



An Existential-Phenomenological Investigation of the Experience of Being Accepted in Individuals who have Undergone Psychiatric Institutionalization

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Abstract

This study represents an existential-phenomenological investigation of the experience of being accepted in individuals who have undergone psychiatric institutionalization. Written protocols of narrative accounts were collected from nine individuals drawn from a partial hospitalization programme, with the analysis of these narratives revealing seven basic constituents of the focal experience. The paper concludes with a discussion of the clinical implications of these findings for understanding this experience as it relates to psychotherapy with individuals who experience severe mental illness symptoms and/or stigma.

Carl Rogers (1965) stated:

Unconditional positive regard involves relating from therapist to client, not as a scientist to an object of study, but as a *person to a person*. [The therapist] feels this client to be a person of self-worth [and] of value no matter what his condition, his behaviour, or his feelings. He respects him for what he is, and *accepts him as he is*, with his potentialities. (p. 22)

Since as early as I can remember, the experience of being accepted has been one of great personal and professional significance. As I have grown, my own observations, lived-experiences, and research interests have led me to understand this experience in a certain way: namely, to associate acceptance with attachment, relationships, and the building of an inner foundation that can carry the weight of a secure self-construct. My interest in the present study was to investigate the experience of being accepted by seeking out first-hand accounts of individuals who have experienced being accepted subsequent to the

seemingly inevitable stigmatization of having been institutionalized with severe mental illness symptoms.

Over the course of the past 60 centuries, people with severe mental illness experiences have been managed by society, families and governing agencies in widely different ways. In a review of the literature, I examined the various factors that contributed to the various methods of management, including religious beliefs, cultural perspectives, scientific discoveries, the advancement of medicine, technological developments, and social movements. This review revealed an extensive history of treatment methods that invalidated, injured, dehumanized, rejected and stigmatized individuals who have undergone psychiatric institutionalization.

Additionally, I found a notable shortage of studies illuminating first-person accounts of what it was like to be an institutionalized patient at any point throughout the decades. A clear deficit exists in scholarly work that focuses at all on first-person patient experiences, including the experience of being accepted. Perhaps one of the reasons this deficit exists hinges on the ever-present stigma that the experiences of severely

mentally ill individuals are not as important as their behaviours. The traditional model for examining mental health experiences has comprised measuring observed behaviours and symptoms, and, accordingly, extracting calculations of progress or regression. Even with this history, mental health professionals continue to invest in the improvement of diagnostic tools, the accuracy of diagnosing psychological disorders, and the use of intervention to increase treatment effectiveness. To date, most of the research has been from one side of the equation: the side of the expert.

Differing from the traditional approach, the present phenomenological investigation was guided by a philosophical and theoretical framework that promised an in-depth understanding of treatment from the recipients' perspective, particularly as it pertains to the potentially healing aspect of the experience of being accepted. This focus is relevant not only to the healing profession, but to society at large. While the field of clinical psychology has begun to consider the therapeutic necessity of incorporating first-person accounts into research and its outcomes, it would nevertheless appear that we are only at the beginning.

Phenomenology and the Research Question

Phenomenological research, as it has evolved from the philosophical writings of Edmund Husserl, the recognized founder of phenomenology, enables researchers and psychologists to examine and better understand how phenomena are experienced in their most essential state of being (Valle & Halling, 1989). Phenomenological research joins other qualitative approaches in its ideological attempt to embrace experience, novelty and genuine curiosity in ways of collecting and interpreting data (Marecek, 2004).

The emphasis phenomenology places on first-person descriptions of lived experience differs from more traditional qualitative methodological approaches. An increased understanding of the efficacy of existential-phenomenological methodology in researching the lived experience of individuals with severe mental illness could bring about a much-needed shift in the way psychologists investigate the experiences of this population in the future.

Phenomenological methodology evolved in response to the inadequacy of classical research approaches to access or reflect the lived reality of human experience. As stated by May, Angel, and Ellenberger (1958):

The impetus for *phenomenology* was ... the growing awareness of certain psychiatrists that the classical psychological frame of reference, inherited from the eighteenth century, was no longer adequate for exploration of many psychopathological conditions. In 1914, for example,

Blondel, on the basis of his own studies of mental patients, showed that we do not understand what the psychotic individual really experiences. When we say that a hallucination is a perception without an "object" or "a delusion is erroneous judgment which is maintained in spite of contrary evidence", we give verbal formulations that ... are unable to convey to us how a mental patient actually experiences hallucinations and delusions. Even worse, these definitions give us the false impression that we understand the patient. (p. 95)

It is hoped that the findings of this study will serve the field of psychology by bearing witness to, and offering deeper understanding of, the lived experience of being accepted in individuals who have historically been viewed in a negative light.

