Understanding the stigma of psychosis in ethnic minority groups: A qualitative exploration

Abstract

Psychosis is a mental health difficulty which is widely stigmatised. The stigma of psychosis can lead to detrimental consequences and cause further distress. The aim of this study was to explore the experience of stigma and discrimination of psychosis from the perspective of service users from ethnic minority backgrounds. A total of 21 semi-structured interviews were conducted with service users with psychosis from ethnic minority backgrounds examining their experiences of stigma from psychosis. Qualitative data was analysed using thematic analysis. Five superordinate themes were identified, ‘social and cultural context of stigma’, ‘stigma is a family problem’, ‘stigma and discrimination within mental health services’, ‘intrapersonal impacts’ and ‘managing stigma within relationships’. Stigma is a significant concern for people with psychosis from an ethnic minority background. It is important that stigma and discrimination is appropriately assessed and considered within the care of people from ethnic minority backgrounds.

Key words: psychosis, stigma, qualitative, thematic analysis, ethnic minority

Introduction

Stigma has been defined as as a sign of disgrace or discredit, which sets a person apart from others (Byrne, 2000). People who experience psychosis are one of the most stigmatised groups within current western society (Wood, Birtel, Alsawy, Pyle, & Morrison, 2014). The Schizophrenia Commission (2012) identified that 87% of people with psychosis reported experiences of stigma. People who experience psychosis are associated with the most negative stereotypes including dangerousness, violence and aggression compared to other mental health diagnoses such as depression and anxiety (Angermeyer & Dietrich, 2006; Crisp, Gelder, Goddard, & Meltzer, 2005; Wood et al., 2014). As a result they experience the highest levels of discrimination including increased segregation, poor housing, homelessness, restricted employment opportunities, and reduced financial autonomy (Corrigan & Shapiro, 2010). Stigma can have significant detrimental impacts upon the individual including depression, hopelessness, reduced help seeking, and poorer recovery (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Livingston & Boyd, 2010). Stigma can also cause a reduction in social networks and social support due to increase social distancing from the public (Lundberg, Hansson, Wentz, & Bjorkman, 2008; Thonon & Laroi, 2016; Wood, Byrne, Enache, & Morrison, 2016).

It is widely documented that people from ethnic minority backgrounds have higher incidents rates of psychosis, particularly among the African and Caribbean populations (Kirkbride et al., 2012). A number of hypotheses have developed as to why this may be the case including cultural factors leading to misdiagnosis, social factors including deprivation and social disadvantage, and psychological factors such as appraisal and attributional style (Kirkbride et al., 2012; Sharpley, Hutchinson, Murray, & McKenzie, 2001). One large population study identified that social factors such as racism play a particular role in the high prevalence of psychosis within ethnic minority populations (Karlsen, Nazroo, McKenzie, Bhui, & Weich, 2005). It has been demonstrated that stigma and discrimination increase the likelihood of a diagnosis of psychosis in ethnic minority populations as well as being a significant problem post-diagnosis (Halvorsrud, Nazroo, Otis, Hajdukova, & Bhui, 2018; Vyas, Wood, & McPherson, 2021).

People from ethnic minority backgrounds experiencing psychosis are more likely to be the subject of multiple stigmas including mental health stigma, racism, and cultural misunderstanding (Chakraborty, McKenzie, Hajat, & Stansfeld, 2010; Halvorsrud et al., 2018; Islam, Rabiee, & Singh, 2015; Pyle & Morrison, 2013). A Time to Change (2014) survey identified that 93% of ethnic minority populations with mental health difficulties report facing stigma and discrimination. They reported difficulties making and keeping friends, being shunned by people they know, difficulty in finding and maintaining employment, and difficulties with their social life, which was significantly higher than compared to their White counterparts. Moreover, people from ethnic minority backgrounds with mental health problems are more likely to experience lack of socioeconomic mobility, poorer living conditions and lack of access to desirable resources (Halvorsrud et al., 2018; Williams & Williams-Morris, 2000).

