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TITLE: Let's talk about psychosis

RUNNING TITLE: Discussion of psychotic symptoms in psychiatry.

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ABSTRACT

Background: Research suggests that while patients wish to talk about positive psychotic symptoms, psychiatrists may be reluctant to do so in routine outpatient consultations.

Aims: To explore the content, context and impact of discussion of positive symptoms within psychiatric consultations.

Methods: Thematic analysis was applied to first discussions of positive symptoms, and overall impact assessed on the length of the consultation and the therapeutic relationship.

Results: Sixty-five of 143 consultations contained discussion of a positive psychotic symptom. Symptom discussion neither harmed the therapeutic relationship nor lengthened the consultation. Patients' disclosures strongly corresponded with psychological models of psychosis, emphasising personal meaning and emotional impact. In contrast psychiatrists focused on topographical characteristics, such as frequency and location. Strengths in psychiatric practice included using open questions, positive reinforcement and offering explanations tentatively.

Conclusions: Findings support discussion of positive symptoms within outpatient consultations, to include necessary assessment of topography and risk alongside exploration of patients' subjective experience.

KEY WORDS: Psychosis, positive symptoms, communication, psychiatric consultation.

INTRODUCTION

Symptoms of psychosis are primarily treated with antipsychotic medication with variable impact [1]. In recent years emphasis has been placed not just on the outcomes of treatment itself but on the process of delivery of such treatment, for example there has been a shift towards a more 'patient-centred' approach to treatment in physical healthcare [2] and in mental health care and in psychiatry (e.g. [3]). In addition the past 25 years has seen a growth in psychological interventions for psychosis, with early studies showing that it is both possible and therapeutic to discuss the content, meaning and emotional consequences of delusions (e.g. [4]) and auditory hallucinations (e.g. [5]). Talking with patients about the content and emotional impact of psychotic symptoms has historically been discouraged and may present a particular challenge for psychiatrists [6]. There are no evidence-based recommendations or guidelines for psychiatrists to shape their practice in this area, and psychiatrists may avoid discussion of psychotic symptoms (e.g. [7]) for fear that discussing the content and emotional impact of psychotic symptoms will be too time-consuming, lead to collusion or disagreement, increase risk, and harm the therapeutic relationship. Little research has explored these issues. The current study uses mixed methods (questionnaire data and thematic analysis) to explore how patients and psychiatrists talk about positive psychotic symptoms in routine consultations. This method has high ecological validity, provides rich data, and in tandem with questionnaire data on therapeutic alliance, further examines whether discussion of

positive symptoms impacts the therapeutic relationship.

METHODS

Data and participants

Data were collected as part of two studies exploring communication in routine outpatient psychiatric consultations between psychiatrists and patients with a psychotic illness. All consultations took place in East or Northeast London in the normal consultation rooms of the psychiatrists and were video-recorded using a digital video camera set up and switched on prior to the start of the consultation. All aspects of the consultation (including time, length, venue, content and style) were intended to remain unchanged by inclusion in the study and to be uninfluenced by the recording as far as possible.

Participants were consultant psychiatrists and higher-level psychiatry trainees (ST4-6). Following their recruitment, the psychiatrists identified patients on their caseloads meeting ICD-10 criteria for a diagnosis of schizophrenia or schizoaffective disorder and who were being seen regularly in outpatient clinics. Patients were excluded on the basis of substance misuse, organic brain disorder or needing an interpreter. Written informed consent was received from psychiatrists and patients prior to their participation. Ethical approval was granted by Southampton and Southwest Hampshire Local Research Ethics Committee [Ref 05/Q1702/94] and East London REC 1 [Ref 10/H0703/12].

In total 143 consultations were analysed. Consultations ranged in length

between 5 – 42 minutes with an average length of 19 minutes. In some consultations other people were present apart from the psychiatrist and patient including the patient's carer, family or other members of their care team such as a care coordinator. Consultations were not excluded from the analysis on this basis. A typical consultation covered a range of topics including review of the patient's mental state, medication and associated side-effects, living arrangements and home management, social activities, and daytime activities (e.g. day centre attendance or work).

