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# Acute inpatients’ experiences of stigma from psychosis: A qualitative exploration

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## Abstract

Stigma is a common difficulty for those who experience psychosis. Experiences of stigma are yet to be explored with acute inpatients who experience psychosis. To examine the subjective experiences of stigma with acute psychiatric inpatients who experience psychosis. Twenty five psychiatric inpatients with experiences of psychosis were interviewed using a semi-structured interview measure of stigma to examine their subjective experiences. Thematic analysis was used to analyse the qualitative data. The qualitative analysis identified three superordinate themes, 'stigmatising social environment and networks', 'stigmatised person with psychosis', and 'stigma interactions'. A graphical representation of these themes and their interaction was developed. Stigma is a concern for acute psychiatric inpatients with psychosis. This concern should be explored in future research, and where appropriate addressed during admission to acute psychiatric care.

Key words: inpatient, stigma, thematic analysis, interviews

Declaration of interests: None

Practitioner points:

- Stigma is a concern for acute inpatients that experience psychosis. It is a concern during admission as well as in the community.
- Participants identified sources of stigma within the inpatient unit from staff and the medical treatment offered.
- Participants identified emotional, cognitive, and behavioural responses to stigma which impact on their mental health difficulties.
- Stigma, where appropriate, needs to be discussed and addressed during an admission to acute psychiatric care.

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## Introduction

Stigma is a mark of disgrace associated with a specific characteristic or quality that a person possesses (Link et al., 1997). Stigma is highly associated with a schizophrenia-spectrum disorder and is perceived as the most dangerous and unpredictable psychiatric diagnoses by the public (Crisp et al., 2005). The detrimental impact of stigma on an individual's well-being and recovery has been extensively researched through quantitative research (Corrigan et al., 2006; Link et al., 2001; Link et al., 1997). Researchers have also attempted to understand these detrimental impacts from a service user perspective using qualitative research (Buizza et al., 2007; Knight et al., 2003; Pyle & Morrison, 2013; Schulze & Angermeyer, 2003). In a recent qualitative study conducted by Burke et al. (2016), stigma equated to misunderstanding and discrimination from others and led to negative impacts on self, emotions, behaviours and recovery. Moreover a systematic review of the qualitative literature (studies which examined the subjective experiences of stigma through semi-structured interviews or focus groups) identified two important stigma factors (Wood et al., 2015). Firstly, stigma was identified as a socially ubiquitous issue penetrating all layers of participants' social systems. Secondly, key components were identified which could potentially tackle stigma, and these included: education and understanding, acceptance, disclosure, and communication.

To date, the majority of qualitative studies of stigma have been conducted with a community sample who have a schizophrenia-spectrum disorder (Wood et al., 2015). Being admitted to an acute psychiatric inpatient ward can often be a distressing experience, particularly if the service user is admitted involuntarily (Gilburt et al., 2008). Service users have reported feeling unsafe and described experiences of verbal and physical abuse (MIND, 2004). The most recent UK national Care Quality Comission (2009) survey illustrated that these issues are still of concern as almost half of inpatients were not always involved in decisions around their care and 20% of inpatients reported that they were not always treated with dignity and respect. Arguably, these reported experiences of acute inpatient admission echo the stigma experiences identified in previous qualitative research (Dinos et al., 2004; Gonzalez-Torres et al., 2007). A possible explanation for this is that important elements of the dominant biomedical model of treatment underpinning inpatient care for people experiencing psychosis have been shown to perpetuate stigma (eg., diagnostic labelling, biogenetic causal beliefs; Read et al 2006; Angermeyer et al., 2011; Haslam et al., 2015).

Very few published research studies have examined inpatients' subjective experiences of stigma. McCarthy et al. (1995) interviewed sixty inpatients about their knowledge of their diagnosis, attitudes to admission and having their social network involved in their care. They found that families of psychiatric inpatients were unlikely to know about their care, that service users are reluctant to disclose their diagnosis and details of their admission. Given the ongoing need to improve inpatient services (Care Quality Comission, 2009), it would seem important to explore inpatients perspectives of stigma. This study aimed to examine the subjective experiences of stigma in service users with a schizophrenia-spectrum diagnosis and who are currently admitted to an acute psychiatric inpatient unit. It will utilise a semi-structured interview measure which has been successfully used to assess stigma among community-based individuals with psychosis experiences (Burke et al., 2016).