Historical Treatment of Individuals With Mental Illness

According to the National Alliance on Mental Illness (2013), approximately 61.5 million people in America experience mental illness in any given year. A major problem is that those who have been institutionalized have tended historically to be invalidated, scrutinized, judged, demoralized, and all too often viewed, by society and physicians alike, as hopeless and useless (Porter, 2003). This problem is not in the past. It is current, as the social stigma of mental illness continues to be prevalent (Corrigan, 2000), with this stigma in itself being a significant cause of depression, self-deprecation, low self-esteem, and lowered life satisfaction in individuals who have suffered severe mental illness symptoms (Corrigan, 1998; Corrigan & Watson, 2002; Link, 1987).

The recognition and treatment of mental illness experiences dates back to as early as 5,000 BC. The analysis of holes in human skulls from this era indicates that early man attempted to relieve physical and psychological suffering by means of trephining – the practice of using a stone instrument to chip into the skull and create a hole from which evil spirits could be released (Porter, 2002). It is believed that our early human ancestors associated psychopathology primarily with supernatural phenomena such as evil spirits, demonic possession, and/or a wrathful deity (Porter, 2002). Throughout history, the association of mental illness with spiritual punishment has led to punitive blaming and merciless attitudes with regard to treating the symptoms.

In ancient Mesopotamia, priests sought to alleviate sufferers of demonic possession by using mystical rituals such as exorcisms, incantations and atonements (Alexander & Selesnick, 1966). Treatment often

concentrated on punishment, judgment, and religious repentance. Religious superstition became socially widespread as a means of protecting oneself or one's family from future spiritual contamination. Priests commonly branded people suffering from mental illness as being punished by God, and, in turn, mainstream society viewed sufferers as God's castaways or souls overtaken by evil. Perhaps these earliest associations have led to the stigma of mental illness that continues to this day.

Some cultures looked upon mental illness experiences not as afflictions, but as unique spiritual capabilities. For example, instead of viewing mental illness as a punishment, Eastern cultures, such as those of India, commonly believed that unusual behaviours or psychotic symptoms such as hallucinations were actually positive connections to gods. Even today, hallucinations are considered by many contemporary African tribes to be evidence of communication with the realm of the spirits, and Hindu culture continues to demonstrate a remarkable tolerance for what is considered to be disturbingly bizarre behaviour in Western societies (Foucault, 1961/2006).

Despite the medical and scientific advancements that would occur over the course of the following 4,000 years, individuals with mental illness and their families living in Europe, and eventually the United States, would continue to face religious, political and social rejection. Throughout the regions of Europe that identified as predominantly Christian, family members were often so ashamed that they concealed sufferers in cellars or animal pens (Porter, 2002). This abandonment of mentally ill people led to a surge in their homelessness and, subsequently, the perception that sufferers were indigent, unlawful, and immoral. Those who were deemed dangerous or unmanageable, whether in family homes or on the streets, were given over to police and thrown in jails or dungeons, sometimes for life (Porter, 2003). The commonplace societal perception of mental illness as an affliction exclusively caused by immoral behaviour or spiritual disobedience would continue to cause widespread rejection of sufferers for centuries to come. In many prevalently Christian fundamentalist communities in the United States, this outlook on mental illness continues to be inculcated to this day (Hood, Hill, & Spilka, 2009).

The Asylum

In naming the system of care that would house and treat the mentally ill, it is worth noting how the word "asylum" came to be applied. The term asylum is synonymous with retreat, refuge, safe haven, and even sanctuary. Yet, asylum practices in the early 18th and 19th centuries retain dreadful reputations to this day. As often referenced in popular culture,

asylums are commonly associated with the infamous inhumanities of this era. The horror films that portray asylums as psychologically frightening facilities in the business of detainment, destitution, and medical experimentation, are more accurate than we would like to believe. Over a 100-year span, "asylums run by mad-doctors" (Porter, 2003) were defined by the torments and howling miseries of their residents. Bloodletting, starvation, sleep deprivation, chains and fixed restraints, seclusion, water and temperature shock, near-drowning and near-suffocation tactics, spinning chairs, and hysteria-inducing "therapies" designed to somehow "exhaust" psychosis by using terror were commonly implemented in the name of therapy at various points in history.

Pinel's Approach: A Light In the Darkness

Amidst centuries of dehumanizing and unaccepting attitudes of doctors toward individuals with severe mental illness experiences, one psychiatrist stood above the rest. Phillippe Pinel practised during the Age of Enlightenment, an era characterized by a shift from traditional religious sources of authority toward science and rational thought (Porter, 2002). Pinel was the first psychiatrist to conceptualize individuals with mental illness experiences as equal members of society. In 1794, Pinel orchestrated a complete overhaul of the living conditions at one of the most notoriously inhumane asylums in France, La Bicetre. Originally, Pinel took charge of La Bicetre as a means of testing his hypothesis that mentally ill patients could substantially improve if they were treated not only with respect but also with kindness. He thus unchained patients, made sure they were clean, eradicated the use of abusive treatment techniques, and provided them with sunlit rooms, exercise, and positive attention (Porter, 2002). Deutsch (1949), who provided significant detail on Pinel's humanistically oriented reform of the standard of care for psychiatrically institutionalized individuals, summed up the basic ethic of Pinel's approach as being that "the patients were not to be considered either as sub-humans or social pariahs, but as men and brethren" (p. 97).