This stigma is also embedded within current mental health services. It has been identified that mental health services may not be offering the appropriate care to meet the needs of ethnic minority populations with experience of psychosis, and that they are more likely to be subject to compulsory admission and restrictive treatment (Fernando, 2003; Halvorsrud et al., 2018; NHS Digital, 2020). Current mental health services are largely based within the medical model and offer contrasting conceptualisations of mental health to those from ethnic minority backgrounds who often value a model of understanding which includes religion and spirituality (Islam et al., 2015). It has been identified that a ‘one-size-fits-all’ approach to mental health care does not effectively meet the needs of ethnic minority service users and it is imperative to understand the needs of this population in order to adapt services appropriately (Mantovani, Pizzolati, & Edge, 2016).

Stigma and discrimination have been identified to play a major role in difficulties engaging in services from ethnic minority populations and therefore needs to be better understood. To the author's knowledge only a small number of qualitative studies examining has been conducted with ethnic minority populations experiencing psychosis. Franz et al (2010) interviewed first episode psychosis service users from African American backgrounds about their stigma experiences and identified that participants feared being labelled with psychosis, that the family system was significantly impacted by stigma, and that stigma delayed help seeking from serives. Another study qualitatively examined second generation south Asian users of early intervention for psychosis service experiences of stigma and discrimination (Vyas et al., 2021). Their findings indicated that stigma manifests differently based on individual experiences, culture and multiple intersecting stigmatised characteristics such as race, religion and socio-economic status demonstrating the intersectional nature of mental health stigma (Vyas et al., 2021). There is a need to further develop this evidence base and examine ethnic minority populations experiencing psychosis experiences of stigma and discrimination. Therefore, the aim of this study was to examine ethnic minority service users' subjective experiences of stigma from psychosis.

Methodology

Design

This study utilised a qualitative methodology and conducted semi-structured interviews with participants to examine their experiences of stigma. This study received full ethical approval from the Research Ethics Committee (BLINDED) and was sponsored by the BLINDED.

This study is reported in line with the Consolidated Standards for Reporting Qualitative research (COREQ) guidelines (Tong, Sainsbury, & Craig, 2007).

Participants

Participants were recruited from an inner London acute psychiatric inpatient unit and eligible participants were identified by nursing staff on the ward. The following inclusion criteria applied: (i) aged between 18-65, and (ii) 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. Participants in this study were recruited as part of another study which aimed to validate a qualitative semi-structured interview measure of stigma (Wood, Burke, Byrne, Enache, & Morrison, 2016).

Interview schedule

Participants were interviewed using the semi-structured interview measure of stigma (SIMS) in psychosis and full detail of the measure development can be found in the published paper (L. Wood, E. Burke, et al., 2016). The SIMS items were developed from a systematic review of qualitative literature (Wood et al., 2015) and in consultation with a service user panel who also had experience of psychosis. The SIMS has been used successfully in other sample populations to examine subjective experiences of stigma (Burke, Wood, Zabel, Clark, & Morrison, 2016; L. Wood, R. Byrne, et al., 2016). The SIMS examines three broad areas of stigma including experienced stigma (overt experienced of discrimination from the public), perceived stigma (what an individual thinks people believe about a stigmatised group and also how they believe they are viewed personally (LeBel, 2008)), and internalised stigma (impacts of stigma on self-esteem, mood, relationships, recovery, relationships with services, behavioural change). The broad interview questions can be found in table 1. The semi-structured interview measure was used flexibly in order to allow for pertinent topics regarding to service user experience of stigma to be followed-up.

[INSERT TABLE 1 HERE]

Procedure and analysis

The study followed guidance by Tong et al. (2007) to ensure methodological rigor. This included ensuring the quality of reporting, establishing strategies for reliability and validity in data collection and analysis, and embedding findings within a service user perspective. Interviews were conducted by authors LW and GE who have experience in collecting qualitative research data. Interviews were conducted within the psychiatric hospital in a quiet room off the ward. Before the interview commenced, participants gave written informed consent and completed a demographics sheet. A debrief following the interview was also offered. The interviews lasted on average 30.27 minutes and ranged from 14.03 minutes to 42.04 minutes.

