PSYCHIATRIC HOSPITALIZATION AND RESILIENCY: EXPERIENCES OF ADULTS WITH SERIOUS MENTAL ILLNESS UPON REENTERING THEIR COMMUNITIES

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ABSTRACT

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Psychiatric hospitalization can be viewed as a difficult life event that can cause disruptions in several life domains (Cohen, 1994). Individuals who experience a psychiatric hospitalization are at a greater risk for experiencing readmission to the hospital and social stigma that can interrupt their ability to function in daily life, and even suffer work-related setbacks (Loch, 2014). Much of the research characterizes resiliency as a set of traits possessed by an individual. Studies using such measures found that adults with serious mental illness [SMI] have lower resiliency scores than the general population. However, relatively little is known about specific aspects of resiliency that adults might rely upon in their adjustment to community life after psychiatric hospitalization.

The present qualitative study examined first-person accounts of eleven adults coping with a serious mental illness who have experienced a psychiatric hospitalization in a 24-month period. The research examines components of resiliency that assist adults in community adjustment following a psychiatric hospitalization. Results identify themes among participant perceptions of system- and individual-driven helpful and unhelpful aspects of the hospitalization. Results also provide more details to the nuances in individual resiliency components (i.e., goal-setting, commitment, patience, humor, past accomplishments) and social components that help adults with serious mental illness bounce back from psychiatric hospitalizations. About half (n=6) of the sample identified bouncing back to the same level of life satisfaction whereas the remainder identified bounding back to a higher level of life satisfaction. These results contribute to a better understanding of resiliency components associated with better post-discharge community integration which will help mental healthcare workers better serve individuals reentering their community.

Keywords: psychiatric hospitalization, resiliency, SMI, community integration

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INTRODUCTION

As of 2014, approximately 13.1 million (4.2%) adults in the United States cope with at least one serious mental illness ("Serious Mental Illness," n.d.). As defined in the 2014 National Survey on Drug Use and Health, a serious mental illness (SMI) meets DSM-5 diagnostic criteria for a mental, behavioral, or emotional disorder which results in a substantial impairment in functioning (e.g., schizophrenia or related disorders, long term mood disorders, severe anxiety disorders) (Center for Behavioral Health Statistics and Quality, 2015). Since a serious mental illness impacts an individual's everyday functioning, individuals often seek treatment to manage their symptoms. For many people living with SMI, inpatient psychiatric care is utilized as a treatment option with the goal to help adults with a mental illness live a meaningful life in the community. In a 2008 national survey, approximately 7.5% of people with serious mental illness who were seeking treatment received inpatient psychiatric care ("Use of Mental Health Services," n.d.).

Since the deinstitutionalization movement of the 1960s, inpatient psychiatric care has emphasized the importance of community integration (Kliewer, McNally & Tripany, 2009). Inpatient care now consists of understanding the patient's background and reason for admittance, treating symptoms, and developing and discharge plan (Sharfstein, 2009). Discharge plans are made up of recommendations for continued community mental healthcare and are presented to the patient (and possibly family members) prior to the patient leaving the hospital care (Sharfstein, 2009). Ideally, patients receive efficient treatment to stabilize symptoms and quickly return to their communities, carrying out any necessary treatment in outpatient settings.

Although the current emphasis on rapid treatment and discharge has many advantages, there are also a number of disadvantages for the patients (Cohen, 1994). The current approach to

inpatient care relies heavily on proper inpatient treatment and hospital culture (Sharfstein, 2009), effective discharge planning and implementation (Carlock, 2016; Sharfstein, 2009), and the presence of support networks for the individual (Sharfstein, 2009; Sledge et al., 2011; Vigod et al., 2013). Less than ideal hospitalization circumstances increase stress experienced by the patient and inadequate community reintegration leads to increased readmission rates (Loch, 2014).

At an individual level, inpatient hospitalizations are life-interrupting and stressful for many adults (Cohen, 1994). Admission into the inpatient psychiatric ward implies that individuals are unequipped to care or manage their psychiatric needs and requires that they be removed from their previous environment spontaneously to tend to these needs. Often, a psychiatric hospital stay is typically a result of an adult's decline in daily functioning and admission to the hospital is typically unplanned and occasionally, involuntary. Ideally, hospitalizations are mental health sanctuaries, where individuals can spend their time in a warm, positive environment. Unfortunately, the reality of hospitalization is quite contrary (Cohen, 1994). Inpatient settings typically strip patients of their autonomy, limit their communication with others, and restrict their privacy (Cohen, 1994). The stress from the inpatient experience alone will likely warrant recovery when the individual reenters their community.

Readmission remains as one of the greatest risks to post-discharge individuals with a serious mental illness (Loch, 2014; Owen, Rutherford, Jones, Tennant & Smallman, 1997; Vigod et. al, 2013). In a study conducted by Owen and colleagues (1997), 128 patients were monitored for 6 months post-discharge from an inpatient psychiatric unit. By the end of the six-month follow-up, 30% of this sample had been readmitted to the hospital at some point within the given period. In another study in Brazil, 169 adults with SMI were tracked for 12 months following

their hospital discharge. Nearly 43% of the participants were readmitted to the hospital at least once within the designated timeframe (Loch, 2012). High return rates indicate poor discharge planning or implementation, and/or ineffective inpatient treatment. Regardless, readmitted individuals face the life-interrupting hospitalization experience yet again.

Social stigma from mental illness is another negative consequence of psychiatric hospitalization (Loch, 2014). A 2014 study by Rüsch and colleagues found that among their sample of 186 adults with mental illness, there was a significant relationship between stress from the mental illness stigma, shame about mental illness, and self-contempt about an involuntary admittance to the hospital (Rüsch et al., 2014). Individuals in this sample that experienced greater self-stigma from their mental illness consequently possessed a lesser sense of empowerment (Rüsch et al., 2014). In addition, the intrinsic impact of social stigma negatively impacts an individual's occupation and overall quality of life (Abiri et al, 2016; Rüesch, Graf, Meyer, Rössler & Hell, 2004; Khalaf Beigi, Mohammadi Shahbolaghi, Rassafiani, Haghgoo, & Taherkhani, 2015; Townley & Kloos, 2011). Many adults with SMI may face an impaired ability to work (Kahlaf et al, 2014), resulting in decreases in pay, unemployment, or an increase in social stigma from their mental illness (American Hospital Association [AHA], 2012). Outside of work, returning from the hospital requires a social transition back into the community that can be heavily influenced by the social stigma experienced by the individual. An adverse hospitalization experience could make this transition even more challenging and possibly increase social stigma.

Several studies have recognized the challenge of psychiatric hospitalization and explored the components within the hospital system that promote or hinder mental health recovery (Quirk & Lelliot, 2001; Gilburt, Rose & Slade, 2008; Stenhouse, 2013; Moses, 2011; Cohen, 1994).

Quirk and Lelliot (2001) highlight the detriments on recovery that associate with poor relationships and contact with hospital staff and the lack of safety and activities. In addition, a few studies have identified the positive effects on treatment and recovery when patients have positive relationships with staff (Gilbert, Rose, & Slade, 2008) and are able to develop feelings of safety (Gilbert, Rose, & Slade, 2008; Stenhouse, 2012) and trust (Gilbert, Rose & Slade, 2008). Several studies have identified the helpful impact of engaging supportive others in the life of the patient during the discharge process to aid recovery (Vigod et al., 2013; Sledge et al., 2011). There are few existing studies that explore patient perspectives of helpful and unhelpful components of the hospitalization. A qualitative study conducted by Moses (2011) explored likes and dislikes about hospitalization experiences among 80 first-time adolescent inpatients. Helpful components of the hospitalization reported by participants included support received from others, psychotherapy and education, and positive environments. Unhelpful components included lack of freedom, ineffective nature of treatment, frightful experiences, and other (Moses, 2011). This study provides initial insight to first-time adolescent inpatient critiques of hospitalization. However, the findings are specific to a non-SMI adolescent population and are not generalizable to adults living with SMI. Moses (2011) conducted the interviews with participants seven days post-discharge. Recovering from adversity, particularly the detriments of psychiatric hospitalization, may require more time than one week. Lastly, many of the critiques were targeted at systems-level activities within the hospitalization. Patients spend much time without structured activities to attend and little is known about free time activities that inpatients find helpful or unhelpful.

In summary, the goal of community mental health care since deinstitutionalization has been to have people with serious mental illness live in the community. Inpatient care provides a

temporary safe-setting to stabilize the patient, readjust any medications, and guide them to continue outpatient community care. However, hospitalizations can be stressful and disruptive, requiring its own skill set of recovery from the distress and inflated stigma in social, living, and employment domains. This implies that upon discharge, adults with serious mental illness not only must cope with their psychiatric symptoms, but also readjust to daily life while facing readmission challenges. Research has identified helpful and unhelpful factors of the hospitalization experience among first-time adolescent patients (Moses, 2011) but little is known about the helpful and unhelpful hospitalization components identified by adults with SMI and the effect these factors have in the full recovery process.

Resiliency

Over the course of the last two decades, the construct of resiliency has been used to understand how individuals cope with adversity. Resiliency is generally defined as an ability to bounce back from adversity or life challenges (Reich, Zautra & Hall, 2010; Hamel & Valikangas, 2003; Herrman et al., 2011). Early resilience literature suggests that resilience is made up of preexisting protective factors and reactive coping-like mechanisms which are thought to consist of personal traits and environmental influences (Rutter, 1985 & 1987). This general definition is the underlying foundation from which different research domains adjust to fit their own understanding of the construct.