## Method

### Participants

Convenience sampling was undertaken to recruit participants for this study. Participants were recruited from an inner London acute psychiatric inpatient unit and identified via nursing staff. Participants were included if they were (i) aged between 18-65, (ii) were currently admitted to a psychiatric inpatient ward, and (iii) met ICD-10 criteria for schizophrenia, schizoaffective disorder or delusional disorder or met criteria for an early intervention service to allow inclusion of first episode service users without a diagnosis. Exclusion criteria were moderate to severe learning disability, organic impairment, participants not having the capacity to consent to research participation, non-English speaking participants, severe thought disorder, and a primary diagnosis of drug and alcohol dependency.

### Interview Schedule

Participants were interviewed using the semi-structured interview measure of stigma (SIMS) (Author, in submission). The SIMS was developed through a systematic review of qualitative literature and in consultation with a service user group. It has been used successfully with a community sample who experience psychosis as a qualitative interview schedule (Burke et al., 2016). The SIMS examined three areas of stigma: experienced stigma, perceived stigma, and internalised stigma (Brohan et al., 2010). Please see table 1 for questions included in the SIMS. These questions were asked in relation to lifetime and also during hospital admission in order to provide space for participants to speak about the most pertinent stigma experiences. Interviews were designed to last between thirty to forty-five minutes. The semi-structured interview offered consistency in topics but also allowed flexibility for the interviewer to be led by participants' responses. Participants were invited to talk about any other issues related to stigma that were not elicited by the interview questions.

As the interviews were undertaken, the SIMS evolved and additional questions were added regarding experiences of stigma or discrimination within the psychiatric inpatient setting.

[INSERT TABLE 1 HERE]

## Procedure and Data Analysis

Full ethical approval was sought for this study from the NHS Research Ethics Committee (14/LO/2164) and the study was sponsored by the University of Manchester. To ensure quality control, the study protocol followed guidance outlined by Thomas and Harden (2008) which includes guidance on the methodology utilised and reporting of the research. Interviews were conducted by the first author LW (n=17) and third author GE (n=8) who are both trained and experienced in qualitative research data collection methods. All interviews took place within the acute psychiatric inpatient ward in a quiet side room. Participants gave written informed consent and completed a demographics sheet prior to completing the interview. The interviews themselves lasted on average 30.48 minutes (range 11.47-48.02).

Interviews were recorded and transcribed verbatim by authors LW and GE. Quality checks of transcription were undertaken by comparing five randomly selected transcripts with recordings. Analysis was undertaken using NVivo software version 10 (QSR, 2012). Transcripts were analysed using procedures for thematic analysis outlined by Braun and Clarke (2006). Thematic analysis was chosen as it is well-suited for working with data gathered using a pre-developed semi-structured interview measure. Thematic analysis requires decisions to be made about the epistemological position that the analysis will take. These decisions were made to best achieve the aims of the study. A realist approach was adopted to work with the data which assumes a directional relationship between meaning, experience and participants' language. Themes were extracted inductively and were strongly linked to the data. Themes were identified by examining the explicit meaning of the data and not looking beyond what the participant has said.

Analysis was conducted in conjunction with data collection in order to achieve saturation, and was an iterative process. Saturation was deemed to be achieved when the research team agreed that no new themes had been identified. First author LW coded all interviews included in the study. Authors GE and RB examined consistency of coding by coding two randomly selected transcripts respectively. Agreement was achieved if the subsequent coding did not identify any new codes not identified by the initial coding.