Interviews were recorded and transcribed verbatim by authors LW, GE, MF and SL. Quality checks were ensured by comparing five randomly selected transcripts with recordings. No discrepancies in the transcriptions were identified. Analysis was conducted using NVivo version 12 (QSR, 2016). Analysis was completed using procedures of thematic analysis recommended by Braun & Clark (2006). Thematic analysis is a qualitative approach that can be used flexibly and requires the user to make a number of key decisions prior to its use. For the purposes of this study, a critical realist position was taken and themes were identified inductively and were data-led. Transcripts were read then re-read by researchers and initial coding was undertaken at latent level. The initially codes identified were merged into themes by grouping together semantically similar codes. Higher order themes were identified and agreed upon within the research team. The final analysis led to structure of themes and sub-themes.

Results

A total of 21 participants were included in the study, 16 males and 5 females. Sample demographics can be found in table 2.

[INSERT TABLE 2 HERE]

Thematic analysis was conducted and identified five superordinate themes and sixteen subordinate themes. The themes identified can be found in table 3. All participants interviewed described problems with stigma and discrimination in relation to their experiences of psychosis.

[INSERT TABLE 3 HERE]

Social and cultural context of stigma

The first theme identified the how stigma was present throughout all aspects of the participants' social and community context. Stigma was described as a pervasive experience and something that they found in multiple settings.

Psychosis is the worst mental health problem you can have

Participants reported that psychosis was one of the most stigmatised mental health problems and associated with a variety of negative labels including being crazy, violent, a drug addict, and a danger to society. They reported that this was perpetuated by the media who only portrayed negative images or stories of psychosis.

"I think they [a person with psychosis] are viewed as a dangerous person. 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. I remember the stories in the news a while ago with a man who was hacking up children and the teacher protected them, I think she was given an OBE. Do you remember that story?... with things like that there, I think people would be very paranoid after hearing stuff life that (participant 16).

Moreover, participants reported that psychosis was a more stigmatising diagnosis associated with more negative stereotypes compared to other mental health diagnoses.

"*it isn't really necessarily like anxiety or depression you know, people with anxiety and depression are normally viewed as docile… is usually that they category people with schizophrenia and explosive behaviour*" (participant 41).

My cultural community don't understand and reject me

A number of participants spoke about how their cultural community of origin did not understand mental health and were rejecting towards those with mental health problems. Some reported that mental health problems do not exist as a concept in their culture, which resulted in them being blamed and viewed as weak for having difficulties.

"*in my culture mental health is not seen as mental health, mental health is seen as a sign of weakness. If you are stronger than you have stronger faith…especially with men you are supposed to take your problems and do with them and not let them get to you so that is why you no mental health is seeing very differently*" (participant 26)

As a result, people participants would notice members of their community distancing themselves from them.

"*most people they would not associate themselves around it [psychosis]*" (participant 27)

Managing multiple social struggles

All participants reported a number of social problems in addition to mental health stigma and discrimination. These included racism, sexism, financial difficulties, homelessness, imprisonment and unemployment, which seemed to collectively contribute to their distress.

"*It [stigma] is responsible I think. they [the wider public] think low of me, they are dismissive of [me], nobody has a positive comment about me, about my recovery, and this is a hospital here…I am not in the community yet having to face people again. Cos it's a long time since I've been in hospital, since 2008. And even before it is a long time first I was there send prison and before that I was homeless. So, much misery to contemplate with, comes very easy to slip into this phase where I am at, to sit outside and do nothing about things*" (participant 30)

A number of participants explained that being from poor and deprived backgrounds also made recovery difficult. They reported that stigma led to reduced opportunities. One participant reported that he was contemplating committing crimes in order to survive.

"It's [stigma] made it worse, it's this thing about not having enough money stuff, it makes you contemplate things you wouldn't normally do, like burglary or robbing somebody that you wouldn't normally do… but I've started to contemplate it you know" (participant 16)

Stigma is a family problem

Participants spoke about how the experience of stigma was an experience which impacted their whole family. They described how their family were an extremely important source of support for managing stigma but were also the victims of stigma, as well as stigmatising themselves.

My family are victims of stigma too

Stigma was not just an experience which impacted solely on the participant but also had wider impacts on their family too. They explained that participants' families would be stigmatised for having a relative experiencing psychosis.