There are different levels from which researchers and practitioners can assess resiliency that include individual, family, community, and cultural levels (Fleming & Ledogar, 2008). The field of positive psychology has extensively explored the concept of resilience focused on the individual level of analysis. The current positive psychology approach generally views resiliency as a definitive, individual characteristic rather than a combination of individual characteristics

and environmental factors (Friedman & Robbins, 2012). Therefore, current positive psychology assessment approaches lack recognition that environmental factors could influence an individual's overall resiliency. This is particularly problematic if the researchers are interested in understanding the impact of the unique adversity on the individual's ability to bounce back. A more nuanced assessment of resiliency allows for the possibility that resiliency levels can fluctuate for a single individual faced with different kinds of stressful life circumstances (Friedman & Robbins, 2012). Although current resiliency measures (i.e., CD-RISC, Connor & Davidson, 2003; RS, Wagnild & Young, 1993) yield a resiliency score that can be compared across groups, without understanding the environmental influences on resiliency and population-specific considerations, it is difficult to draw meaningful, generalizable conclusions. With resilience assumed to be an individual trait, little can be inferred to understand how specific populations recover from shared adverse experiences.

Understanding resiliency from a specific adversity should consist of understanding the gravity of the specific resilience components that aided in the recovery (Luthar, Sawyer & Brown, 2006). For example, if someone says their involvement in the church helped them through their divorce, it is important to explore what exactly about their church involvement helped them. It may be that they sensed God's forgiveness, formed friendships with others who experienced divorce, gained access to additional fulfilling volunteering activities, etc. In this example, the individual who identified their church as a means of resiliency may say that they enjoyed the new friendships but that was not nearly as helpful in their recovery as was sensing God's forgiveness. Therefore, this person would likely say that though both their new friendships and God's forgiveness contributed to their overall resiliency, they identified that God's forgiveness was the driving factor in their recovery. By simply endorsing general resiliency

components, it is impossible to determine the nuanced details of the resilience factors and their weight of contribution in their overall recovery. Nonetheless, understanding the factors that contribute to resiliency is the first step in understanding what makes people resilient.

The work of Rutter (1985 & 1987), Kobasa, (1979), and Lyons (1991) helped to synthesize early studies of resiliency and to identify key components associated with the construct. These resiliency components typically reflect two overarching categories: social components and intrapersonal components. Some social components that are thought to contribute to resiliency are: engaging the support of others (Rutter, 1985; Rutter, 1987), maintaining close and secure relationships (Rutter, 1985; Rutter, 1987), and/or seeking out help after experiencing adversity (Crowe et al., 2015). However, the perceived importance and role of strong interpersonal relationships among adults with SMI when recovering from psychiatric hospitalization has yet to be understood.

Positive, strong, and secure interpersonal relationships have been thought to greatly contribute to individual resilience (Rutter, 1985 & 1987). Research with children found that negative effects of stress were mitigated when in the presence of others who reminded them of security and comfort (i.e., parents), suggesting that close and secure relationships contribute to resiliency (Rutter, 1985). Among spousal research studies, those individuals that had strong, secure relationships, found their partner as supportive, and sought help from them when needed were also likely to experienced buffered effects of stress (Rutter, 1985). Additionally, a focus group study with people with mental illness found that help-seeking was associated with higher reports of resiliency (Crowe et al., 2015).

Regarding intrapersonal components of resiliency, research suggests that individuals with greater resiliency share some of the following traits that include identifying individual or

collective goals for themselves (Rutter, 1985), committing to obligations (Kobasa, 1979), experiencing past success (Rutter, 1985), having patience (Lyons, 1991), and/or using humor to help them through difficult situations (Rutter, 1985).

Setting and completing personal goals influences resilience likely because of the resulting sense of fulfilment and motivation for working through the process (Rutter, 1985). Research has indicated that greater commitment to goals decreases illness effects from stress (Kobasa, 1979). The effects of setting and committing to goals has been widely researched among populations with SMI, with many of these studies exploring goal-setting in regards to treatment planning (see McGuire, Lysaker & Wasmuth, 2015; Tabek et al., 2015). Personal goal-setting by adults with mental illness has only been studied within therapeutic recreation settings (Moxham et al., 2017). For five days, adults with SMI who attended a "recovery camp" were asked to set personal goals for themselves that could be completed during their stay. Participants identified goals that were later classified into four categories that included connecting with others, challenging themselves, developing healthy habits, and mental health recovery (Moxham et al., 2017). However, these goals were designed with the mindset that they could be completed within a 5-day retreat. Therefore, little is known about the type of personal goals set by adults with mental illness in their everyday lives.

Experiencing past successes (Rutter, 1985), having patience (Lyons, 1991), and using humor (Rutter, 1985; Kuiper, 2012) have been identified as individual components of resiliency. Previous research has identified that women who experienced success in different areas of their lives as children (e.g., relationships, academics, sports, etc.) also grew to have more success in various areas of adulthood, including a strong, supportive romantic relationship. However, no research has been done to understand the prevalence and types of previous successes experienced

by adults with mental illness. Patience has also been recognized to have a buffering effect of stress (Lyons, 1991). During distressing situations, having patience allows individuals to problem-solve more than individuals who generate intense emotional responses (Lyons, 1991). The degree to which someone with mental illness views their capacity to maintain patience during and after adversity has yet to be studied. Lastly, humor has been recognized as both a protective factor for resilience and a helpful reactive coping technique (Kuiper, 2012; Rutter, 1985). Among SMI populations, humor used in therapeutic interventions positively influences individual perceptions, attitudes, judgements, and emotions (Gelkopf, 2011). Although humor has been widely supported as having positive effects, little is known about if and how adults with SMI use humor during adverse situations.

Resiliency for Adults Coping with Mental Illness

Several studies examine resiliency for people coping with SMI. These studies view living with serious mental illness as the adverse condition that warrants resilience. Researchers who examine individual resiliency in samples of adults with SMI typically use well validated self-report measures such as the Connor Davidson Resiliency Scale (CD-RISC; Connor & Davidson, 2003) or the Resiliency Scale (RS; Wagnild & Young, 1993). The CD-RISC was developed for general public use but has since been universally utilized to measure resiliency across different populations and adversities using previously identified resiliency traits (Connor & Davidson, 2003). A more recent development of a resilience scale designed to assess resiliency among individuals with bipolar disorder has been developed with the purpose of tracking treatment progress and resilience specific to bipolar symptom prevalence and intensity (Echezarraga, Las Hayas, González-Pinto, & Jones, 2017). The development of this scale validates the concern that

resilience should be contextually understood, and that nuances of resilience may vary by populations (Echezarraga et al., 2017).

In a 15-year-long longitudinal study, Torgalsbøen (2012) explored the resiliency levels of individuals who have recovered from schizophrenia. Fifteen participants with schizophrenia were recruited for the study. At the completion of the study, participants were assessed for psychosocial functioning, resiliency (using the CD-RISC), and updated diagnosis. Eight of the 15 participants no longer met criteria for a diagnosis of schizophrenia and were considered to have recovered from the disorder. Their CD-RISC scores were indicative of the resiliency associated with recovery from schizophrenia; higher levels of psychosocial functioning were positively correlated with resiliency scores. Additionally, resiliency scores for those people who maintained their diagnosis of schizophrenia were consistent with the mean score for that population as measured by the CD-RISC, which was significantly lower than the resiliency scores for the general population (Connor & Davidson, 2003; Torgalsbøen, 2012). The study concluded that individuals who have recovered from schizophrenia have higher resiliency scores compared to those who maintained their diagnosis of schizophrenia over the course of the study.

A study conducted in Japan compared resilience scores between 41 patients with schizophrenia who resided in both urban and rural settings (Yoshida et al., 2016). Results suggested that there were no significant differences in the resiliency scores (as derived from the 25-item Resilience Scale) based on urban or rural residential location. However, those adults who endured their illness longer and/or indicated having a higher quality of life also had higher overall resiliency scores (Yoshida et al., 2016). Unfortunately, other than urban or rural residence, no further environmental or community factors that could have influenced resiliency were explored (Yoshida et al., 2016).

Choi and colleagues (2015) conducted a study to understand resilience and bipolar symptoms (i.e., impulsivity and depressive episodes) using the CD-RISC. They collected data from 62 outpatient individuals with a bipolar diagnosis and 62 non-psychiatric controls. Results indicated that higher degree of impulsivity and greater frequency of depressive episodes were associated with lower resiliency scores, suggesting that individuals with bipolar symptoms display less resiliency when compared to individuals without a psychiatric history/diagnosis (Choi et al., 2015).

When comparing the resiliency scores from the CD-RISC across populations, results suggest that adults with SMI scored significantly lower than those in the general population (Connor & Davidson, 2003). Not only do these scores differ from the general population, the CD-RISC scores from a sample of adults coping with serious mental illness in Australia were lower than the scores from outpatient individuals with other mental disorders (Hansen & Tomassen, 2010; Connor & Davidson, 2003).

Results from studies assessing resilience scores among mental health consumers all highlight the same conclusion, namely that individuals with psychiatric disabilities (i.e., SMI diagnoses) score slightly lower than individuals with less severe mental health diagnoses, and score greatly lower than non-psychiatric individuals. Scales such as the CD-RISC and RS serve useful for an understanding of how resilience differs between people with mental illness and non-psychiatric individuals but provide no information about the discrepancy in overall scores between samples.