Measures

A questionnaire captured sociodemographic variables including age, gender, ethnicity, marital status, first language and employment status as well as clinical variables including illness history, weeks spent in hospital, and number of voluntary or compulsory hospital admissions.

In order to capture each patient's current symptom profile the *Positive and Negative Syndrome Scale for Schizophrenia* (PANSS; [8]) was completed. The PANSS is an approximately 45-minute clinical interview, which rates 30 symptoms - on a 7-point Likert-scale - that make up three subscales, the positive scale, negative scale, and general psychopathology scale. The PANSS was conducted directly with patients by trained researchers who were not involved in the patient's treatment and who were unaware of the content of the psychiatric consultation.

The Scale To Assess Therapeutic Relationships in Community Mental Health Care (STAR; [9]). The STAR is a measure of the clinician – patient therapeutic relationship in community psychiatry. There are two versions; clinician and patient, each with established reliability. Each scale is made up of 12 items comprising three subscales: ‘positive collaboration’ and ‘positive clinician input’ in both versions, ‘non-supportive clinician input’ in the patient version, and ‘emotional difficulties’ in the clinician version. Each psychiatrist and patient completed the STAR directly after the consultation.

Procedure

Each consultation was analysed for the presence of a discussion of a currently present psychotic symptom. All segments of the consultations that included the first instance of a discussion on the topic of one of the patient’s positive psychotic symptoms were extracted. Where there was discussion of more than one positive symptom the first instance of discussion of each symptom was extracted. 10% of the consultations were independently rated for content that included discussion of a psychotic symptom by a second rater in order to establish inter-rater reliability.

Quantitative analyses were applied to compare patient and consultation characteristics of those consultations that included discussion of a psychotic symptom to those that did not.

Thematic analysis was applied to the extracts containing discussion of a positive psychotic symptom and adhered to guidelines for conducting and

reviewing qualitative research in order to promote and maintain high rigour and quality control in this field [10, 11]. Analysis was conducted on written transcripts of the consultations using a computer software programme called 'Dedoose' suitable for the analysis of mixed-methods research incorporating both quantitative and qualitative data [12]. The software enabled both the extraction of individual data extracts from larger data items, and the coding of extracts using an evolving and extensive list of codes. Codes could be further delineated into subcodes, allowing for broader themes, incorporating a number of subcodes, to evolve during the analysis.

RESULTS

Context of discussing psychosis and impact on consultation time and therapeutic relationship

Of the 143 consultations analysed, 65 contained discussion of at least one present, positive psychotic symptom: hallucinations (mostly auditory) were discussed in 62% extracts, and delusions in 41%. In the remaining 78 consultations, patients reported not experiencing current positive symptoms. A second rater independently assessed the presence/absence of discussion of positive symptoms in 15 consultations, yielding 100% agreement.

The group of patients whose consultation included symptom discussion were compared to the group whose consultation did not. Chi squared tests for independence and *t*-tests indicated no differences between the

groups on any demographic variables including age, gender, ethnicity, marital status, first language or employment status. In terms of clinical characteristics there were no differences between groups in illness history, weeks spent in hospital, and number of voluntary or compulsory hospital admissions. However, clinical differences were evident between the two groups according to their scores on the PANSS whereby those patients whose consultation included discussion of present psychotic symptoms had significantly higher scores on the PANSS positive symptom scale ($t(143) = -6.13, p = .001$) and the PANSS general psychopathology scale ($t(143) = -3.87, p = .001$) than those whose consultation had no discussion of present psychotic symptoms. Overall there was a significant difference between the groups in the total score of the PANSS ($t(136) = -15.19, p = .001$), but there was no significant difference between the groups on the PANSS negative symptom scale (see Table 1 for summary of group comparisons).