"*When she [daughter] went to university she was living with four or five other girls and I had gone to prison then and I had mental issues and she became friends with one girl and she had told her about me I guess you wanted to share it with somebody. And as they settled down they stop being such good friends and something went missing from the girls room, the girls room and she accused my daughter of it and my daughter said no [person's name] says she should have gone to prison like me and my daughter said why and she said well you are as crazy as your dad*" (Participant 26)

Participants often described feeling low and ashamed for the stigma they had brought to their family.

*I feel I've let my family down at times. Sometimes I feel I've let myself down at times but I got to a place where I was depressed (*Participant 29*)*

Stigma is particularly painful when it comes from my (extended) family

Participants described receiving stigma and discrimination from both immediate and extended family. The explained that their family often did not understand their experiences of psychosis/mental health and would perceive them as incapable of being able to fulfil their family duties.

"Okay, this time, this experience, one of my elderly brother, …he said you shouldn't be going to witness the wedding, I should be, he is showing that he is more respectable than I am. That really upset me and I said listen you are an elderly person and people won't say it but he was saying that I'm worthless and he is more superior" (participant 28).

When stigma came from their immediate family participants found it particularly upsetting and difficult to cope with which impacted on their self-esteem.

"when my family judge me, that is has been knocking my self-esteem… it hurts me that they fact my family have judged me. I mean my family have seen me unhappy first or at risk of my life with suicide so that is." (participant 33)

Keeping mental health within the family and sharing the load

One of the most important protective factors of stigma was having family support. Participants who could speak openly about their experiences of psychosis with their family and received support were better able to manage their experiences of psychosis and stigma. Participants often described keeping their mental health experiences within the immediate family and not sharing it with extended family or wider networks.

"I keep it very private with my wife, what I did in 1995, she accepted me, I was in a very poorly condition, no hygiene and she accepted me then, with the help of professional and everybody I see the light at the end of the tunnel, it motivate me" (participant 28)

Stigma and discrimination within the mental health system

This theme outlined key issues which prevented participants from engaging fully with mental health services. This ranged from individual factors such participants being concerned about the stigma attached to accessing services through to the delivery of poor care. Only a couple of participants acknowledged the important role that mental health care played in their recovery journey.

Accessing help is stigmatising

Initially, participants described being concerned about the stigma attached to accessing mental health services which made them reluctant to access support from services. This stigma was a significant barrier to asking for help.

"It's like a mental block or a process through the brain to see what it's going to be like. The stigma of supposedly being psychotic, and then depression as well. The stigma of things actually combining… But basically there's not one easy word to explain what stopped me from going to [services]" (participant 33).

One participant explained that being hospitalised was particularly stigmatising in her culture and how the term translated to being in a "crazy house".

"I mean the real translation of the word rehab is crazy house not psychiatric hospital, the word is pagal which means crazy house, it's spelt PAGAL. Pagal means saying crazy so it's kind of more of a translation linked to a psychiatric asylum, mad crazy. That tells you it fits. And is always hidden, people are ashamed is not just the individual that it is seen as a reflection of the parents, the siblings, so you know so you just want to hide it". (participant 26)

Receiving poor care

Most participants described negative experiences of the mental health system and explained that they had not received high quality person-centred care. One participant spoke about a recent interaction they had with a clinician which the experienced as invalidating.

"*yes, they said its all in your head. In no terms like that, it's all in your head, go away and think about what you've just said. When you come back and say you don't feel like that anymore, we can come back and release you from hospital. [they] haven't directly said that.*

But that's how I feel like I've been treated… That's why don't feel like I've had access to all the services in the past" (participant 2).

Participants also described explicit stigma and discrimination from mental health services which made engagement with mental health services a challenge.

"think my last set of doctors used to stereotyping me quite a lot, said that you are a person that you can't improve, that nothing will work, no medication work. I think that the stigma was, they stigmatized me that is the worst thing someone can hear that you can never gonna be, never gonna improve as a patient". (Participant 30).

Only a couple of participants reported positive impacts of mental health care with most reporting that they did not feel that mental health services were meeting their needs.

"there has been a lot of treatment that is new to me. It made me think about whether I am doing the right thing, it makes you question it. I realised that it did help me, to calm myself." (participant 7)

Moreover, any positive impact of mental health services was described as short-term.