Echezarraga and colleagues (2017) recognized the need for psychiatric illness-specific measures of resiliency and developed the Resilience Questionnaire for Bipolar Disorder. The 23-item scale was developed to understand resilience specific to the ever-fluctuating nature of

bipolar symptoms and serve as a tool to monitor patient responses to adversity appraisal and outlooks on recovery. Items were categorized into five resiliency factors: self-management of bipolar disorder symptoms, determination and commitment to recover, balanced self-care, self-confidence, and feeling interpersonal support (Echezarraga et al., 2017). This scale proves promising for the evolution of resilience assessment as it recognizes the need for unique resilience measures for specific populations. Even when accounting for unique attributes of special populations, this scale does not offer insight to the perceived role of interpersonal relationships during recovery. Additionally, this scale does not consider situation-specific adversities that could impact resilience scores. Without controlling for contextually-based adversities, it is difficult to parse out whether the resiliency from psychological symptoms is a true result of the presence of uplifting resilient components or rather the lack of debilitating environmental challenges. For example, it seems logical that two people with bipolar disorder who have been making progress towards their treatment goals may score drastically different on the resilience measure if one had recently experienced significant trauma. Without accounting for situational stressors, it is difficult to draw generalizable conclusions about resilience, even in specific populations. Therefore, perhaps assessing resiliency should be two-fold, where participants share both specific demographic characteristics and adverse life experiences.

Amount of resiliency one possesses has been widely studied via self-report survey measures, but relatively little is known about how people view their resiliency in regard to their mental health recovery. Crowe and colleagues (2015) are among the few who explored resiliency among the population of individuals with a serious mental illness using qualitative techniques. In their 2015 study, 17 adults with a mental illness participated in four focus groups about relationships between mental illness stigma, help seeking, and resiliency. Upon completion,

dialogues from the focus groups were transcribed and analyzed using content analysis techniques. Researchers concluded that those adults who sought out support for their mental illness experienced increased resilience and decreased stigma. Findings also suggested that stigma and decreased help seeking resulted in lower resilience (Crowe, Averett & Glass, 2015). It would appear from these results that resiliency might decrease adults' perceptions of social stigma which might in turn help adults' readjustment back into the community after a hospitalization.

A 2014 study by Palmer and colleagues compared self-reported happiness and resiliency for 72 individuals diagnosed with schizophrenia and 64 healthy participants. This study used two measures to assess resiliency, 10 item CD-RISC and the Hardy-Gill Resilience Scale (Palmer et al., 2014). The Hardy-Gill Resilience Scale (HGRS) is used to assess adverse event-inspired resiliency but does not allow for specification of the adverse event. Rather, this scale asks participants to recall a stressful life event and respond to the nine-item inventory while considering the adversity of their chosen event (Hardy, Concato, & Gill, 2004). Results from the study found that adults with schizophrenia had significantly lower average scores on trait and adverse event-inspired resiliency than people in the healthy control group. The authors concluded that happiness should therefore be a goal for treatment within adults with serious mental illness, however, more research is necessary to suggest similar implications for resiliency (Palmer et al., 2014).

The majority of existing studies of resiliency for adults coping with serious mental illness focus on individual characteristics and do not adequately explore possible environmental or community conditions that may or may not have impact on adults' overall sense of resiliency and individual appraisal of adversity. Moreover, current measures of resiliency are designed to

be universally used and yield just one overall resiliency score, and researchers are not able to explore any common themes in resiliency components endorsed by different populations. To date, the Resilience Questionnaire for Bipolar Disorder appears to be the only published measure designed specifically for adults with one type of psychiatric disorder. This measure taps into resiliency from the challenge of individuals who live with the symptoms of bipolar disorder. Although this is a promising step in the evolution of resiliency studies, it appears that no research to date has examined a specific adverse situational life event on adults' perceptions of resilience for individuals with a serious mental illness. Furthermore, existing resilience measures are relatively brief and do not allow for nuanced understanding of how different resiliency components influence overall bounce back.

Summary

Psychiatric hospitalization can be an extremely disruptive life event for adults coping with serious mental illness. Psychiatric hospitalization can decrease an individual's autonomy, and leave a person feeling devalued and questioning the authenticity of care from providers (Katsakou & Priebe, 2007; Miedema & Stoppard, 1994). Although much has been written about psychiatric hospitalization as a form of short-term treatment and discharge procedures that contribute to continued community care (Carlock, 2016; National Institute of Mental Health [NIMHE], 2005; Sharfstein, 2009), ways that adults recover from the disruptive circumstances of psychiatric hospitalization itself are hardly discussed in scholarly literature.

Current literature has conceptualized resiliency primarily as an individual level trait as demonstrated by the content of most self-report measures of resiliency (Connor & Davidson, 2003; Friedman & Robbins, 2012; Wagnild & Young, 1993). In considering factors that might impact and individual's ability to recover from adversity, researchers have identified

commitment, goal-setting, patience, sense of humor, social support, and past success to be components of resiliency (Connor & Davidson, 2003). One resiliency measure was recently designed for individuals with bipolar disorder to understand how individuals bounce back from the presence of symptoms (Echezarraga et al., 2017). However, research is needed that examines adults' perceptions of resiliency in an environmental context as the ability to "bounce back" from a specific set of adverse circumstances or events. Such an approach to the study of resiliency assumes that an individual can be more or less "resilient" depending on both environmental and individual factors and that resiliency can vary across circumstances and change over the life course. Previous studies of resilience among people coping with serious mental illness suggest that self-reported resiliency is generally lower in this population than in non-psychiatric samples (Connor & Davidson, 2003). However, such studies provide little information about reasons for differences in self-reports of resilience for people with mental illness or factors that might contribute to perceived resiliency.

The Present Study

The present qualitative study examines the lived experience of adults with serious mental illness who have experienced a recent psychiatric hospitalization. The research focuses on aspects of resiliency that may contribute to adults' views of their community reintegration after discharge from an inpatient psychiatric facility. Given the disruptive impact of psychiatric hospitalization on everyday life, it is hypothesized that aspects of resiliency play a meaningful role in individual readjustment to community life after hospital discharge.

Specifically, the present study poses the following questions: 1) How do adults with mental illness describe their psychiatric hospitalization experience? 2) What individual aspects, if any, of resilience (i.e. setting individual or collective goals, committing to obligations, having

experienced past success, having patience, and/or using humor) do adults identify as relevant factors in their readjustment to community life following psychiatric hospitalization? 3) What perceived social and community level resiliency components (i.e. engaging the support of others, maintaining close and secure relationships, and/or seeking out help after experiencing adversity), if any, do adults feel assisted them in their overall reintegration to the community following psychiatric hospitalization?

METHOD

Participants

The sample consisted of a total of 11 adults living with mental illness who have experienced at least one psychiatric hospitalization. To be eligible to participate in the study, individuals needed to be between the ages of 18 and 65 years old, have a current diagnosis of a serious mental illness (i.e., bipolar disorder, major depression, and/or any schizophrenia related disorder) and have had experienced a psychiatric hospitalization within six months to two years from the time of the interview. Of the 23 adults who completed a prescreening questionnaire, 13 individuals met criteria to be eligible for the study. A total of 12 individuals participated in the interviews and the interview material of one person was eliminated from the final sample due to incomplete responses. Individual characteristics of the 11 participants included in the final sample can be found in Table 1.

The majority of the sample was Caucasian (82%), and the mean age of participants was 43.4 years (SD = 14.16). Slightly over half the sample consisted of women (55%). The majority were also independently renting an apartment (55%), and single (44%), and involved in the community (63%). In terms of education, 18% completed some high school, 9% completed high school, 36% completed some college, 27% obtained an Associate’s Degree, and 9% obtained a Master’s Degree. Just over half the sample (55%) was employed at the time of the interview.

The total sample (n=11) mainly consisted of participants with a diagnosis of bipolar disorder (82%) with the remaining participants diagnosed with a schizophrenia-related disorder. Ten of the 11 participants (91%) reported that they were taking psychotropic medications for their symptoms at the time of the interview. A total of five participants (45%) previously

experienced between one and six hospitalizations, three (27%) experienced between seven and 12 hospitalizations, and three (27%) experienced over 13 hospitalizations. Three participants (27%) reported that they had been hospitalized involuntarily at the time of their last hospitalization. The mean length of the most recent hospital stay for the sample was 8.9 days (SD=5.34, n=10).

Measures

Psychiatric Hospitalization and Resiliency Interview Protocol. This semi-structured interview protocol (Appendix A) was designed for the present study to collect demographic information as well as allow individuals to share their experiences during psychiatric hospitalization and their resiliency efforts when adjusting back to the community. The protocol begins with introducing the participant to the structure of the interview and obtaining informed consent followed by the main body of inquiry.

Participants were asked to describe the details before, during, and after their most recent hospitalization. During participant descriptions of their experiences in the hospital, they were asked to describe helpful and unhelpful factors of the hospitalization that contributed to their overall recovery. Participants were also prompted to consider helpful/unhelpful hospitalization components at the levels of the system (e.g., “What did the hospital-system do that was helpful/unhelpful?”) and individual (e.g., “What did you do while in the hospital that was helpful/unhelpful?”).