Initially 1219 codes were identified, and were then collapsed with overlapping codes to form 201 potential themes. These themes were reviewed and finalised within a triangulation meeting involving the full research team (to minimise risk of individual biases in interpretation), where individual themes were discussed and grouped together to form superordinate and subordinate themes. A final thematic structure to represent study findings was then decided upon. The themes were shared with three randomly selected participants to gain feedback and changes were made accordingly. Overall, participants thought the themes made sense and applied to them. Participants suggestions for changes included: amending the wording of themes into simpler lay language; emphasising (more) that stigma is not just confined to a psychiatric admission but rather may penetrate all areas of their lives; and ensuring that the unirelational nature of stigma was emphasised, i.e. that it’s mainly caused by others but has detrimental impacts on them.

## Results

Twenty five individual interviews were included in the analysis. Demographics for participants can be seen in table 2.

**[INSERT TABLE 2 HERE]**

The thematic analysis identified three superordinate themes, 'stigmatising social environment and networks', 'stigmatised person with psychosis', and 'stigma interactions'. These themes are represented graphically in figure 1. All themes reflected experiences that participants had during hospitalisation as well as in the community, as both were outlined by participants as equally important. All quotes below which are not explicitly related to stigma were in direct response to a stigma related question (table 1), thus given the realist method of analysis were taken as themes of stigma.

### Stigmatising social environment and networks

The superordinate theme of 'stigmatising social environment and networks' described the social setting surrounding the individual and the types of stigma which occur within this context. There are multiple types which range from negative labelling to marginalisation. This theme reflects the pervasive nature of stigma for individuals with psychosis.

*Negative labelling and stereotyping of psychosis*

All twentyfive participants identified negative labelling and stereotyping of psychosis as something they are aware of and had experience of. Participants felt that the media portrayals were the main perpetuators of negative labelling and stereotyping. The most common labels identified by participants were being dangerous and unpredictable, "People just have that one view that schizophrenics are highly dangerous and murderers!" (Participant 18), seen as crazy and abnormal, "seen as crazy people doing crazy things" (participant 7), viewed as an illness, “you are mentally ill, so that's how some of the [inpatient ward] staff perceive you” (participant 30), as inadequate or a failure “you know, [they say] look at yourself, you're useless, you're worthless you haven't done, that you haven't achieved. You're in a mental hospital. You're crazy” (participant 26) and as a druggie or drunk, “the manager in the bed and breakfast, when I used to talk to her she used to dismiss me used to say I am drunk ‘go away you are drunk’ even though I'm not drunk ‘don't talk to me’" (participant 30).

Two participants went as far as to compare a diagnosis of schizophrenia to a horror movie. “if you say to someone you’ve got schizophrenia, they step back. Or your psychosis, the film comes into mind like Psycho, like I’m going to kill them or something… That film psycho, that I am a mass murderer” (participant 32).

Negative labelling and stereotyping of psychosis occurred within all of the participants’ social networks including friends and family, “I've had friends that have seen me in that way, I'm a schizophrenia, schizophrenic so must be a murderer. A friend did see me in that way” (participant 2).

All participants felt that negative labelling and stereotyping was maintained by negative portrayals in the media. This included news stories “I remember the stories in the news a while ago with a man who was hacking up children and the teacher protected them” (participant 16) as well as soaps “you know like that episode of East Enders were you know that woman with bipolar people, before that that lady Stacey, relapsed, the way they are portrayed in the acting” (participant 20). Participants reported that the way their social network viewed them was influenced by the media, “Most people just follow what's in the media and is only a few people in the minority who can see where you're coming from and see your story” (participant 5).

### *Discriminatory behaviour towards people with psychosis*

Nineteen participants described experiencing discriminatory behaviour as a consequence of their psychosis. The most common forms of discrimination were verbal abuse “One person said go back to the psychiatric ward” (participant 5), and being treated like a child “I feel that I am treated more like a child erm, than my siblings, …But even with friends, [they] push me around” (participant 15), and being continuously judged “all they [family] do is judge, it’s all conditional, no unconditional positive regard” (participant 19), and being ignored “my sister, the thing is I'm not really in touch of my family at the moment apart from my dad. They sort of ignore me… like I don't exist” (participant 13).

Participants who did not describe any discriminatory behaviour were those who were experiencing their first episode of psychosis “I haven't [had any experiences of discrimination], I haven't had this [psychosis] long enough” (participant 4).