Pinel developed a programme called moral therapy, which held that rehabilitation could only occur if the patient's living conditions were improved. He believed that a healthy mind and body could not be achieved in subhuman living conditions, therefore making institutional reform essential (Goodwin, 1999). Moral therapy included activities such as exercise and lessons on healthy living and good hygiene, as well as activities individually tailored to each patient's interests, such as reading, writing, or music. Pinel sought to reorient his employees to the humanness of their suffering patients and underscored the absolute necessity of treating patients with respect

and kindness. Regarding the experience of acceptance that may have been a healing aspect of the moral therapy treatment paradigm, Deutsch (1949) wrote, "It meant nothing less than the complete humanizing of the institution in its entirety" (p. 225). Pinel's work on hospital and asylum reform ultimately influenced the shift in treatment modalities in much of Europe and the original American colonies.

In addition to Pinel's radical new implementation of asylum care, his method of data collection – talking to patients about their experiences – was controversial and ahead of its time. It raises questions about how the research itself may have impacted the patients. Pinel's method of assessment was based on gaining direct patient feedback and deriving insights from their reported experiences. For the first time, patients deemed severely mentally ill were met by a physician who sat at their bedside and conversed with them like fellow human beings. One cannot help but wonder what patients felt when they were with a doctor who did not shame them but instead regarded them as suffering individuals worthy of kindness, dignity, and respect.

Treating patients with basic human kindness proved effective in reducing symptoms (Whitaker, 2002). In the first decades of moral treatment, 35–80% of all patients admitted were discharged within one year (Bockoven, 1972). This conclusion was based on physician observations of patient behaviour, and in practice implied a marked reduction in psychotic thoughts and disturbing behaviour. Thomas Kirkbride, a physician whose work was influenced by Pinel, was known for having produced positive treatment outcomes under Pinel's tenure by employing moral therapy methods (Whitaker, 2002). Of the 8,546 patients admitted from the 1840s to the 1880s, 25% were discharged as improved and an incredible 45% were reported cured (Morton, 1973).

The person-centred nature of Pinel's approach was a century ahead of its time, and after it was abandoned by more "hospital-based" therapies in the mid 1850s, this approach was not actively applied again until the publication of Carl Rogers's (1951) seminal *Client-Centred Therapy: Its Current Practice, Implications and Theory*.

Institutionalization and the Medical Model

By the late 19th century, asylums were being transformed into what are now referred to as institutions, these institutions being resurrected from the structures of abandoned, dilapidated hospitals. In adherence to the contemporary medical paradigm for treating severe mental illness, the presence of medical equipment was considered not only necessary but the primary means of enforcing treatment. Instead of employing

terror or psychological experimentation to manage psychosis, advancements in industry, science and technology paved the way for radical new modes of intervention. Insulin coma therapy, electroshock therapy, metrazol convulsive therapy, and prefrontal lobotomy surgeries became the new standard of care (Deutsch, 1949; Scull, 1989; Whitaker, 2002).

In 1954, Thorazine (chlorpromazine) was introduced to the United States as a means of managing psychotic symptoms (Whitaker, 2002). This treatment was quickly likened to lobotomy albeit without the permanence of surgery. The advent of psychoactive drugs led to a common misconception that mental illness could be effectively managed with medication alone (Rocheffort, 1984). As such, neither group nor individual psychotherapy was prioritized or even viewed as beneficial to institutionalized individuals. This belief is one of the many aspects that eventually led to the deinstitutionalization movement that began in the 1960s (Fuller, 2008).

Reintroduction of Psychotherapy

Freud (1957) in effect decreed that psychiatrically institutionalized individuals diagnosed with severe mental illnesses, primarily schizophrenia, could not benefit from psychotherapy due to their incapacity to form deep attachments with others. This conclusion stood in stark contradiction to the implications of the 30 years of psychotherapy-oriented moral therapy treatments successfully applied by Pinel. Yet, Freud's declaration resonated cogently throughout the field of psychiatry. As a result, psychotherapy for institutionalized individuals with severe mental illnesses became virtually nonexistent by the mid 1950s (Lysaker, Glynn, Wilkniss, & Silverstein, 2010).

Carl Jung, however, believed that it was indeed feasible for individual psychotherapy to be offered to individuals with schizophrenia (Lysaker et al., 2010). Jung maintained that people with schizophrenia were receptive to talk therapy when it was applied by a trained clinician with specialized skills, citing one particular case of a woman patient who had described to him the hopes and disappointments of her life (Lysaker et al., 2010). Well before the recognized formulation of kinder and more humane therapies, Jung believed that symptoms, even bizarre ones, could be linked to the patient's self-concept and life history. In addition, he believed that a primary purpose of therapy involved not only increasing patients' psychological understanding but enabling the redefining of their self-concepts, even in the case of people with severe mental illness (Lysaker et al., 2010).