"at the moment I feel as though I am under an umbrella when it's raining, but when I leave here, I leave the umbrella and I will have to get wet need, so will will see if it am getting drenched or I'll get a little drizzle" (participant 1).

"*I personally think that, the medication is alright for a short period of time*" (participant 20)

Intrapersonal impacts

The stigma and discrimination that participants had experiences which had impacted their sense of self and identity. Participants reported struggling with these difficulties in addition to already distressing experiences of psychosis. Furthermore, these experiences intertwined and further worsened one another.

I feel inferior and ashamed

All participants described some feeling of shame and inferiority as a result of stigma. Participant explained that they often felt like a failure, disempowered and out of control. However, some participants explained the importance of trying to overcome this.

"*"I have very low self-esteem, low self-confidence, self-worth, all of it. I have an inferiority complex. I am trying and learning very gradually but surely and surely to love myself again" (Participant 1).*

These feelings of shame and inferiority were exacerbated by thoughts of self-blame and believing they had should have coped better.

"*it's more not embarrassed but a sense of failure on my part because if I was mentally strong and could have should have dealt with it myself because I didn't, becoming the mental health professional's problem*" (participant 26)

Finding my purpose and place in society

Many participants reported struggling with societal and family expectations of them because of their experiences of psychosis. For example, participants spoke about not being able to meet expected gender roles, reach expected life milestones, and contribute meaningfully to society. However, all participants wanted to do these things and wanted understanding and support from others in order to do so.

"Yeah that I can't look after myself. I'm 47 this year as I mentioned and all my mates and friends, they're all married, they got married ages ago, I missed the boat because I'm ill.

Now, it difficult to catch up with them because of all got kids and not only that, but the children are growing up at rapid speed... Yeah, it is a worry because I want to be in a relationship, but I'm not, … I am quite feminine, I am quite traditional and I want to be able to cook, or clean for him and iron shirts and that sort of thing and do the traditional things" *(participant 1)*

"I do get upset and angry sometimes, just ask myself, why are people doing that [being stigmatising] to you? But it motivates you more, more towards being a value member of society" (participant 28)

Stigma is a constant worry

A number of participants described constantly worrying about stigma. They reported that it is a particular worry when going out and mixing with others. One participant reported that he only goes out at certain times of the day so people don't wonder why he is not working.

"*yes I do worry, I don't want to go out of the house until about midday because people be on a lunch break. Sam always worried about what people think of me. I don't talk very well but I don't know why I just rushed through my words*". *(participant 6)*

"I'm always aware of it. I always she the challenge not to get in a predicament. I try my best not to get into a predicament. I try my best to stay away from condensed areas." (participant 29)

Stigma and psychosis are a vicious cycle

Many participants described that stigma and their experiences of psychosis were intertwined and had detrimental impacts on one another. A number of participants reported that their stigma experiences worsened their voices and feelings of paranoia.

"*The fear of stigma because, if I get anxious, the voices get worse. So its kind of a vicious circle, I need to go out to get more confidence in these sorts of things. Then I get more anxious and then the voices get worse and it becomes a vicious circle*." *(participant 26)*

"I was definitely getting more paranoid about people. I was always thinking that they were thinking what I was thinking, like oh what if they were thinking things that I was thinking about myself." (participant 33)

Navigating interpersonal relationships is a challenge

All participants reported that stigma made it very difficult to navigate relationships and being a member of wider society. They all reported personalised ways of managing stigma which usually resulted in them not being able to be themselves or live their lives as they would like to.

Managing the overt signs of psychosis

Many participants reported that they objectively looked different to the general population due to their experiences of psychosis. For example, participants reported that may behave oddly around others, respond to voices, or are not be able to undertake self-care, which would indicate to others that something was wrong and draw attention to them.

"... I went out in [my local town] my shoes were dirty, my clothes were dirty 10 people started to give me money they thought I was a beggar, that I was a beggar. And I was returning the money and saying I don't need it. What people do perceive you if you can't take care of yourself and that's one of the big symptoms of my illness schizophrenia, is very difficult of take care of yourself, you have no motivation. So, for me was an eye opening experience you know I didn't like it, I don't like that" (participant 30).

Participants described having to conceal their experiences of psychosis in order to stop this from happening.