### *Stigma of hospitalisation and involuntary admission*

Psychiatric hospitalisation was described by twenty-one participants as being a stigmatising experience. Firstly, participants explained they had experiences of stigma and discrimination during their admission from ward staff: “*Interviewer (I):* Have you experienced any stigma whilst you were on the ward, on here? *Participant (P):* Sometimes, yes…because the staff dismissed me…I just think that they are discriminating against me at times because of my illness” (participant 30). Participants explained that medical treatment was too quickly offered which they perceived as stigma: “*I:* So you quite feel that maybe doctors, psychiatrists, are stigmatising? *P:* Yeah, and some of the nurses as soon as I say I’m hearing voices, I can’t cope they will all make me, quick take this medication, rather than sitting and talk to me" (participant 32). Participants also referred to the perceived stigma attached to being admitted to a psychiatric hospital  "once that people know that you know, that you have been into a mental home that's it, you just got a label there and then" (participant 36).

### *Dominant use of the medical model and understanding psychosis as a biological illness*

Six participants commented upon the dominant use of the medical model and how this maintained stigma. Diagnostic labels such as schizophrenia and psychosis were deemed to have negative connotations: "All of it [medical diagnosis] is so wrong. Even psychosis is wrong because it's got psycho in it. Paranoid schizophrenic…there is no good connotations anyway" (participant 6).   Participants also spoke about the over-reliance of medical treatment as a form of stigma: "*I:* Do you think staff see you as incapable then? *P:* Yeah I think erm, people should receive encouragement to take care of themselves, like, erm people come round and help them with their cooking or….  It's very much based on, I'll give you a tablet, I'll give you medication.  It's very erm, the treatment seems very harsh sometimes that people in here receive" (participant 15).

### *Multiple social stigmas*

Six participants, all from ethnic minority groups explained that mental health stigma worsened when you had to face additional stigmas such as racism "racism. It's like people judging people about their race, is that kind of thing really. You're such a minority" (participant 17), and negative cultural understanding of psychosis "the cultural bits you know. We are worthless, don't deserve respect, things like that [due to experiences of psychosis]" (participant 28), not meeting gender requirement "especially with men you are supposed to take your problems and deal with them and not let them get to you so that is why you know mental health is seen very differently" (participant 26).

### *Lack of opportunity for people with psychosis*

Ten participants described having a reduction in opportunities, and limits set on their life due to being associated with psychosis. Lost opportunities primarily concerned gaining meaningful employment and not being exploited "so this thing about job experience is a load of rubbish. They just use you, they use my friend in [UK supermarket] and just used to and when the job applications came up he wasn't invited to go for a job. That's discrimination, very much so" (participant 18), and other social issues such as lack of secure housing due to stigma from neighbours, "the main one was the phone call from neighbour [to the council to evict participant]. The people who live in the flat above. That is definitely stigma" (participant 17).

## Stigmatised person with psychosis

The second theme 'stigmatised person with psychosis' reflected the personal impacts and internalisation of stigma. This theme highlighted the cognitive, behavioural and emotional impacts that stigma has on the individual with psychosis.

### *Stigmatising thoughts and rumination*

Seventeen participants reported that stigma impacted on their cognitive processes and content in a detrimental way. The majority of participants reported that they would ruminate and dwell on stigma "I start thinking thoughts of people don't like me, then I see other people, I think I'm an outcast in society and I'm different and I'm in hospital" (participant 17).

Participants also discussed the content of their cognitions being stigmatising and self-critical: “just really critical and yeah, really aware that the person might not think I am normal, or they might have a bad judgement” (participant 8). Participants would also internalise the negative labels: “I feel like a failure!” (participant 32). Participants also spoke about often worrying about what others think of them “The hate from people…. I was worried that people can see you through me and know that I [have psychosis], make fun of me” (participant 26).