In the 60-plus years since Jung's initial psychotherapeutic work, studies suggest that psychotherapy-

based treatments for persons with symptoms of severe mental illness can be efficacious (Bowers, Banquer, & Bloomfield, 1974; Hogarty, Kornblith, Greenwald, & DiBarry, 1995; Josephs & Josephs, 1986). In one study of institutionalized persons with symptoms of schizophrenia, the results indicated that a negative self-evaluation was strongly associated with schizophrenic symptoms such as hallucinations or active psychosis (Barrowclough et al., 2003). A visible correlation between symptoms of schizophrenia and negative self-evaluation indicates to some extent a strong relationship between self-esteem and these symptoms.

Results from research conducted in the late 20th century suggest that, in the case of individuals with severe mental illness experiences, psychotherapy can be efficacious (Calton, Cheatham, D'Silva, & Glazebrook, 2006; Coursey, Keller, & Farrell, 1995; Zahniser & Coursey, 1991). In a first-person account-based study conducted on a stratified random sample of 212 respondents with severe mental illnesses, Coursey et al. (1995) found that the therapeutic relationship and feelings of empowerment were the primary factors causally related to efficacy, with 72% of their respondents reporting that individual psychotherapy had brought positive changes to their lives. The therapeutic issues of greatest importance to the patients were not related to illness but instead to "human concerns" (p. 283).

Humanistic Treatments for Severe Mental Illness

For institutionalized individuals, the humanistic psychology movement represents a light at the end of the tunnel. According to Watson, Goldman, and Greenberg (2011), the reductionist stances of both psychodynamic and cognitive behavioural approaches at that time fell short with regard to the study and understanding of human experience. In contrast, humanistic and experiential therapies offered a holistic, growth-focused theory of the self. One of humanistic psychology's founders, Abraham Maslow (1962), introduced the notion of self-actualization into the psychotherapeutic process, perceiving personal growth as a dynamic process of "becoming".

The humanistic and existential therapeutic movements illuminated the inner-subjective processes that promote healing (Maslow, 1962), with the self being regarded as an aware, subjective being and self-reflecting agent (Heidegger, 1927/1962; Perls, 1973; Rogers, 1957, 1965). Watson et al. (2011) outlined several fundamental assumptions the humanistic orientation shares that pertain to human functioning:

First, a phenomenological perspective with an emphasis on subjective experiencing; second, a belief in the actualizing or growth tendency; third, a view of the person as an

agent capable of self-awareness, self-determination, and choice; and fourth, a style of interpersonal relating that respects and values the other while struggling to fully understand the other's experience. (p. 142)

It is important to note, however, that, in the context of his interest in this new way of conceptualizing therapy and being with clients, Maslow believed that it would not be accessible to people with severe mental illnesses. He wrote:

Although invaluable and a greatly needed corrective to contemporary psychology, such a *zeitgeist* was not conducive to the study of individuals with severely reduced functioning, such as retardation, geriatrics, or psychosis. (cited in Prouty, 2002, p. 579)

Prouty (2002) reviewed 50 years of research and concluded that the focus of humanistic psychology has traditionally been on higher levels of human functioning such as peak experiences and self-actualization. Contrary to Maslow's view, he argues that treatment modalities could focus on lower levels of functioning and thus be used with individuals with severe mental illness. Proceeding from the belief that people with not only learning disabilities and psychological regression, but chronic schizophrenia, and even dementia, can benefit therapeutically from humanistic therapies, Prouty (2002) makes the case that humanistic psychotherapy techniques could be useful and efficacious for individuals experiencing more than just the "existential distress" frequently associated with higher functioning clientele (p. 579).

Regarding psychotherapy per se, Carl Rogers was a profoundly influential humanistic psychologist who developed and advocated client-centred therapy. Rogers's approach to psychotherapy was guided by a set of core conditions – unconditional positive regard, empathy, and congruence – that he believed would facilitate the client's self-actualizing tendencies, and emphasized the essential importance of the therapist's presence conveying the complete and unconditional acceptance of who the client is (Watson et al., 2011). Rogers (1957) defined unconditional positive regard as "a warm *acceptance* of each aspect of the client's experience" (p. 98), empathy as "sensing the client's private world as if it were your own" (p. 99), and congruence as "the therapist [being] freely and deeply himself, with his actual experience being represented by his awareness of himself" (p. 97).

Rogers's continued emphasis throughout the course of his career on the experience of acceptance had a powerful impact on the emerging field of psychology as much as on the individuals receiving psychotherapy.