Discussions of psychotic symptoms ranged from 20 seconds to 14 minutes 12 seconds, with the average length being 3 minutes 9 seconds. Discussion of psychotic symptoms equated to an average of 16% of the consultation time. There was no significant difference when comparing total duration of consultation between those with or without discussion of positive symptoms. Furthermore, the post-consultation ratings of the therapeutic relationship by both the patient and the psychiatrist, as measured using the STAR, were no different for consultations with or without discussion of positive symptoms (see Table 1).

[INSERT TABLE 1 HERE]

Table 2 shows demographic details of the 65 patients who discussed positive symptoms. The 65 consultations including discussion of a positive psychotic symptom were conducted by a total of 29 psychiatrists (23 male). The length of the relationship between the psychiatrist and the patient varied and ranged from many years to first time of meeting. A carer or other person was present in 18 of the consultations.

[INSERT TABLE 2 HERE]

Qualitative thematic analysis: Talking about psychosis

The 65 transcripts containing discussion of at least one positive psychotic symptom yielded 86 extracts (46 consultations contained one extract, 18 contained two, and one contained four). A thematic analysis network was developed around two over-arching core themes, 'patient disclosure', and 'psychiatrist focus' (Figure 1), representing what each brought to the process of navigating discussion of positive symptoms.

[INSERT FIGURE 1 HERE]

Patient Disclosure.

The core theme of patient disclosure incorporated four themes. In the first theme, 'characteristics of psychotic symptoms', hallucinations and delusions were talked about differently so were placed in separate categories. For hallucinations (53/86, 62%) the four most salient themes

were perceived identity (of voice or image, 27), relationship (12), intention (malevolence, or benevolence, or both, 26), and control and power (14), which linked closely with command hallucinations (14). Negative relationships (feeling criticised, bullied) with voices were more common than positive relationships, with most patients perceiving voices as predominantly or exclusively malevolent (*"Yeah, I am not really sure whether I should discuss it with you at some point because it's personal. Basically they can be overpowering and I don't think there is a way of coping. I think it's basically the ball's in their court... It feels like they are controlling me."*)

Patients discussed delusions in 35/86 (41%) extracts and although there was overlap, the main categories of delusions described included surveillance and persecution (23), mind reading (9), thought control (9), reference (7) and grandiosity (4).

In 40/86 (47%) of extracts the patient referred to their 'emotional response' to the psychotic symptoms, with the majority referring to negative emotions including distress (22), worry (10), fear (10), and confusion (6) (*"Demoralised. Well I sometimes feel I'm losing my privacy, my confidentiality. That's what I find upsetting"*). Seven patients described feeling neutral about their symptoms, having become accustomed to them over time, and only two described positive emotions (happiness) in relation to any aspect of their psychotic symptoms.

'Explanatory models' for symptoms were alluded to in 48/86 (56%) extracts, and fell broadly into the sub-themes of 'medical' (17) (*"Well I*

know it's part of my illness"), 'spiritual' (13) (*"I just felt that I was under possession"*), 'supernatural' (8) (*"I was followed by a spaceship... and I believe they took control of me"*) and part of a delusion of persecution (16) with some overlap across categories.

In 36 instances (42%) patients made reference to 'coping strategies' – the most common being to ignore or actively resist symptoms (14) (e.g. answering back to voices), daily activities or hobbies (13) and benefits of medication (7).

Psychiatrist focus.

A large proportion of psychiatrist talk in the extracts was questions. This was in contrast to patients who asked a total of only 10 questions across all 86 extracts. Psychiatrists initiated discussion of symptoms in 52 of the 86 extracts (60%) with a range of questions. Most frequently (28) initiating questions referred directly to a specific symptom (*"do you hear any voices?"*); or referred to information from a previous consultation (17) (*"You told me in a previous appointment that you were hearing some voices?"*); or were broad and generic (7) (*"have you experienced any unusual feelings?"*). Information gathering questions were coded in 68/86 extracts (79%) and included questions to expand the details of patient's descriptions, clarify details and check understanding. In discussions about hallucinations, psychiatrists' questions often related to topographical aspects of the experience such as spatial location (*"Where does it come from? Is it within your head or do you hear it from outside?"*) and frequency. In discussions about both persecutory delusions and command