"*I think I act quite normal. In my experience, since being diagnosed with bipolar/schizophrenia, the public don't know about my mental health situation. I've kept under wraps, undercover. No one's really said to me that you're looking at you that you're looking, acting abnormally."* (participant 1)

Avoidance and lack of disclosure

All participants spoke about avoiding places and people due to fears of being stigmatised by the public, friends and family. Participants reported that avoidance limited their quality of life but that it was the only way to manage stigma. As a result, participants reported that they often felt isolated and lonely.

"Yeah, its stops you from going anywhere, I don't want to get confronted with the stigma in the first place so therefore I get withdrawn and reclusive" (Participant 33).

One participant described quite specific strategies he employed in order to avoid people that he used to know prior to having experiences of psychosis.

"... I try not to go out between 12 and 2. Lunchbreak whilst people are on their lunchbreak. Fitness first, I try to avoid going out before 8.30. I try and go out at 5am to go get alcohol and I will erm avoid going out at 5-6.30" (participant 21).

Participants also spoke about the difficult they had disclosing about their experiences of psychosis to others. This was mainly due to fears that others will judge them and not understand their experiences.

"I can't express myself and that's usually because of stigma by someone not being able to understand what psychosis we have, yeah it's quite frustrating, you want to express yourself

and them not being not able to understand that their view of psychosis is the right way" (participant 41).

Personalised ways of coping

All participants described having to develop strategies to manage stigma, which were personalised and quite varied. This included sticking up for themselves and fighting against stigma, being more accepting of their experiences of psychosis, developing a better understanding of themselves, peer support, prayer and accessing religious support. Prayer and religious support was one of the most frequently cited coping strategies.

"I've tried to change it so, when I pray I'll be praying for everyone and the family. Then, I might behave to pray and this and that about drugs praying and then I will come up and I will try to change to prayer. If the thought was tempting my head" (Participant 33).

Discussion

This study aimed to examine the subjective experiences of stigma from the perspective of ethnic minority participants who also have experiences of psychosis. Five superordinate themes were identified, 'social and cultural context of stigma', 'stigma is a family problem', 'stigma and discrimination within mental health services', 'intrapersonal impacts' and 'managing stigma within relationships'.

The first theme 'social and cultural context of stigma' highlighted the importance cultural and social factors which impact on participants' experiences of stigma. All participants described experiences of psychosis as significantly stigmatised, which supports previous research (Pyle & Morrison, 2013; Wood et al., 2015). Participants also reported a lack of understanding from their cultural communities about psychosis and wider mental health issue, which often resulted in stigma, particularly when participants were not able to meet expected social roles or life milestones. This has also been found in another recent qualitative study about stigma conducted with second-generation south Asian populations experiencing psychosis (Vyas et al., 2021). Moreover, participants also had to contend with other significant social problems such as racism, sexism, homelessness, imprisonment, and financial issues demonstrating the multitude of social issues service user may be experiencing in addition to stigma. This again supports previous research which demonstrates that ethnic minority groups are often facing multiple social difficulties which intersect to further disempower and marginalise (Williams & Williams-Morris, 2000). This highlights the importance of services appropriately assessing an individual's social and cultural context and asking about an array of potential social difficulties.

Stigma was also identified by all participants to be an experience embedded within their family network. This would seem to support previous literature which has identified that in some ethnic minority cultures a fear of brining shame to the family, submergence of individuality, and somatisation of symptoms, and a restraint of strong feeling mean that stigma is a more shared experience across the family (Schock-Giordano, 2013). It is likely that this is exacerbated in psychosis given that all participants described it as the most stigmatised mental health issue. It has been identified that family play an important role in an ethnic minority service user's care when they are experiencing psychosis and thus family based interventions to help manage stigma may also be helpful to help for service users and their family (Edge et al., 2018).

The theme 'stigma and discrimination within mental health services' identified that participants experienced a number of barriers engaging with mental health services for a variety of different reasons. This is widely documented across the stigma literature (Halvorsrud et al., 2018; Mantovani et al., 2016), and supported by this current study. This study identified specific factors as to why participants struggled to utilise mental health services including the stigma of seeking help from mental health services and the lack of personalised quality care provision. This demonstrates that mental health services need to continue to adapt to the needs of ethnic minority populations in order to offer culturally competent personalised care (Heffernan, Neil, & Weatherhead, 2014). Recommendations to develop culturally sensitive mental health care include staff acknowledging, accepting and valuing the cultural difference of others, improving staff's cultural knowledge, adopting a reflexive practice, all of which can be achieved through appropriate teaching and training (Bhui & Warfa, 2007).