Researchers in the 21st century have examined the effects of acceptance in the therapeutic relationship, viewing it as an essential ingredient for positive change. Unconditional acceptance is now recognized as providing the optimal conditions for activating a client's capacity for growth (Barrett-Lennard, 2002; Bohart & Tallman, 2010; Bozarth, 2001; Freire, 2001). According to Watson et al. (2011),

In this manner, the nondirective client-centred therapist provides a unique environment in which individuals are maximally free to reflect on themselves and pursue their own trajectory of growth and self-healing. These therapists (Bohart & Tallman, 2010; Bozarth 2001; Schmid, 2003) de-emphasize technique in favour of the quality of relationship between clients and therapists and a belief in the clients' actualizing tendency. (p. 154)

A central question, however, remains: Has this theory impacted individuals who have undergone psychiatric institutionalization? In 1957, Rogers embarked on an extensive research project on the effectiveness of person-centred therapy with hospitalized patients diagnosed with schizophrenia (Kirschenbaum, 2007). The findings of this 10-year study indicated support for the relationship between positive outcome and therapist congruence and empathy. In addition, these findings suggested that the absence of the two conditions, therapist congruence and empathy with the client, was related to relapse (Watson et al., 2011). Rogers's efficacious application of person-centred therapy with individuals experiencing severe mental illness symptoms has aligned with my own work as a clinician and was an impetus for the present research.

Research Methodology

Utilising an existential-phenomenological research method reflects my intention to efficaciously capture the essence of the experience being researched (Giorgi, 1989; Giorgi & Giorgi, 2004). Researchers have noted the empowering and validating personal experience that can arise in those who have been asked about their experience first-hand. In addition to illuminating the experience of being accepted of individuals who have undergone psychiatric institutionalization, it was my hope that participating in this research would provide the co-participants with a supportive experience in which they would feel heard.

Nine co-participants were asked to "Please describe, in as much detail as possible, a time when you felt the experience of being accepted." Their written accounts were carefully read, sifted into meaning units, and these synthesised into essential constituents. The results represent the thematic accounts that were gleaned by means of this methodological approach.

Results

The findings of this investigation revealed that the experience of being accepted in individuals who have undergone psychiatric institutionalization consists of seven essential constituents:

- feeling joy
- feeling valued
- feeling understood
- feeling loved
- feeling belongingness
- being respected
- being unacceptable

These seven constituents and the ways in which they interrelate serve to inform clinicians and researchers regarding the ways in which individuals who have previously undergone psychiatric institutionalization experience themselves in the world.

As a psychotherapist, I have worked with numerous individuals who have undergone psychiatric institutionalization, which not only stirred my interest in their experience but also coloured my perspective on the experience being researched. It was therefore necessary, in analyzing the descriptive data in this study, to acknowledge my pre-existing biases and expectations with regard to the experience and then to bracket my preconceived notions by holding them in my awareness throughout the course of the analysis.

The first six of the seven constituents reflected positive dimensions of the experience, while the last constituent, "being unacceptable", seemed to stand alone as a more negative aspect. However, upon deeper reflection, I came to realize that possibly being unacceptable acts as a reference point that the other experiences and feelings can be measured against. It is, perhaps, the moments of feeling unacceptable in one's life that enable one to fully experience, even cherish, the moments of being accepted. Feeling unacceptable is also important when examining the internalized self-rejection that is often an active and damaging force working within individuals with symptoms of severe mental illness.

The literature paints a powerful portrait of scenes that have taken place for centuries in the lives of people with symptoms of severe mental illness. A seemingly ever-present message of "you need to change" exists in their lives, a message that can be felt in the subtext of every patient-doctor relationship where "changing" is the focus of treatment. Whether it is relieving psychological symptoms, which is to many the most important aspect of moving toward health and happiness, or shifting and guiding behaviours, change remains the central focus of the therapy (e.g., "How can we change you?" or "How can we help you

change who you are?”). A common thread in familial and societal messages is, “You are not okay being who you are”, a message that also often underlies the psychotherapeutic setting and process. Following is a description of each of the constituents.

Feeling Joy

As a psychotherapist, considering the experience of being accepted in the context of *feeling joy* increases my curiosity and excitement regarding its healing properties. For many, especially those who have little or no support system, or who have been abandoned by their loved ones, the experience of feeling joy seems unattainable.

Feeling Valued

The experience of *feeling valued* seemed to act as an antidote to the painful experience of worthlessness that most often accompanies stigma and self-stigma (Corrigan, 2000). Examples of statements reflecting this constituent were: “*In my life, before my mental illness took over, I was highly regarded*”, “*Just knowing that maybe I couldn’t excel in something, but I was still valued*”, and “*I was accepted and allowed to put my best foot forward and that was enough, and I flourished*”. A stigmatized individual has been referred to in the literature as the “bearer of a ‘mark’ that defines him or her as deviant, flawed, limited, spoiled, or generally undesirable” (Jones et al., 1984, p. 6). To be valued in a relationship that offers genuine acceptance is worthy of clinical attention.

Feeling Understood

Van den Berg (1972) recognized the conflict between the perceived reality of people without symptoms of mental illness and that of a person experiencing delusions or hallucinations. According to van den Berg, a patient with schizophrenia is not necessarily out of touch with reality, but is instead someone with a radically different perspective on reality who is misunderstood by others. Link, Cullen, Struening, Shrout, and Dohrenwend (1989) demonstrated that, consistent with the experience of stigma, persons with mental illness believe that most people will reject them, and that patients who self-stigmatize the most have less social support from individuals outside of their immediate household. Feeling understood is thus antithetical to feeling stigmatized.