### *Withdrawal from relationships, isolation and behavioural change*

Twenty participants reported some behavioural change as a result of stigma. The most significant changes were avoidance of people: “yeah, I just keep to myself and avoid socialising in general. I was definitely keeping myself to myself and keeping quiet, and I knew people were going to ask me about it [mental health] so I just avoided it” (participant 7), and situations: “I also avoid places where people might think that I'm unemployed [due to stigma]. I used to go to the gym in the morning when people would've thought I was unemployed so. So I stick to in the afternoon and early morning” (participant 6). Participants had also developed their own idiosyncratic coping mechanisms to manage stigma such as ignoring stigma: “I will just try to ignore it [when people are saying stigmatising things] or just smile” (participant 5), putting on a façade “I have to put on a façade…. So blend in, I have to put an act on. Yeah” (participant 19), and not letting the media portrayals effect you “You see things on the news all the time. Like a guy with schizophrenia and the police. Me, I think rationally I think logical” (participant 8).

### *Impacts on emotions and psychosis*

Stigma was a source of significant emotional distress for twenty-two participants. This could either be as a consequence of a direct experience of stigma or from perceived stigma. Depression and low mood were the most commonly cited emotional consequences for over half of participants: “it [stigma] just makes it worse, it [stigma] makes me feel pretty low. It’s just another layer on it” (participant 26). Worry and anxiety about stigma was also referred to by half of participants, “yes it [stigma] does worry me a lot. I don't go out sometimes because I'm afraid people will ask me what do I do for living” (participant 6). Participants also explained that they experienced shame and embarrassment as a result of stigma, “stigma suppose its like erm, the kind of thing you don’t want to talk about something that’s like embarrassing or shameful” (participant 15).

Over half of participants explained that stigma impacted on their experiences of psychosis. Participants reported that it make them feel more paranoid when they were out in social situations “the pub can be difficult because, sometimes, sit on my own in the pub, I’m paranoid anyway and I’ve got schizophrenia and I’m paranoid, I think the old men don’t like me cos I’m ill” (participant 17). Auditory hallucinations were also impacted upon by stigma, they worsened due to stigma but also had stigmatising content “it’s the voices that give me the stigma. If I don't hear the voices, I'm okay” (participant 1).

*Noticeable behaviours as a consequence of mental health and medication*

Nineteen participants explained that their behaviours when experiencing psychosis made it obvious to their social network that they have psychosis which can cause stigma, “If you start going into a room on your own when you only start hearing voice people will look at you and notice you they will think you're going mad” (participant 6). Participants also explained the side effects of the medication made them a target of discrimination, “yes, they do the behaviour changes. One thing is that you have an illness and on top of that you have a truck load of medication that alters your behaviour, you know like I started to put on weight" (Participant 30). It was also stated that there was some truth to the negative stereotypes, such as some people actually being dangerous "She works for the ambulances, and she was taking someone through to [mental health hospital] actually and he turned on her" (participant 32).

### *Inferiority and low self-esteem*

Finally, sixteen participants reported that stigma impacted on their self-esteem and confidence "yeah, I have had low self-esteem and not good enough to talk to people and been more critical after talking to people as well" (participant 8). Participants also spoke about feelings of inferiority compared to others who didn't have psychosis, "*I:* have you felt more inferior due to stigma then? *P:* yeah, I have had low self-esteem and not good enough to talk to people and been more critical after talking to people as well, how it went and stuff". Participants also described a sense of defeat in relation to stigma "pretty bad. I mean this is nothing I can do about it [stigma] so that makes it even more, it makes you feel pretty bad about yourself because it is hard to know" (participant 26).

## ***Stigma interactions***

The theme 'stigma interactions' encompasses the relationship between the individual with psychosis and their stigmatising social environment. They are dual processes meaning that these difficulties come from both sides of the relationship.