hallucinations psychiatrists' questions referred to potential risk posed by the patient, either to themselves or others (7). In 20 of the 86 extracts (23%) psychiatrists asked questions exploring the meaning patients attributed to their psychotic experience, using questions that were open, broad, non-leading and gave no indication of the psychiatrist's viewpoint (*"And how do you explain it to yourself, when you hear the voice?"*). In some instances (11/86, 13%) the question asked by the psychiatrist conveyed disagreement about the patient's account through use of words such as "really", "actually" and "literally" (*"Do you actually think that?"*).

Psychiatrists gave explicit 'explanations' for psychotic symptoms in eight of the 86 extracts (9%). All explanations were characterised by cautious language such as "I believe", "I think", and "I suppose", as well as conditional statements such as "it might be" or "could be": for example, *"I quite often hear people say that they can hear voices when they come and see me here in the clinic, and I suppose my theory about it is that it's to do with an illness that they have. It's part of, it's a symptom of an illness. And their mind is playing tricks on them. Do you think that might be the case with you?"*. Psychiatrists also commonly (17/86) offered an implicit explanation for psychotic experiences (20%). Typically this took the form either of a closed question (*"What I mean is, is it possible that you could be wrong about this, that there is no force out there. That this is just something in your mind possibly? That you've been mistaken. Could it have been part of a mental illness such as schizophrenia?"*).

The sub-theme 'positive talk' was coded in 34/86 extracts (40%), with the most common illustrations being empathy (17), positive statements (17), and reassurance or normalising (8). Empathy most often took the form of a single statement referring to the patient's possible emotional response to the psychotic symptom in question (*"some of these experiences must be very disturbing"*). Positive statements were most commonly employed in giving positive feedback to a patient with regards to efforts they were making, either in relation to adherence to their treatment, or to progress made in terms of an improvement in their mental health. Reassurance or normalisation was given to patients in response to descriptions of their symptoms or questions about the symptoms. Reassurance and normalisation invariably took the form of generalising the experience to the broader population (*"many people find it difficult to explain things like voices"*).

'Disagreement' occurred in 8/86 extracts (9%), all concerning delusions rather than hallucinations. None led to lasting breakdown in a consultation, but rather a change of topic, a shift by either party to a less oppositional position (*"I was just saying what I think"*), or an explicit acknowledgment of impasse (*"you know, we just have different views of these things"*).

'Treatment options' were raised in 28/86 extracts (33%), the majority (22/28) concerning medication (compliance, benefits, dosage). In a handful of extracts psychiatrists referred to other potential treatment

options for psychotic symptoms including psychological therapy (3), daytime activities (3) and general healthy living (1).

DISCUSSION

In summary, results from the descriptive quantitative analyses indicated that of 143 routine psychiatric consultations 65 contained a discussion of at least one present positive psychotic symptom, and 78 did not. PANSS scores from independent clinical assessments strongly suggest that this reflected meaningful differences in symptomatology: those who discussed positive symptoms scored higher on PANSS positive symptoms and overall psychopathology scales, but not negative symptoms; and the two groups did not differ on demographics or illness history.

One immediate concern is that engaging in discussion of positive symptoms might not be containable within limited time. In the present study discussions of psychotic symptoms took up on average 16% of the total time for those 65 consultations which included discussion of positive symptoms. Yet consultations that included discussion of symptoms lasted no longer than those that did not. This shows empirically that discussion of psychotic symptoms need not lengthen consultation time, and attests to the psychiatrists' skill in managing discussion of symptoms and balancing this with other topics.