Adrian van Kaam (1959) is well known for his phenomenological study of the experience of “really feeling understood”. In his study, 365 students were asked to provide a written description of an experience of really feeling understood by someone. Through his analysis of these accounts, van Kaam identified nine essential constituents of really feeling understood by someone: (a) perceiving signs of understanding from the person, (b) perceiving that the other person co-experiences what things mean to the

subject, (c) perceiving that the person accepts the subject, (d) feeling satisfaction, (e) feeling initially relief, (f) feeling initially relief from experiential loneliness, (g) feeling safe in the relationship with the person understanding, (h) feeling safe experiential communion with the person understanding, and (i) feeling safe experiential communion with that which the person understanding is perceived to represent. The fact that the present findings revealed *feeling understood* to be a constituent of the experience of being accepted suggests a deeply shared mutuality between these two experiences.

Feeling Loved

In analyzing the descriptive data, it became clear that feeling loved and feeling joy were in fact separate constituents. Upon further bracketing and reflection, it struck me that the experience of feeling loved and the experience of joy were distinctly different. Baumann (2000) found that the experience of *feeling loved* is linked to feeling trust and hope. From co-participants’ statements such as “*They met me right where I’m at and love me for all of my flaws; that is the experience of being accepted*” and “*They love me for everything, guts and all*”, I came to understand that feeling loved and being accepted are inseparable.

Feeling Belongingness

As Rogers (1957) illustrated in his emphasizing of the therapeutic importance of unconditional positive regard, accepting others implies their being welcomed – *feeling that one belongs* is thus an essential aspect of the experience of being accepted. Brockington, Hall, Levings, and Murphy (1993) and Taylor and Dear (1980) point out how individuals with severe mental illness are very often feared and excluded from most communities. Co-participants described the way in which the experience of acceptance combats this stigmatizing consequence. Examples of their statements include “*The people were so warm, they really sucked me up, and I felt accepted*”, “*I was family*”, and “*I felt embraced, I was just embraced*”.

Laing (1967) discovered an interpersonal aetiology in his research on the families of schizophrenic patients. Rather than seeing schizophrenic behaviour as a defensive escape from hurtful relationships, Laing saw it as a creative adaptation to an otherwise unliveable situation. According to Josephs and Josephs (1986),

Laing believed that schizophrenics, by not adjusting to societal norms, have the freedom to enter the “other world” ... where perhaps they would experience an “existential rebirth” ... if others encouraged and sanctioned such an experience rather than labelling it pathological. (p. 108)

Laing’s perspective is an empowering one. However,

when a support system is rejecting or nonexistent, the experience of feeling belongingness is difficult to attain. The results of the current study suggest that this experience is directly related to the experience of being accepted, an experience that may begin with the patients themselves. In light of this understanding, I began to ask how patients label themselves? Do they see themselves as someone who is a castaway, an outsider, and/or someone who doesn't belong? If this has been their life experience, in what ways can they have a different experience of themselves in the world? Laing's (1967) ideas regarding what he called "existential rebirth" are worth considering in this context.

In reflecting on the ways in which my way of being with my therapy clients affects how we experience one another in the therapeutic setting, I considered a dynamic wherein neither party need sacrifice his or her personal vision but, instead, both perspectives are expanded. In this container, I can envision a new reality that is co-created by my clients and myself. Winnicott (1971) placed this process under the rubric of "transitional phenomena" (p. 1). According to Josephs and Josephs (1986), "Winnicott viewed psychotherapy as two people playing together, mutually creating a novel symbolic reality that transforms the world in which each lives" (p. 109). In this way, one can see the implications that the experience of being accepted might have on the therapeutic relationship, on relationships outside of therapy, and, ultimately, on a patient's or client's life.

Being Respected

The co-participants' reports equate the experience of being accepted with the experience of being regarded as equal to other human beings, and as such thus *being respected* as an equal. According to Josephs and Josephs (1986), the self-concept of individuals with severe mental illness often involves seeing oneself as a "failure at being anything that one could respect as worth being" (p. 185). The desire to be respected appears to be gratified to some significant degree in the experience of being accepted.

Being Unacceptable

As previously stated, without this experience to serve as a reference point, the others may not have been recognized as such, or as meaningful. Individuals who have schizophrenia often internalize the stigma they have experienced from the world around them, which can result in feelings of hopelessness and diminished self-worth (Yanos, Roe, & Lysaker, 2008). It may begin as *being unacceptable* to others, but often becomes a matter of also being unacceptable to themselves.

Loneliness and hopelessness arise when one's happiness is tangled up in the stigma of being labelled

as mentally ill. The rejection by society, family, and loved ones because one behaves differently or fails to be something different is deeply felt. As one co-participant said, "*No matter how hard I tried to do what they expected from me, I could never do it, my brain couldn't do it.*" This statement embodies the defeat that I have often heard described in therapy by these individuals – the ongoing experience that it is difficult, if not impossible, to be the way one's family so badly desires him or her to be.