Then, participants were asked to describe different areas of resilience that they utilize in both their daily life and particularly when recovering from the hospitalization. Participants were able to endorse and explain their use of select resiliency components. After that, participants

were encouraged to reflect upon their recovery from the hospitalization and identify what they believed helped them bounce back from the hospitalization experience.

Participants were also invited to share information about their current and former social relationships and community life (such as employment and living situations). Basic demographic information (e.g., gender, age, income, etc.) and mental health history and current mental health diagnosis was also obtained. Lastly, participants were asked to share advice they would give to future hospitalization patients.

Procedure

After receiving approval from the Institutional Review Board of a Midwestern University, participants were recruited through advertisements at local psychosocial rehabilitation clubhouses and through flyers posted at various local community mental health centers. Individuals interested in participating engaged in a brief pre-screen phone interview with the primary investigator to determine eligibility. This brief interview consisted of questions regarding the individual's mental health diagnosis, psychiatric hospitalization history, and perspectives on their recovery from that experience. Adults that met the eligibility criteria were invited to participate in the study.

Adults were asked to complete a semi-structured interview that lasted approximately 90 minutes. Interviews were audio recorded and took place at a private location convenient for both the researcher and participant which included public libraries, community centers, coffee shops, and homes. Upon completing the survey, participants were given a $25 gift card as a token of appreciation for their participation in the study. Interviews were then transcribed verbatim and reviewed for accuracy.

Data Analysis

The present qualitative study used content analysis techniques, as described Miles, Huberman & Saldana (2014). Content analysis is fitting for the present study because it is guided by previous research findings which informed the development of the interview protocol. The data analysis process began by transcribing the interviews verbatim followed by two researchers checking the accuracy of the transcriptions against the audio recordings. The primary researcher then read through the complete interviews, making note of any salient themes that emerged and later coding these themes. The primary researcher consulted with an independent researcher in the development of these codes.

This process led to the development of a coding manual which consisted of 14 codes and 114 sub-codes which were used to analyze the data. The primary researcher coded each interview transcript according to themes described in the manual. A total of 256 utterances were coded by the primary researcher. To test for interrater reliability, a second, independent researcher coded 29 randomly selected utterances using the operational definitions detailed in the coding manual. Raters initially agreed on 90% of the codes, but after review and discussion, reached 100% agreement.

Participant utterances were analyzed in two fashions. The first approach compared responses between participants within the whole sample (n=11). The second approach divided the sample into two groups (i.e., those that recovered from the hospital "back to normal" (n=6) and those that recovered "better than before" (n=5)) and compared commonalities in responses between the two groups.

RESULTS

Hospitalization Experience

Helpful hospital experiences. All participants described helpful components of the hospitalization that they believe overall aided their recovery. Table 2 summarizes themes related to helpful components of the hospitalization. Ten participants (91%) found *activities in the hospital that they initiated by themselves* to be helpful. Five participants described *prayer* to be helpful for them. Amy, a 38-year-old woman with a schizophrenia-related disorder said, “When I first got there, I asked for a Bible…When they gave me my Bible, I took it to bed with me. I slept with it and if I couldn’t sleep, I would read the Bible.” Four participants found *engaging in art activities in the hospital* to be helpful for them. Activities could include coloring independently or with others, crafting, and/or attending art-related classes. Four participants stated that *eating while in the hospital* was helpful for their recovery. Two participants reported that *listening to and/or playing music* was helpful for them while in the hospital. Todd, a 33-year-old man who was in the hospital for six days said, “That was a big deal to me being able to play some music because it had been so long...So being able to take [the keyboard places] was really cool of [the staff].”

Nine participants (82%) reported finding *external activities and initiatives* helpful in their recovery *in the hospital*. External activities or initiatives consist of things not driven by the individual which can include external support from friends or help from the hospital system. Six participants found *attending classes or groups* in the hospital to be helpful for their recovery. One participant, Tegan, illustrated this by saying, “If they had exercise, aerobics, or occupational therapy, or group therapy sessions or recreational therapy, any of that, I took part in that… That kept me focused and giving me some tools that I needed in order to turn around.” Six participants

indicated that *obtaining social support from others* while in the hospital (e.g., other patients, friends at home, etc.) was helpful for them. One participant, Edward, explained that while in the hospital, he sought “out other people to talk with. And you can sit there and relate to what they talk about, you know.” Three participants suggested that the *help they received from hospital staff* (e.g., obtaining assistance when needed, encouragement for their recovery, etc.) aided in their recovery. Todd described his experience as, “They work proactive. I don’t know what it was but they had a 6th sense for things. Like stupid stuff like, ‘You need a nicotine patch?’ ‘Yeah.’ That’s the big one and then everything else they did was just super professional and really well done.”

Unhelpful hospitalization experiences. Ten participants (91%) identified *unhelpful components of the hospital system* that deterred from their recovery. Table 3 summarizes themes that emerged within this category. Six participants found that *being around other patients in distress* while in the hospital was unhelpful in their own recovery. For example, Amy said, “Everybody was talking about drugs and alcohol. When I got out the first thing that everyone wanted was a beer. That’s not what I should have done. That was not helpful. When I got out, the first thing I did was call my pastor and was like, ‘I got a beer in front of me.’ Because that’s all they were talking about was drugs and alcohol.” Three participants explained that their *lack of autonomy* in the hospital was unhelpful in their recovery. Josh illustrated his perspective saying, “And then they shift your day, turn the TV’s and stuff off and the phones off at 11 o’clock at night. Once they do that, they turn the TV off so you’re sitting there just sitting in the dark and if you go back to your room all you’re doing is just sitting there. Thinking, thinking, thinking.” Four participants spoke about the *unhelpfulness of the doctors and/or support staff* working at the hospital. Paul described his experience as, “the support staff seemed always mad about

anything. If you ask them for something they would act like it was the biggest thing in the world. For stupid little stuff. And then they would get even madder if you thought they were a nurse, cause they wore similar uniforms and. They, they were not helpful." One participant identified the *classes or groups* held by the hospital to be unhelpful for her.

Three participants (27%) also identified *unhelpful components of the hospitalization that they initiated themselves*. In other words, these unhelpful components were not a result of the hospital system itself. Two participants identified their *lack of sleep* to be unhelpful for them. One participant, Madison, described her challenges with sleep as, "I tried to go to sleep early but that didn't work. I still was up til like 11:00 and I tried to go to sleep at 9:30 and I was still up at 10:30…So you couldn't get to sleep up there."

Hospitalization and recovery. Overall, when participants were asked to describe the degree to which hospitalization was helpful, eight participants (72%) identified the hospital stay to be helpful in their ability to get better. The remaining three participants (28%) identified that the hospital was not helpful in their recovery. A series of contingency tables were constructed to examine differences in the distribution of helpful and unhelpful responses based on participant gender (male/female), diagnostic category (bipolar/schizophrenia), psychiatric hospitalization experiences (1-6 hospitalizations, 7-12 hospitalizations, 13 or more hospitalizations), or type of hospital admittance (voluntary/involuntary). Results of Fisher's Exact Test (appropriate for small samples) indicate no significant differences as expected by chance between the distribution of helpfulness/unhelpfulness responses based on their gender (p = .54), diagnosis (p = 1.0), number of hospitalizations (p = .73), or voluntary nature of admittance (p = .15).

Eight participants (72%) reported that during the hospitalization, they believed they would be capable of recovery. Two participants believed they were capable of recovery before

entering the hospital and one participant believed in his recovery after he was discharged from the hospital. Of the eight participants that believed in their recovery while in the hospital, five (45%) suggested that *receiving external support* helped them foster this belief. External support consists of receiving instrumental, mental, or emotional support from others that provided a supportive outcome that could not have been created by the participant alone.

Six participants (54%) reported finding the use of *internal motivation* to be helpful in their belief in recovery while in the hospital. Internal motivation is defined by utilizing self-driven initiatives that led to a participant's belief in their ability to recover. Three participants (27%) found the *strong spiritual faith* to be helpful for them. Josh stated, "Staying spiritually connected with my mother" helped him believe in his ability to recovery.

Resiliency Efforts in Hospitalization Recovery

Participants described their use of activities associated with resiliency during their recovery from the hospitalization. Participant descriptions of each of these aspects of resilience were categorized into overarching themes and sub-themes (see Table 4).

Goals. All participants identified setting goals for themselves which consisted of short-term and long-term goals. Seven participants (63%) identified setting *daily living goals*. Such goals could include maintaining healthy daily hygiene, cleaning the house regularly, etc. For example, Paul, a 28-year-old man with Bipolar Disorder said, "it would be something extremely small like picking up the dishes in my room and taking them upstairs... Or doing a single load of laundry." Five participants (45%) described having goals that focus on *enhancing their interpersonal life* through activities like attending the clubhouse, getting married, etc. Another participant, Karen, with Bipolar Disorder, said "[I'm working toward] getting up, going to the

clubhouse." Five participants (45%) set *mental and/or physical health-related goals*. Examples of these goals are meeting the doctor's requests to lower weight, exercising, and not having to return to the hospital. Edward, a 61-year-old man with Bipolar Disorder, said "And the other goal that I met was trying to walk more and get my weight down a little bit."