### *Lack of understanding*

Nineteen participants explained that lack of understanding about psychosis was one of the most significant maintaining factors of stigma. The lack of understanding was predominantly about the cause and maintenance factors of psychosis, as well as the reason people with psychosis behaved in certain ways, e.g. respond to voices. Participants explained that they themselves may not understand psychosis “people might not necessarily understand it that much themselves and neither might not the person who is suffering from it” (participant 10), and neither did their social network “I remember in the community that people don’t understand their illness. They don’t understand so they will think that they are a highly, highly dangerous person” (participant 8). Problematically, this lack of understanding also came from mental health staff on the inpatient ward, “yes, they [ward staff] said it’s all in your head. In no terms like that, it's all in your head” (participant 2). This lack of understanding often resulted in discriminatory behaviour “people don't understand or have their own interpretation of it causes you a lot of problems in society” (participant 18).

### *Lack of disclosure and communication about psychosis*

Lack of disclosure and communication about psychosis was also reported to be an extremely prevalent concern for twenty-one participants. All participants described some difficulty in disclosing their experiences of psychosis due to fears of stigma “no not a lot really. It is not easy to talk about. I can't talk about it” (participant 13). Disclosure was predominantly to immediate family and mental health professionals “I've told me mum, don't tell anybody until I am well. So I will only talk to my immediate family and professionals” (participant 28). Participants also explained that disclosure often led to negative responses and lack of understanding from their network “I remember in the community that people don’t understand the illness. They don’t understand, they will think they are a highly, highly dangerous person” (participant 21).

The other main difficulty regarding lack of disclosure is that participants’ social networks also found disclosure difficult and discouraged participants from disclosing due to feelings of shame and embarrassment “My family have said, said erm don’t talk about that [psychosis] now, and things like that but I’m one of those people who isn’t like that I don’t care who knows just to save face or whatever" (participant 15). When family members have disclosed about their psychosis, the family members themselves have faced stigma, "she [my daughter] became friends with one girl and she had told her about me…something went missing from the girls room, and she accused my daughter of it and … [she] says she should have gone to prison like me and … you are as crazy like your dad" (participant 26).

### *Loss of social contact and distancing due to stigma*

Loss of social contact and distancing was also a significant concern for nineteen participants. Participants explained that different people in their social network would distance themselves from them when they found out about their psychosis "they will visit a relative who's got cancer but they don't give me any time. So they don't understand it" (participant 18). Participants explained that they had superficial relationships "I'm on Facebook, and everyone leaves a comment: "Oh, I hope you are ok, and blah blah", and everyone says "You've got a lot of friends", but they do not call me, or ever come to see me…" (participant 32). Participants explained that they lost relationships completely "I've had mental health problems then you worry that they aren't going to like you so I don't have friends because of that really. Great big gap in my life really, I don't have any friends" (participant 17).

Participants also explained that because of fears of stigma that they isolated themselves from others "I keep myself to myself all the time. Always. Always." (participant 16). They explained that the stigma goes away if you self-isolate "you know if I'm in my room and I haven't been out stigma goes away" (participant 26).

## Discussion

This study aimed to explore the subjective experiences of stigma from the perspective of acute inpatients with experiences of psychosis. Stigma was identified as a prominent issue embedded within the social networks of the participant which was particularly challenging to change. This was evident in the inpatient setting as well as in the community. This study identified that stigma is a prominent issue for psychiatric inpatients with psychosis.

The superordinate and subordinate themes identified in this review broadly reflected themes identified in the recent thematic synthesis of service user perspectives of stigma in psychosis (Wood et al., 2015). Within the review, the stigmatised individual was seen as stigmatised and in the centre of their stigmatising social network. The reviewdentified key stigma processes important in tackling stigma, such as increased disclosure and compassion, education and understanding, and social support. The theme structure described by Wood et al. (2015) also reflected themes identified by Burke et al. (2016) who used the same interview tool with outpatients, but importantly also identified some key differences. In particular, the emphasis on hospitalisation, involuntary admission, and the medicalisation of psychosis. This indicates that inpatients' priorities for stigma do not conceptually differ from service users in the community who experience psychosis. However, it does highlight that the psychiatric hospital may perpetuate the stigma found for service users in the community.