Even accepting the possibility that "*I will always be this way*" and that "*This is a part of who I am*" can be painful for many sufferers of ailments, perhaps because it can feel like giving up all hope. The experience of being asked (or expected) to change, whether it be by physicians or family, can affect the way patients perceive themselves. The essence of acceptance implies some level of "being okay" with something or someone. It is my understanding of this group's essential constituent that the absence of being accepted is not only experienced through the social construct of relationships, but is also experienced throughout the relationship an individual has with him- or herself.

Perceiving themselves through the lens of stigma often leads to self-stigma, which inevitably results in both low self-esteem and low self-efficacy (Corrigan & Calabrese, 2005). Link, Struening, Neese-Todd, Asmussen, and Phelan (2001) regard self-stigma as internalized public stigma, their model addressing the losses in self-esteem and self-efficacy. According to this model, people develop views of mental illness early on from family lore, personal experience, peer relations, and the media's portrayal of mental illness. Based on these mostly negative preconceptions, a public stigma develops that is characterized by the rejection and devaluation of those with mental illness (Corrigan & Calabrese, 2005).

Another aspect of this constituent involves self-esteem. Often operationalized as ratings of personal worth (Corrigan, Faber, Rashid, & Leary, 1999), researchers have regarded self-esteem as comprising multiple factors including self-deprecation and self-confidence (Owens, 1994) and self-competence and self-liking (Tafarodi & Swann, 2001). In examining self-stigma, Corrigan and Calabrese (2005) have also addressed self-efficacy, defined as the expectation that one can successfully cope with life demands so that individual goals are achieved (Bandura, 1977, 1989). As such, self-efficacy is a cognitive appraisal of past experiences leading to future outcomes. According to research on the impact of self-stigma (Corrigan & Calabrese, 2005), individuals who do not believe they will be efficacious in pursuing specific goals are likely to avoid situations where achievement of these goals is predominant.

Personal Reflections

The experience of acceptance, and the way I have felt it prereflectively towards my own psychotherapy clients who have experienced psychiatric institutionalization, inspired me to begin this study. When working with these clients therapeutically, the experience of being accepted impacts both of us, seeming ever-present in the room. In employing the process of bracketing during the analysis of the written protocols, I came to recognize that I am biased *in favour* of individuals experiencing severe mental illnesses, and negative towards the societal norms. Not only can the assumptions underlying such biases be inaccurate, but they can also be unhelpful when left unacknowledged. Holding my assumptions in awareness throughout this process has helped me recognize how much my preconceptions impact my own life-world experience.

I especially identified with the experiences of feeling belongingness and feeling understood. Written statements that ended up being integral to these two constituents, and particularly because they were so much a part of my own experience, required more effort regarding the bracketing and rebracketing processes as I attempted to clearly delineate the meaning of each co-participant. Being a part of this research has expanded and shifted who I am, and not only as a clinician who strives to best serve and understand her clients.

Clinical Implications

This study was designed not only to deepen our understanding of the experience being researched, but also to offer the co-participants an opportunity to be a part of something potentially meaningful that they could help create. From this, it was my hope that clinicians would in turn become more receptive and sensitive to the lived experiences of individuals who have undergone psychiatric institutionalization. The results of this study are intended to be understood through a comprehensive lens that could apply to individuals who have had (and/or continue to have) severe mental illnesses.

The seven key constituents that emerged represent an extensive range of positive feelings, thoughts, and states of being that are implicit in the experience of being accepted. These findings speak to the range of clinical issues and attendant treatment modalities that are apparently relevant to the experience of being accepted, offering positive and life-enhancing psychotherapeutic outcomes for individuals who experience the multifold and varying effects of mental illness. In addition, the client-clinician relationship, as a pivotal therapeutic alliance that implicitly incorporates the experience of being accepted, would seem worthy of clinical consideration.

Exploring the ways in which the experience of being accepted is enacted in the client-therapist relationship is a starting point for bringing this experience into the therapeutic milieu as a tool. A therapist's application of being accepted as a therapeutic medium for people who have undergone psychiatric institutionalization can be likened to Rogers's (1957) use of unconditional positive regard as a therapeutic technique.

The present findings suggest that acceptance both inside and outside of therapy may be therapeutic to those who have experienced symptoms of mental illness, stigma related to mental illness, or both. By becoming aware of the particular need for acceptance in those individuals, clinicians will be more likely to create an atmosphere in which clients will genuinely feel accepted, mental health practitioners being in a special position to listen, validate, and bear witness to a client's experience.

It is also important to think about the therapist's role in fostering this experience in clients. Rogers (1957) explored how the clinician's presence, attitudes, and treatment modality can contribute to the experience of being accepted in individuals who have been psychiatrically institutionalized. A clinician's treatment modality can affect the experience of being accepted simply through the kinds of questions asked and attitude presented. Whether or not it is a therapist's intention, these attitudes are felt by clients and can impact the experience of being accepted in the here and now in the client-therapist relationship.