A total of 72% of participants reported having set goals reflecting *personal development/betterment*. Goals in this category could include *setting career goals* (n=4; 36%), *exerting autonomy* (i.e., buying a car, gain living independence, etc.) (n=3; 27%), co*mpleting immediate, self-fulfilling tasks* (i.e., crafting, reading, and donating goods) (n=3; 27%), and one participant (9%) identified setting *spiritual growth goals*.

Nine participants spoke to the degree of difficulty they experience when committing to their goals. Four participants (36%) said it is *relatively easy* for them to commit to and complete their goals while two others (18%) identified this process to be *difficult* for them. There were three participants (27%) who described that the relative ease or challenge that they face while attempting to complete a goal *depends on the nature of the goal*. Regardless of the difficulty, ten participants (91%), endorsed working towards outstanding goals until they are complete. Some participants shared how they are able to continue to pursue their most challenging goals through internally-driven and externally-driven motivators.

Temper. Participants were asked to describe their overall susceptibility of frustration by self-identifying as someone who becomes *easily frustrated* (n=3; 27%), or someone who tends to be a more *patient person* (n=4; 36%). Four participants (36%) stated that their temper depends on their mood and were therefore unable to place themselves in one of the two categories. Nine participants reported coping with their frustration at the individual level by utilizing coping techniques that fall under two categories: *relaxation/meditation* (n=5; 45%) or by taking *active*

de-escalation measures (n=7; 63%). Vickie, a woman with Bipolar Disorder, described using relaxation/mediation methods to help her deescalate, “And I’ve actually really had to pray about [having patience].” Active de-escalation measures are utilized by Sondra, a woman with Bipolar Disorder, “[When I get frustrated,] I quit. Walk away from it awhile.”

Happiness. Participants were asked to reflect on their happiness before and after the hospitalization. Five participants (45%) reported that they are *happier now* than they were before the hospital, three participants (37%) described feeling *just as happy* as they were before the hospital, two (18%) reported feeling *less happy now* than before the hospital, and one participant was unable to provide a response. Participants indicating finding current happiness among their *finances* (n=2), *hobbies* (n=7), *social life* (n=7), *spiritual life* (n=3), *accomplishments* (n=1), and *eating* (n=1). William described finding happiness in his hobbies, “things that make me happy is harvest time now. Growing things.” Karen described the happiness her pet brings her by saying, “My cat [makes me happy]…He sleeps with me when I don’t feel good, he sleeps with me when I do feel good...He’s my companion. I talk to him when I don’t have nobody to talk to and he’ll sit there and listen.”

Humor. All of the participants reported using humor in their daily lives. Edward described his value of humor, “It’s very important. It makes you happy, it gives you something to think about that’s a happy thought. People appreciate my jokes and I appreciate telling them.” Ten participants (91%) also described using humor to cope with difficult times in life. One participant, Paul, described his experience using humor to cope, “I mean that’s one of the things I used to do when I was really depressed is … put on something really funny.”

Past Accomplishments. Ten of the 11 participants shared proud previous accomplishments. Seven participants (63%) shared *accomplishments only involving themselves*.

These accomplishments consist of gaining living independence (n=1), holding jobs for long periods of time (n=2), obtaining an education (n=3), and completing projects (n=1). Amy explained pride in “My college degree because I went through college - part of it, mental. You know, mentally ill. I had my first episode when I was in college. And then when I got out of the hospital, I finished it. I could have gave up but I was like, ‘I want to do this. I have to do this.’ I’ve always wanted a degree, so I finished it.” Four participants described feeling accomplishment in activities that *involved the participant and others*. Sondra described her pride in caring for her animals, “I’m proud of my animals. They’re all healthy. Um, even the baby. It was sick- he’s healthy.”

“Bounce Back” Experiences Post Hospitalization

All participants identified fully bouncing back (i.e. recovering) from their hospital experience. Six participants (54%) believed that they *bounced back to the same level of life satisfaction* that they had before the hospital, when they were not in a psychiatric episode. The remaining five participants identified *bouncing back to a higher level of life satisfaction* compared to their level of life satisfaction before the hospital, when they were not in a psychiatric episode. Table 5 summarizes themes that emerged within this category. A series of contingency tables were constructed to examine differences in the distribution of those that believed they bounced back to the same or higher level of life satisfaction based on participant gender (male/female), diagnostic category (bipolar/schizophrenia), psychiatric hospitalization experiences (1-6 hospitalizations, 7-12 hospitalizations, 13 or more hospitalizations), or type of hospital admittance (voluntary/involuntary). Results of Fisher’s Exact Test indicate no significant differences as expected by chance between the distribution of same/higher level of

life satisfaction responses based on their gender ($p = 1.0$), diagnosis ($p = .18$), number of hospitalizations ($p = 1.0$), or voluntary nature of admittance ($p = .54$).

All participants who reported that they bounced back to a higher level of life satisfaction (n=5), said *making new life enhancements or changes* helped them bounce back. Amy described how her relationship with God grew since she got out of the hospital and explained ever since then she believes, “I have a better outlook on life now. I don’t know. I’ve noticed more joy in my life - the spirit of joy and peace.” Five of the six participants who bounced back to the same level of life satisfaction said that *regaining something that was lost* during the hospitalization helped them bounce back. Sondra described her experience reinstating activities she values in life, “I’ve been going to church and I go down and see my brother whether they like it or not. And I see the kids whether *they* like it or not.”

Participants who bounced back to a higher level of life satisfaction than before the hospital differed from those who bounced back to the same level of life satisfaction in their use of prayer in the hospital, and changes in social relationships. Four of the five participants who identified *praying* while in the hospital as helpful for them also reported that they bounced back to a higher level of life satisfaction than before the hospital. Additionally, participants that bounced back better than before the hospital described having *relationships that grew* (n=4) and *weakened* (n=4) since the hospitalization. All five participants that stated they bounced back to a higher level of life satisfaction identified at least *one change in the relationship(s)* in their life since the hospitalization.

Advice

Participants were asked to provide advice for people who will be adjusting back to life form a psychiatric hospitalization. Advice responses from participants were categorized into three themes: *medical advice* (n=5), *social advice* (n=5), and *individual advice* (n=10), and further broken down into subcategories. Table 6 summarizes the categories that emerged from the data. Subthemes of individual advice were categorized into two groups: *behavioral* and *cognitive* advice. Behavioral advice consisted of participant responses that described recommended activities or behaviors that could be helpful for future hospital discharge patients. Cognitive advice consists of thoughts that can be helpful while recovering from future hospitalizations. Edward shared his advice to encourage people to work towards finishing tasks, “Do something that you know to make yourself feel good even if it’s like doing the dishes and getting it done. If you finish them then you feel accomplishment.”

DISCUSSION

The present qualitative study examined 11 adults personal accounts of hospitalization experiences and resiliency efforts in recovering from a psychiatric hospitalization. Participants described helpful and unhelpful components of the hospitalization which were divided into two categories: individually and externally initiated activities. Participants identified engaging in individually-driven activities such as prayer, art, eating, and music to be helpful for their recovery while in the hospital. External activities identified as helpful were attending classes and receiving support from hospital staff. Participants also described resiliency components that helped their recovery from the hospitalization. Resiliency components highlighted were setting and committing to goals, susceptibility for frustration (i.e., temper), state of happiness, ability to engage in humor, and having previous accomplishments. Lastly, differences in participants' views about their sense of their recovery from the hospitalization allowed the sample to be divided into two groups: adults who felt that they had bounced back from the hospitalization to the same level of life satisfaction as before the hospitalization, and adults who reported that they bounced back to a higher level of life satisfaction. Those individuals who said that they bounced back to the same level of life satisfaction described reintroducing something of value into their life that was lost due to the hospitalization such as regaining their autonomy, having access to friends and supportive others, and having access to treasured items. Adults who felt that they bounced back to a higher level of life satisfaction described making new life enhancements or changes as a result of the hospitalization. Examples of this include developing a better social life and changing careers.

All 11 adults living with serious mental illness recognized the hospitalization as a challenging, disruptive setback from which required recovery. Despite the adversity, the majority

of participants in the present study believed in their own ability to recover from the hospitalization experience and mental health symptoms while they were in the hospital. Hospital system-driven components that were identified as helpful and unhelpful for their overall recovery are similar to helpful and unhelpful components among first-time teenage inpatients (Moses, 2011). These findings suggest that the helpfulness/unhelpfulness of components unique to the hospital system extend to adults living with serious mental illness with one or more hospitalization experiences.

Psychiatric inpatients are faced with much free time in between appointments and other structured activities. However, relatively little was known about how patients choose to spend their free time in a psychiatric hospital setting. Most participants in the present study described engaging in self-initiated helpful activities while in the hospital, with the most common activities being practicing art, prayer, eating, and listening to and/or playing music. Although previous studies have shown the positive effects of engaging in similar structured activities (Kim et al., 2018; Yang et al., 2015), the present study suggests the potential benefit of self-initiated (i.e., "patient-initiated) activities during psychiatric hospitalization. Likewise, some participants in the present study endorsed self-initiated unhelpful activities in the hospital. This finding of unhelpful self-initiated activities suggests that there may be unhelpful activities available to patients in their free time that can hinder their overall recovery. Overall, free time activities selected by inpatients may be related to their perceptions of overall recovery from the hospitalization experience itself.

A primary aim of this study was to understand the exact resilience components used by adults living with serious mental illness when they recover from psychiatric hospitalization. This approach to understanding resilience challenges the popular belief that resilience is a fixed

individual trait consistent across adversities. The present study both supports previous findings of resilience and adds to our understanding of aspects of resilience that adults with SMI use to help them bounce back from the adversity of psychiatric hospitalization.

