeney, L. C. Potts, K. Trevillion, and L. M. Howard. 2022. "Factors Associated With Re-Admission in the Year After Acute Postpartum Psychiatric Treatment." *Archives of Women's Mental Health* 25, no. 5: 975–983.
- Weller, B. E., M. Faulkner, O. Doyle, S. S. Daniel, and D. B. Goldston. 2015. "Impact of Patients' Psychiatric Hospitalization on Caregivers: A Systematic Review." *Psychiatric Services* 66, no. 5: 527–535.
- Williams, B., and G. Wilkinson. 1995. "Patient Satisfaction in Mental Health Care: Evaluating an Evaluative Method." *British Journal of Psychiatry* 166, no. 5: 559–562.
- Woodward, S., K. Berry, and S. Bucci. 2017. "A Systematic Review of Factors Associated With Service User Satisfaction With Psychiatric Inpatient Services." *Journal of Psychiatric Research* 92: 81–93.

Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** inm70123-sup-0001-supinfo.docx.