Phenomenological research prioritizes an individual's lived experiences. Again, this focus is the strength of this method and allows for individual experiences to be generalized so that others who have encountered a similar situation might gain a deeper understanding of their own lived experience. For individuals with severe mental illness, telling their story in a safe therapeutic setting can facilitate their healing process (Deegan, 1993). Being asked about the experience of being accepted can create a forum where an individual can share his or her experiences as a person with a serious mental illness. Instead of focusing on the illness, the focus is on the person as an individual who faces the challenges of everyday life (Deegan, 1993; Onken, Craig, Ridgway, Ralph, & Cook, 2007).

Future Research

More studies utilizing an existential-phenomenological methodology to investigate the lived reality of this particular population could dramatically increase the understanding of mental illness experiences as well as provide a therapeutic medium for co-participants. This study generated seven essential constituents of the experience investigated that warrant further examination. Suggestions for future research follow.

The experiences of *feeling joy* and *feeling loved* have been minimally researched in relation to individuals who have undergone psychiatric institutionalization. What has caused this deficit in the research area may be related to the continued presence of stigma, which is not limited to the stigma perpetuated by societal misconceptions and the media; it can also be present among clinicians and researchers (Corrigan, 2007). Research suggests that, when compared with non-professionals and laypersons, professionals often rank higher in stigmatizing among those who work directly with individuals who have been diagnosed with a mental illness (Corrigan, 2007). This may be related to the diagnoses and categorizations that are taught in graduate-level psychopathology classes, or it may be related to experiences had by professionals with people in this population.

The experience of *being understood* has also been minimally researched. Other than van Kaam's (1959) study, which was conducted over 50 years ago and focused on high school seniors and college students, no study has specifically examined this experience, let alone its relation to the life-world experience of persons who have undergone psychiatric institutionalization. Research is especially needed on individuals who experience stigmatization, who have internalized stigma, and even clients who have previously been viewed as too low functioning to participate.

More specifically, I encourage future researchers to include individuals with mental illnesses who may also have learning disabilities, physical disabilities, cognitive impairments, and even severe symptoms of mental illness such as psychosis. Even though several co-participants had been diagnosed with psychotic disorders, they were able to contribute to this research in a meaningful way – to the extent that the results of this study would not have been possible without their contribution. The present findings demonstrate that the experience of being accepted is not exclusive to high-functioning individuals.

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While the experiences of *feeling valued*, *being respected*, and *feeling belongingness* are inherently different, they all speak to an essential essence of the experience of being accepted, in that they are all related to a sense of equality. The presence of a sense of equality, which included a desire for it, emerged as an essential part of all three of these constituents. In essence, the experience of living with a mental health diagnosis would appear to be implicitly related to the experience of feeling unequal. Although this is an inference made from this data, further research is needed on the relationship between the experience of being mentally ill and the desire to feel as if one is being regarded as an equal/treated with equality.

Of the seven constituents, the experience of *being unacceptable* has been the most researched to date, primarily in the research conducted on the stigmatization of mental illness (Corrigan 1998; Corrigan, 2000; Corrigan & Calabrese, 2005; Corrigan & Watson, 2002). It is noteworthy that, even in the light of being asked specifically to describe the experience of *being accepted*, the co-participants invariably also addressed the experience of *being unacceptable* in their descriptions.

Conclusion

When I originally set out to take part in a project that focused on experiences had by individuals who have undergone psychiatric institutionalization, I did not originally choose to investigate the experience of being accepted. Instead, my original choice was the experience of being heard. This shifted for me over the course of an organically unfolding process, until I was led to this resounding experience. I use the word “resounding” because, since I began this study, I have not gone through a day without thinking about it. As a psychotherapist who understands that she is just as valuable as any other person, I find myself drawn to awakening that belief in my clients.

About the Author

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Dr Jessica S. Winn, LMFT, PsyD, received her master's and doctoral degrees in Clinical Psychology from the American School of Professional Psychology at Argosy University, San Francisco. She completed her post-doctoral residency in Concord, California, at the Hume Centre's Partial Hospitalization Programme, a community mental health non-profit organization. Here she served patients with severe and persistent mental illness experiences by providing individual, group, family, couple, and milieu therapy.

Dr Winn's breadth of clinical experience spans the course of 14 years, including therapeutic work at group homes with adjudicated youth, in a retirement and respite home, at a drug and alcohol residential treatment facility, home-based services with mothers and families with cognitive and/or physical disabilities, and behaviour modification treatment programmes for children and teens. Dr Winn has come to value humanistically and experientially-oriented therapeutic treatment paradigms for co-creating the emotionally corrective experience needed to break dysfunctional patterns that impair quality of life.

Dr Winn is currently employed as a licensed Mental Health Clinical Specialist for the Behavioural Health Services Department for Contra Costa County, California. She enjoys outdoor and community-based activities in California's East Bay with her spouse and their collective five children, ranging in age from four to seven. Dr Winn values hard work along with the physical act of playing – including climbing, planting, surfing, and digging her roots deep with her children in the community where she resides – and is dedicated to the daily practice of the ever-awakening processes towards gratitude, mindfulness, heartfelt service, and the spiritual practice of simple kindness in both her professional and her personal life.

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