Previous literature has identified goal-setting and commitment (Kobasa, 1979; Rutter, 1985 & 1987), patience (Lyons, 1991), humor (Rutter, 1985; Kuiper, 2012), and past accomplishments (Rutter, 1985) as individual resiliency traits. Much of existing research on goals among adults with SMI involve treatment-oriented goals, with few studies addressing personal goal setting in time-sensitive environments (Moxham et al., 2017). The majority of the personal goals articulated by adults in the present study were not directly mental health related, did not have a deadline, and were defined by the individual. Findings from the present study suggest that goal-setting and commitment to working on personal goals may be related to perceptions of recovery for people coping with mental illness.

Previous research on patience as a component of resilience used self-report survey items to determine whether or not participants believe themselves to "have a lot of patience" without exploring what contributes to people's perception of their patience (Connor & Davidson, 2003). Although not all participants in the present study identified as being naturally patient, they all endorsed using coping techniques to help them stay calm through difficult situations. This suggests that maybe the learned coping strategies that help people work through adversity influences resilience more than whether or not the person believes themselves to identify as someone who "has a lot of patience." Lastly, the high endorsement of general humor use and humor as a coping technique suggest potential benefits among people who are trying to readjust to community life after hospitalization.

Measures of resilience among people with SMI on popular measures of resilience, such as the CD-RISC (Conner & Davidson, 2003) indicate that this population scores lower than the general population (see Hansen & Thomassen, 2010; Deane & Andresen, 2006; Torgalsbøen, 2012). However, little is known about reasons for mean differences between adults with mental illness and the general population found in previous research. Results from the present study suggest that resilience components such as goal-setting, commitment, patience, past success, and humor are endorsed among adults with SMI after a psychiatric hospitalization. Participants in the present study provided additional descriptions of aspects of resiliency such as the types of goals they set for themselves, what helps them maintain patience, what they are proud of accomplishing, and what brings them happiness. This suggests that situational factors may also be related to aspects of resilience for these adults coping with the aftermath of psychiatric hospitalization. A recent measure of resilience for people with bipolar disorder recognizes the need for tailored assessments of resiliency for unique populations (Echezarraga et al., 2017). However, this measure reflects the view that it is the symptoms of bipolar disorder that requires adults to be resilient. Research suggests that adults with bipolar disorder typically face a number of challenging life circumstances in addition to their symptoms (Jönsson, Wijk, Skärsäter, & Danielson, 2008). The present study suggests that psychiatric hospitalization, a treatment for mental illness, may be challenging in and of itself.

The present study is among the first to explore resilience among adults with SMI after they experience a psychiatric hospitalization. The narrative accounts of participants reflected two views of "bounce back": adults who believed that they have recovered from the hospitalization experience (i.e., bounce back to "normal"), and those adults who believed that they are now better than previously as a result of their hospitalization experience (i.e., bounce back "better

than normal”). These findings provide insight to the differences in resilience components utilized in this bounce back experience. Those adults who believed to have “bounced back better than normal” attribute this to implementing new experiences/making new changes in their life. This sentiment has not previously been recognized as a factor of resilience. Likewise, those adults who believed to have “bounced back to normal” attribute this to simply regaining access to items/systems that were not accessible during the hospitalization. These findings suggest that making changes in life can have a positive impact on recovering from psychiatric hospitalization.

An unexpected finding was that the majority of participants spoke about the helpfulness of something in their environment as the driving force in their recovery. Whether participants bounced back to “normal” or “better than normal,” many of them described finding benefit in surrounding themselves with treasured possessions, supportive and loving people, or other uplifting environmental sentiments. However, it is unclear whether the participants would view these external components equally as helpful after facing a different adversity. This emphasizes the importance of context in perceptions of resilience and how environmental factors have a large impact on adults’ recovery from psychiatric hospitalization.

Overall, the present study describes aspects of resilience as they apply to the specific adversity of psychiatric hospitalization among adults living with serious mental illness. Adults described individual- and system-level helpful and unhelpful attributes that they believed impacted their setback and bounce back from the hospitalization. Individual resiliency components were consistent with previous resilience findings, however, participant descriptions of *why* and *how* the resilience components helped their recovery suggests that resilience can be influenced by environmental experiences. Furthermore, participants described factors such as social support from close others or being around treasured possessions were particularly helpful

in their bounce back from the hospitalization. This study supports that resilience components can consist of unique individual and environmental factors after adults with mental illness experience a psychiatric hospitalization.

Study Limitations and Implications for Future Research

Despite intriguing findings, the present study is limited in a number of respects. The study used a small, non-random sample of adults living with mental illness in the Midwest recruited for the research primarily through their membership in psychosocial rehabilitation clubhouses. The experiences of hospitalization they reported may not be representative of other adults with serious mental illness in inpatient hospitals. In addition, all participants provided self-reports of their current psychiatric diagnosis and hospitalization admittance information which was not verified by independent sources. Participants varied in age, number of former psychiatric hospitalizations, voluntary or involuntary hospital admittance, and diagnosis, making it difficult to draw any conclusions about how these factors might related to adults' psychiatric hospitalization experience.

The present research is among the first to explore resilience among adults with SMI after the experience of psychiatric hospitalization. Results from the present study suggest that there are nuances in individual and environmental attributes of resiliency, supplementary to the common understanding of resilience, which help adults with SMI exert resilience. Participants explained that they found certain things helpful in their recovery *because* the adversity they experienced was a psychiatric hospitalization. Perhaps recovery from other adversities can be impacted by unique resilience components. By choosing to study resilience among specific populations with specific adversities, researchers and clinicians can better understand how to 1) assess resilience via the development of new measures, questionnaires, etc. and ultimately 2)

promote resilience within unique situations. Future research should consider conducting similar studies where the researchers aim to understand unique attributes of resilience from participants who share both specific identities and adversities.

It should also be noted that the generalizability of findings from the present qualitative study is unclear. The present research was intended as a critical first step in describing the hospitalization experiences of a small sample of adults coping with serious mental illness using a resiliency framework. Directions for future research can include larger cross-sectional and longitudinal studies of resilience after psychiatric hospitalization for adults with specific psychiatric diagnoses. Future research in this area would do well to systematically understand both individual and situational aspects of resilience for adults with psychiatric disability. Future research can contribute to the development of more detailed theoretical perspectives and measures of resilience for particular types of populations facing specific kinds of life circumstances. The present study highlights advantages of studying situational aspects of resilience for adults coping with serious mental illness.

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APPENDIX A. TABLES

Table 1

Sample Characteristics

Participant	Age	Diagnosis	Gender	Ethnicity	Relationship Status	Education	Time since hospitalization (months)	Length of stay (days)	Hospital Admittance
Sondra	52	Bipolar	Female	White	Divorced	Some HS	20	5	Voluntary
Karen	52	Bipolar	Female	White	Divorced	Some HS	19	21	Voluntary
Edward	61	Bipolar	Male	White	Married	Some College	8	3	Voluntary
Paul	28	Bipolar	Male	White	Single	Graduate Degree	18	5	Involuntary
Todd	33	Bipolar	Male	White	Single	Some College	6	6	Voluntary
Amy	38	Schizophrenia -related	Female	Hispanic	Single	Associate's Degree	6	4	Voluntary
William	23	Schizophrenia - related	Male	White	Single	Some College	8	30-60	Involuntary
Vickie	65	Bipolar	Female	White	Divorced	Associate's Degree	6	9	Voluntary
Tegan	48	Bipolar	Female	African American	Divorced	Associate's Degree	20	10	Voluntary
Josh	28	Bipolar	Male	White	Single	Completed HS	6	14	Involuntary
Madison	49	Bipolar	Female	White	Married	Some College	12	10	Voluntary

Table 2

Helpful components of hospitalization

Theme	Number of participants	Exemplar Quote
Self-driven helpful components		
Engaging in prayer	5/11	"When I first got there, I asked for a Bible…When they gave me my Bible, I took it to bed with me. I slept with it and if I couldn't sleep, I would read the Bible."– Amy
Practicing art	4/11	"What helped me was…coloring, occupying myself." – William
Eating/Good food	4/11	"I ate sometimes. They had a refrigerator there so I would get a banana or something out of the fridge like jello or something." – Amy
Listening to/playing music	2/11	"That was a big deal to me being able to play some music because it had been so long...So being able to take [the keyboard places] was really cool of [the staff]."– Todd
Playing Cards	1/11	
Stretching	1/11	
Taking long showers	1/11	
Having alone time to relax	1/11	
Watching TV	1/11	
Journaling	1/11	
Hospital system-driven helpful components		
Theme	Number of participants	Exemplar Quote
Obtaining social support from others	6/11	"[I sought] out other people to talk with. And you can sit there and relate to what they talk about, you know." – Edward
Attending classes/groups	6/11	"If they had exercise, aerobics, or occupational therapy, or group therapy sessions or recreational therapy, any of that, I took part in that… That kept me focused and giving me some tools that I needed in order to turn around." – Tegan
Receiving help from hospital staff	3/11	"They work proactive..That's the big one and then everything else they did was just super professional and really well done." – Todd
Autonomy	1/11	