The current study identified stigma as a prominent issue for participants during hospital admissions. Participants reported a number of incidents of experienced stigma during their stay on the ward, as well as the internalisation of the stigma associated with admission to a psychiatric hospital. Staff delivering psychiatric inpatient care have been found to experience high levels of burnout, compassion fatigue and exhaustion in staff due to the high pressured environment (Hansson & Berglund, 1992). Such emotional exhaustion could contribute to staff treating patients in a stigmatising manner by reducing their capacity to deliver person-centred care. Furthermore, the psychiatric ward environment is usually highly medicalised; as mentioned above, biomedical conceptualisations of psychosis have been shown to be associated with higher levels of stigma (Read & Harre, 2001). This suggests that providing non-medicalised stigma interventions for staff working on psychiatric inpatient wards is of importance. This study has highlighted the continued need to reduce the stigma associated with being admitted to a psychiatric hospital. Public education on psychiatric inpatient wards would be beneficial to reduce the stigma associated with admission.

There were a number of limitations to the study. A number of participants struggled to define stigma despite definitions being given to them, and therefore it is not certain that all participants' accounts relate specifically to stigma rather than other negative experiences not caused by stigma. However, given the method of analysis, all quotations were taken at surface level and included in the analysis. Some participants were also experiencing acute symptoms of psychosis as well as having been administered high dosages of anti-psychotic medication. As a consequence a number of participants found it very difficult to remember and concentrate on interview questions. Furthermore, the inpatient environment can be very noisy which meant, at times, both parties were distracted from the interview process. One other limitation was the use of a predefined interview measure, the SIMS. The validity of the study would have been improved if interview questions were developed specifically for the aims of this study (ie., experience of stigma associated with acute inpatient admission). Additionally, the interviews were relatively short which may be reflective of the interview measure utilised and the context in which it was used. It is recommended that qualitative interviews last between thirty to sixty minutes (Smith et al., 2009), but in this current study interview durations were at the lower end of this recommendation.

In conclusion, stigma is a prominent issue for inpatients which does not conceptually differ from outpatients. Further interventions are required to reduce stigma during inpatient admissions.

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**Table 1 – SIMS interview questions**

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|---|---|
| **1.** | What does stigma mean to you? |
| **2.** | How do you think a person with psychosis is viewed by society? Prompt. Inpatient experience |
| **3.** | Have you had any direct experiences of stigma because you have experienced psychosis? What are they? Prompt. Inpatient experience. |
| **4.** | How do others' views about psychosis and/or your experience of stigma make you feel about yourself? |
| **5.** | Have you experienced difficult emotions as a result of stigma? What? |
| **6.** | Has stigma impacted on your daily life? How? Prompt. Inpatient experience. |
| **7.** | Has stigma affected your relationship with others? How? Prompt Inpatient experience. |
| **8.** | Has stigma impacted upon your experiences of psychosis? |
| **9.** | Has stigma affected you accessing mental health services/treatment? How? Prompt. Inpatient Experience. |
| **10.** | Has stigma had any positive impacts on your day to day life? Prompt Inpatient Experience. |
| **11.** | Has stigma impacted on your recovery? Prompt. Inpatient Experience. |

**Table 2 – Sample demographics**

| **Demographic** | **Mean (Standard Deviation)** | **Range** |
|---|---|---|
| **Age** | 36.48 ( 9.98) | 21- 58 |
| **Hospital Admissions** | 4.72 (3.70) | 1-5 |
| **Length of contact with Mental Health Services (years)** | 10 (7.96) | 1-30 |
| | **Category** | **N** |
| **Gender** | Male | 20 |
| | Female | 5 |
| **Employment status** | Employed | 4 |
| | Unemployed | 19 |
| | Student | 2 |
| **Ethnicity** | Black heritage | 5 |
| | White heritage | 10 |
| | Asian heritage | 7 |
| | Mixed heritage | 2 |
| | Other | 1 |
| **Education level** | Secondary | 4 |
| | Further | 8 |
| | Higher | 13 |
| **Marital status** | Single | 22 |
| | Married | 2 |
| | Divorced/separated | 1 |
| **Diagnosis** | Schizophrenia | 16 |
| | Psychotic episode | 8 |
| | Persistent Delusional Disorder | 1 |

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Figure 1 - Graphical Representation of Stigma