The next theme identified intrapersonal consequence of stigma and included feelings of inferiority and shame, impacts on mental health, and finding one's place in society. Collectively, participants described a number of significant detrimental impacts from stigma which are not routinely considered in clinical care. A clear assessment and formulation of such experiences is integral to offering appropriate intervention and support (Wood, Byrne, & Morrison, 2017; Wood, Byrne, Varese, & Morrison, 2016).

Finally, participants found managing the impacts of mental health stigma within relationships a challenge. All participants felt they had to conceal their experiences of psychosis and avoid others in fear that others may stigmatise or discriminate against them, which is in line with previous literature (Vyas et al., 2021; Wood et al., 2015). Participants also had developed personalised coping strategies to manage stigma. Religion and prayer was highlighted as an important coping strategy, which demonstrates the need to integrate religious support into routine mental health care (Heffernan et al., 2014). This demonstrates that services should better support ethnic minority services users to identify personalised ways of coping with stigma.

A strength of the study was that it interviewed ethnic minority service user's about their experiences of stigma relating to their experiences of psychosis. There has only been one other relevant study which focused specifically on second generation south Asian populations (Vyas et al., 2021). However, the main limitation was that it looked at ethnic minority experiences broadly and therefore may have missed the nuanced experiences of service users from different cultural backgrounds. Another limitation was the use of the SIMS semi-structured interview measure. Although, it has been identified as a reliable and valid measure of stigma in psychosis, it was not designed for the specific aims of this study (L. Wood, E. Burke, et al., 2016). The data was initially conducted for the purposes of the measure validation and although relevant follow-up questions were asked, it was not possible to ask participants in detail about factors which deviated significantly from the interview schedule. Therefore, it was not designed to specifically to interview ethnic minority service users about their experiences of stigma. A further limitation was the recruitment of psychiatric inpatients to complete the interviews. A number of confounding factors potentially impacted on the quality of interview data gathered including a noisy and chaotic environment, participants being quite heavily medicated, memory and attention difficulties, and some participants actively experiencing psychosis and thought disorder. This may be reflected in the relatively short interview length which is lower than recommended semi-structured interview times (Creswell, 2009).   Nevertheless, this is a relatively under-researched population and therefore it is essential to gather their perspectives.

In conclusion, people who experience psychosis who are also from an ethnic minority background are subject to experiences of stigma and discrimination. Mental health services need to adapt in order to meet the needs of this population, particularly focusing on offering holistic models of care, and assessing and support them with multiple stigmas.

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Table 1 – SIMS interview questions

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	Range
Age	33.90	21 - 54
Hospital Admissions	3.85	1-15
Length of contact with Mental Health Services (years)	7.57	1-24

	Category	N
Gender	Male	16
	Female	5
Employment status	Employed	5
	Unemployed	14
	Student	2
Ethnicity	Asian	8
	Black heritage	7
	Mixed heritage	4
	Other	2
Education level	Secondary	6
	Further	6
	Higher	9
Marital status	Single	18
	Married	2
	Separated	1
Diagnosis	Schizophrenia	12
	Psychotic episode	7
	Bipolar Affective Disorder with psychosis	2

Table 3 – Theme structure

Social and cultural context of stigma *Psychosis is the worst mental health problem you can have* *My cultural community don't understand and reject me* *Managing multiple social struggles*	**Stigma and discrimination within mental health services** *Accessing help is stigmatising* *Receiving poor care*	***Managing stigma within relationships*** *Managing the overt signs of psychosis* *Avoidance and lack of disclosure* *Personalised ways of coping*
Stigma is a family problem *My family are victims of stigma too* *Stigma is particularly painful when it comes from my (extended) family* *Keeping mental health within the family and sharing the load*	**Intrapersonal impacts** *I feel inferior and ashamed* *Finding my place in society* *Stigma is a constant worry* *Stigma and mental health is a vicious cycle*	