Table 3

Unhelpful components of hospitalization

Self-driven unhelpful components		
Theme	Number of participants	Exemplar Quote
Lack of sleep	2/11	"I tried to go to sleep early but that didn't work. I still was up til like 11:00 and I tried to go to sleep at 9:30 and I was still up at 10:30…So you couldn't get to sleep up there." – Madison
Lying about recovery progress to medical staff	1/11	
Isolating self	1/11	
Hospital system-driven unhelpful components		
Theme	Number of participants	Exemplar Quote
Being around other patients	6/11	"Everybody was talking about drugs and alcohol. So when I got out the first thing that everyone wanted was a beer. That's not what I should have done. That was not helpful." – Amy
Unhelpfulness of doctors and/or support staff	4/11	"the support staff seemed always mad about anything…And then they would get even madder if you thought they were a nurse, because they wore similar uniforms and. They, they were not helpful." – Paul
Lack of autonomy	3/11	"And then they shift your day, turn the TV's and stuff off and the phones off at 11 o'clock at night. Once they do that, they turn the TV off so you're sitting there just sitting in the dark and if you go back to your room all you're doing is just sitting there. Thinking thinking thinking." – Josh
Classes or groups	1/11	

Table 4

Resiliency Components

Goals		
Theme	Number of participants	Exemplar Quote
Daily living goals	7/11	"it would be something extremely small like picking up the dishes in my room and taking them upstairs... Or doing a single load of laundry." – Paul
Enhancing interpersonal life goals	5/11	"[I'm working toward] getting up, going to the clubhouse." – Karen
Mental and/or physical health-related goals	5/11	"And the other goal that I met was trying to walk more and get my weight down a little bit." – Edward
Personal development/betterment	8/11	
Setting career goals	4/8	"I'm working towards…getting a different job. I'm back in school." – Paul
Exerting autonomy	3/8	"Getting out of the group home and getting back to living by myself [is one of my goals]." – Josh
Completing immediate, self-fulfilling tasks	3/8	"I wanna get my books out, my Christian books, and put them [in the church library]." – Sondra
Spiritual growth goals	1/8	

Table 4 Continued

Coping with frustration		
Theme	Number of participants	Exemplar Quote
Relaxation/meditation	5/11	
Listening to music	2/5	
Engaging in prayer	2/5	"[Calming down from frustration] is as simple as saying the serenity prayer and really sit down and think about that and apply that." – Tegan
Reading	1/5	
Coloring	1/5	
Going for a walk	1/5	
Breathing slowly	1/5	
Take active de-escalation measures	7/11	
Stepping away from issues	3/7	"[when I get frustrated,] I leave it behind…and I do something else." – William
Talking with close others	2/7	"[When I'm frustrated,] I go to my people…I'd be like, 'I need help. Please help me.'" – Josh
Accepting failure as part of life	1/7	"You're gonna [face challenges] and you're gonna screw it up…It's okay to just keep trying." – Todd
Engaging in self-talk to push through issue	1/7	

Table 4 Continued

Happiness Generators		
Theme	Number of participants	Exemplar Quote
Hobbies	7/11	
Spending time in nature	4/7	"Things that make me happy is harvest time now. Growing things." – William
Creating art	2/7	
Fixing cars	1/7	
Listening to music	1/7	"Music is like a huge deal with me. I need it all the time, it's like my main coping skill" – Todd
Social life	7/11	
Loving relationships with pets	3/7	"My cat [makes me happy]… He sleeps with me when I don't feel good, he sleeps with me when I do feel good.... He's my companion. I talk to him when I don't have nobody to talk to and he'll sit there and listen." – Karen
Close relationships with others	2/7	
Spending time at clubhouse	2/7	
Setting examples for children	1/7	
Sharing life stories with others	1/7	"Explaining my life experience…[makes me feel] really good." – William
Finances	2/11	
Enjoyable occupation	1/2	
Less expensive bills	1/2	
Spiritual life	3/11	"Being above and in service to God….really is how I stay happy." – Tegan
Accomplishments	1/11	
Eating	1/11	

Table 4 Continued

Humor		
Theme	Number of participants	Exemplar Quote
Humor use in daily life – yes	10/11	“[Humor] is very important. It makes you happy. It gives you something to think about that’s a happy thought” – Edward
Humor use to cope – yes	10/11	“When I was really depressed, [I would]…put on something really funny.” - Paul

Past Accomplishment		
Theme	Number of participants	Exemplar Quote
Accomplishment involving participant only	7/11	
Obtaining education	3/7	“I went through college [when I was learning about my mental illness]… I could have gave up but…I finished it.” – Amy
Maintaining employment	2/7	“[I worked] a horrible nasty job and I learned how to power through it. And it made me proud because I always worked.” – William
Gaining living independence	1/7	
Completing projects	1/7	
Accomplishment involving the participant and others	4/11	
Provide care for dependents	2/4	“I’m proud of my animals. They’re all healthy.” – Sondra
Help others meet their needs	1/4	
Have successful marriage	1/4	“[I’m proud of] my marriage… We made it farther than anybody was saying.” – Madison

Table 5

"Bounce Back" After Hospitalization

Bounce back to same level of life satisfaction		
Theme	Number of participants	Exemplar Quote
Regain something lost in hospital	5/6	
Social support	5/6	"Well the thing that are important to me are being around people that make me happy." - Edward
Autonomy	1/6	"Doing what I want to do…Not having anybody…to answer to…being free [helped me bounce back]." - Karen
Tangible items	1/6	"Looking at pictures of my mom and it helped me remember the good times [helped me bounce back]." – Madison

Bounce back to a higher level of life satisfaction		
Theme	Number of participants	Exemplar Quote
Make new life enhancements or changes	5/5	
Develop better social life	2/5	
Work in a recovery-focused job	2/5	"[Working in recovery] has kept me busy doing something positive, productive, and constructive, too. And that keeps me focused on recovery." -Tegan
Create stronger spiritual life	1/5	
Learn new skills	1/5	"[Growing plants] kind of bounced me back because it's so positive to grow things." – William
Avoid risky situations	1/5	
Buy new items	1/5	

Table 6

Advice

Medical advice		
Theme	Number of participants	Exemplar Quote
Stay on prescribed medications	2/3	
Follow treatment/discharge plan	2/3	
Attend doctor appointments	2/3	

Social Advice		
Theme	Number of participants	Exemplar Quote
Allow and reach out for help from others	2/5	
Maintain close relationships with others	2/5	
Go to psychosocial rehabilitation centers	1/5	

Individual advice		
Theme	Number of participants	Exemplar Quote
Behavioral	5/10	
Stay active	2/5	
Do activities that bring enjoyment	2/5	
Grow plants	1/5	“Grow anything…[when you do, you’re] engaging in positivity and happiness…[which] I think helps people heal the most.” – William
Put effort into recovery	1/5	“Put in some effort. I mean you can just expect to get better doing nothing…actually being proactive and doing what you need to do.” - Paul
Help people	1/5	
Cognitive	5/10	
Be patient with self and adjustment	3/5	“Give yourself at least a few days to get back in the swing of things.” – Todd
Think positively	1/5	
Anticipate the challenge of recovery	1/5	”It’s not going to be easy but just hang in there and you’ll get through it.” – Josh

APPENDIX B. PSYCHIATRIC HOSPITALIZATION AND RESILIENCY INTERVIEW PROTOCOL

Introduction

Thank you for taking the time to meet with me today. I am interested in learning more about your experiences transitioning back into your life after being in the hospital. In order to better understand your perspective, I will be asking you a number of questions that cover several different topics. Please feel free to answer with as little or as much information as you would like, and to ask me questions at any time. This interview should take about an hour to complete.

Consent Form Information

Demographics

I'd like to start by asking you a few general questions about yourself.

1. Age:______
2. Date of Birth: _ _ / _ _/ _ _
3. Gender: _____Male ______Female ____Unidentified
4. Ethic Background:
   - ____ Caucasian
   - ____ African-American
   - ____ Hispanic
   - ____ Asian-American
   - ____ Pacific Islander
   - ____ Other:______
5. Relationship Status:
   - ____ Single, Never Married
   - ____ Married/Partnered
   - ____ Re-married (how long ____)
   - ____ Separated/Divorced (how long ____)
   - ____ Widowed
   - ____ Cohabitating
6. Current Living Situation
   - ____ Live with family member (Relationship __________________)
   - ____ Live with significant other (Relationship __________________)
   - ____ Live independently in group housing
   - ____ Live in constant care facility
   - ____ Live independently
     - ____ Rent a house/apartment/condo
     - ____ Own a house/apartment/condo
7. Educational Background
   - ____ Some High School
   - ____ Some College
   - ____ Bachelor's Degree
   - ____ Graduate Degree
   - ____ Completed High School/GED
   - ____ Associate's Degree
   - ____ Some Graduate School
   - ____ Professional Degree (PhD, JD, MD)
8. Are you currently working? ____Yes ____No
   IF YES, about how many hours per week are you currently working (paid position)? ____ hours per week
9. How much money do you make in a year?
   < $5,000______ $5,001-$10,000______ $10,001-$15,000____

$15,001-$20,000______ $20,001-$25,000_______ $25,001-$30,000____
$30,001-$40,000____ $40,001-$50,000____ > $50,001___

10. What type of mental health problem do you have? (what is your diagnosis?)

    How old were you when you were diagnosed?

    Do you take any medication for your symptoms?
    IF YES
    What types of medications do you take? What is the medication for?
    How does your medication help you?

11. How many times have you experienced hospitalization for mental health reasons? _____

11. How long ago was your most recent psychiatric hospitalization? _____years_____months
12. What hospital were you in? _______________
13. How many days was your last psychiatric hospitalization stay? _________ days
14. Was your admittance to the hospital in voluntary or involuntary?
15. Are you involved with any groups, clubs, or organizations in the community?
    IF YES, what is their name?
    What is your role in _(organization name)?
    How long have you been a part of _(organization name)?

Current Experiences (Post Hospitalization)

Now I would like you to think about your life currently. More specifically, I would like to you to think about your life after you got out of the hospital in (month of last hospitalization).

Situational

I'm going to start by asking you a few questions about your living situation and your job.

1. Where are you living?
    Who are you living with?
    How do you like living there?

2. *IF THEY CURRENTLY HAVE JOB:* What kind of work do you do?
    How do you like your job?

Social

Now I'm going to ask you a few questions about the people in your life.

3. Right now, tell me the people in your life that you are close with. Let's just use first names. (*If participant lists more than ten, interviewer will say,* You've talked about a lot of people, which of those are you closest to?)

How do you know (name)? (relationship)

How often do you talk to (name)?

How close are you to (name): very close, somewhat close, or not very close? (close, secure attachment to others)

Would you say that you sometimes don't get along with (name)?

IF YES, When a problem comes up between you and (name), do you try to fix it?

IF YES, What makes you want to fix the problem?

IF NO, Why don't you try to fix the problem?

When things in life get difficult, do you ask for people to help you? (help seeking)

IF YES, Who helps you? What do they help you with?

Goals and Everyday Experiences

Some people set goals for themselves and try to complete them. An example of a goal could be, telling yourself you are going to clean your kitchen today. By cleaning the kitchen, you have accomplished your goal. Another example would be to plan to call a friend once a week. By calling a friend each week, you would complete that goal. Now I'd like you to think about your goals. It may be hard to remember, so please take your time.

1. Have you been able to set goals for yourself? (Goals)
   Tell me a little about the kinds of goals that you currently have for yourself.
   Do you usually keep trying until you complete your goals? (commitment)
   Out of the goals you have right now, what is the hardest goal to stick to?
2. When you have to do something difficult, like sticking to *hardest goal* how often do you get frustrated in trying to complete the goal? What do you do when you get frustrated? (patience)

Now I'm going to ask you a few questions about your everyday life.

1. Can you talk about what things make you happy or you look forward to right now?
2. Can you talk about what things make you unhappy right now?
3. Overall, how happy would you say you are right now on a scale of 1 to 10, with 10 being the happiest that you have ever been in your life and 1 being the most unhappy you have ever been in your life?

Some people say that they get through tough times because they have a good sense of humor. In other words, they believe that because they are able to laugh a lot, they have been able to work through hard times in life.

4. Would you say that your sense of humor, or ability to laugh a lot, helps you get through hard times? (If so) Can you give me an example of how humor helped you get through a rough time? (sense of humor)

Symptoms and Hospitalization Experiences

Now I'd like to ask you to talk a little about symptoms from your mental illness.

1. How would you describe any symptoms that you experience?

Now I want you to think back to your experience when you were in (name of hospital) in (month).

1. What kind of services did you get in the hospital?
2. In your spare time, what did you do in the hospital?
3. Overall, how did you like it there?

    While you were there, did you believe that you could get better? (self-efficacy)

        IF YES, when did you first realize that you could get better?

        What made you believe that?

4. Did you get a discharge plan when you left the hospital?

    Do you remember some of the big things that were in the plan? (goals)

    IF YES, what was the plan?

    Were you able to stick to that plan when you left the hospital?

        IF YES, what helped you stick to the plan?

        IF NO, what do you think prevented you from sticking to the plan?

Pre-Hospitalization Experiences

Now I would like to talk with you about your experiences before your last hospitalization when everything was going okay. I'll ask the same kind of questions.

Situational

I'm going to start by asking you about your living situation and your job before you went to (name of hospital) in (month of their last hospitalization).

1. During that time, were you still living (describe previously stated living situation)?

   IF NO, what was your living situation?

   How easy or difficult was it to move? (adaptability to change)

   IF YES, How easy or difficult was it to bounce back to your normal life at home after you got back from (name of hospital)? (adaptability to change)

2. *IF THEY CURRENTLY HAVE A JOB:* Were you still working at the same job that you are working at now?

   IF NO, what was your job?

   Did you like your last job more or less than the one you have now? Why?

   How easy or difficult was it to change jobs? (adaptability to change)

   IF YES, How easy or difficult was it to bounce back to your normal job after you got back from the (name of hospital)? (adaptability to change)

3. *IF THEY CURRENTLY DON'T HAVE A JOB:* Did you have a job before you went to the hospital in (month of their last hospitalization)?

   IF YES, what did you do?

   How did you like that job?

   Why did you stop working that job?

Social

Earlier, we talked a lot about who you are close with now. I'd like you to think about the people we talked about earlier and how they helped or didn't help in your experience bouncing back from the hospital.

4. Earlier, you mentioned that you are close with (recite list of names). Do you think some of these people helped you bounce back from your experience in the hospital in (month of last hospitalization)? (social support)

   IF YES, who helped you bounce back?

   How did (name) help you bounce back?

5. Do you think some of these people prevented or stopped you from bouncing back from your experience in the hospital? (social support)

   IF YES, who?

   How did (name) prevent or stop you from bouncing back?

6. Is there anyone who you were close with before the hospital but aren't close with now?

IF YES, who?

What do you think caused the change in how close you feel towards them? You aren't close with them anymore?

Goals and Everyday Experiences

Now I'm going to ask you a few questions about goals that you had before you went to the hospital in (month of last hospitalization).

1. Before you went to the hospital, were you able to set goals for yourself and complete them? (Goals)
   Tell me a little about the kinds of goals that you completed.
   What was the hardest goal that you completed?
2. Earlier you told me that when you work towards your goals now, you (always/sometimes/rarely) get frustrated when you're trying to complete the goal. Would you say that was the same before you went to the hospital?
   IF NO, how is it different?
3. Is there anything in your past that you are really proud of yourself for accomplishing? (past success)
   IF YES, what was that?
   When did you accomplish this?
   What about (that accomplishment) makes you proud?

Now I'm going to ask you a few questions about your everyday life.

4. Can you talk about what things made you happy or what things you looked forward to before you went to the hospital?
5. What things made you unhappy before you went to the hospital?
6. Overall, how happy would you say you were before you went to the hospital on a scale of 1 to 10, with 10 being the happiest that you have ever been in your life and 1 being the most unhappy you have ever been in your life?

Now I'd like to know a little about your symptoms before you went to the hospital.

When you had some of your symptoms come up before you went to the hospital, how did you deal with them?

Your Views

Some people say that they were surprised about how easy it was to bounce back to their normal life after going to the hospital. Other people tell us that they were surprised about how hard it

was to bounce back after being in the hospital. I was wondering how you thought about your experience since you got out of the hospital.

Do you think it was hard or easy to get back to normal after being in the hospital the last time? Do you feel that you are where you were before you went into the hospital? Or are you better or worse off?

If better: Can you tell me about the most important things that allowed you to bounce back better than before? What did *(name of helpful person/thing)* do to help you bounce back?

If the same: Can you tell me about the most important things that allowed you to bounce back as good as before? What did *(name of helpful person/thing)* do to help you bounce back?

If worse: Can you tell me about one or two things that made your time now worse than before?

If you had to give someone advice about the best things to do after getting out of the hospital, what would you tell them?

Closing

We've talked about a number of different things today. Are there any types of things that we haven't talked about that you think are important for me to know to better understand your experience?

It was a pleasure to get to know you, and I thank you for your participation in the study. If you would like to talk with someone in a professional capacity about personal issues, here is a list of community resources. If you think of any questions that you want to ask me, my email address is on the informed consent sheet that I gave you. Thanks again for your help.

APPENDIX C. INSTITUTIONAL REVIEW BOARD (IRB) APPROVAL

DATE: January 12, 2017

TO: Erin Dulek, BA
FROM: Bowling Green State University Institutional Review Board

PROJECT TITLE: [957365-3] Accounts of Resiliency
SUBMISSION TYPE: Revision

ACTION: APPROVED
APPROVAL DATE: January 11, 2017
EXPIRATION DATE: January 10, 2018
REVIEW TYPE: Full Committee Review

REVIEW CATEGORY: Full Committee

Thank you for your submission of Revision materials for this project. The Bowling Green State University Institutional Review Board has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

The final approved version of the consent document(s) is available as a published Board Document in the Review Details page. You must use the approved version of the consent document when obtaining consent from participants. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that you are responsible to conduct the study as approved by the IRB. If you seek to make any changes in your project activities or procedures, those modifications must be approved by this committee prior to initiation. Please use the modification request form for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. All NON-COMPLIANCE issues or COMPLAINTS regarding this project must also be reported promptly to this office.

This approval expires on January 10, 2018. You will receive a continuing review notice before your project expires. If you wish to continue your work after the expiration date, your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date.

Good luck with your work. If you have any questions, please contact the Office of Research Compliance at 419-372-7716 or orc@bgsu.edu. Please include your project title and reference number in all correspondence regarding this project.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Bowling Green State University Institutional Review Board's records.