A second concern that may inhibit psychiatrists from discussion of positive symptoms is that it will trigger disagreement and confrontation, and harm the therapeutic alliance [6]. There is evidence that lack of

'insight' and dissonance between patients' and professionals' explanatory models may reduce treatment satisfaction and therapeutic alliance [13; 14]. In the present study, there were numerous instances of psychiatrists offering a medical perspective on symptoms and of patients expressing conflicting explanatory models (e.g. spiritual, supernatural) - and eight instances of frank disagreement over interpretation of positive symptoms. None led to a breakdown in communication or to the consultation ending. It is likely that this reflects *how* psychiatrists shared their perspectives - using tentative language, and owning it as one perspective, not fact - and thereby avoiding psychological reactance. Zangrilli and colleagues [15] also emphasised the importance of psychiatrists balancing information gathering about the delusional beliefs of patients in acute settings (via challenging and offering alternative explanations) with building a positive therapeutic relationship suggesting a tentative and sensitive approach to these discussions in the first instance. These findings are consistent with the wider literature on communication skills, which highlights the importance of expressing opposing viewpoints openly and empathically without implied scepticism or rejection of the other's viewpoint [16]. Crucially, in the present study there was no difference in either patients' or psychiatrists' ratings of the therapeutic relationship between consultations that did or did not include discussion of positive symptoms.

There is a striking consistency between patient disclosure in this study, and the wider literature on cognitive models of positive symptoms. In

relation to voices, for example, the main themes that patients raised – identity, intention (malevolence or benevolence), relationship, power and emotional response – are empirically validated elements of the cognitive clinical model of voices [5; 17; 18]. It is striking that the same aspects of positive psychotic symptoms as those emphasised by psychological models were salient to patients, even in non-psychological contexts and at times when they were not being asked about these features of psychotic symptoms and provides further validation for these psychological models of psychosis.

As would be expected [19], psychiatrists focussed on information gathering in relation to the form and severity of symptoms, insight and risk; patients primarily discussed their ‘lived experience’ of psychosis, especially their emotional and behavioural impact, ~~and~~ attempts at coping, and the personal meaning they construct to make sense of positive symptoms, all part of their epistemic domain. Attempts at coping were mostly easily accessible, everyday, non-skilled and either free or cheap activities. Although a small number of patients mentioned the benefits of being in company as a way of coping with psychotic symptoms, by way of distraction, not one patient named a close or supportive relationship (e.g. with a relative, partner or friend) when considering things that helped them to manage their symptoms. Furthermore, there was no mention of healthcare or other professionals who might be involved in a patient’s care. This possibly serves to highlight the level of isolation experienced by patients suffering with a psychotic disorder,

whether actual or perceived [20].

Qualitative analysis of transcripts revealed key themes in how patient and psychiatrist navigated 'talking about psychosis'. There were clear points of connection, such as psychiatrist use of 'positive talk' (empathy, reassurance and normalising experiences) which occurred in 40% of extracts. This type of positive talk is widely recommended to strengthen a therapeutic relationship (e.g. [21]), and to acknowledge and validate distress. Positive talk is likely to be particularly important in the case of discussing psychotic experiences as patients described overwhelmingly negative emotions in relation to their symptoms. Frequency of positive talk in the present study compares favourably with a study by Seale and colleagues [22], who reported finding only three examples of supportive listening and empathic and reassuring responses in 92 psychiatric consultations. Also, in nearly half of the extracts containing discussion of psychotic symptoms psychiatrists asked questions pertaining to the meaning of the symptom from the perspective of the patient. The way in which questions were asked about meaning could imply the different motivations underlying these questions; for example, in some cases psychiatrists asked open questions with no explicit reference to an explanation for the symptoms and no indication of their own personal view suggesting that they were inviting the patient to express their own perspective. However, in other examples, psychiatrists used closed questions that included an explanation in the question (e.g. "could it have been part of a mental illness such as schizophrenia?"), thereby only asking

the patient to accept or deny the explanation suggested without giving their own interpretation. This second type of questioning could serve two functions including conveying the psychiatrist's hypothesis, and establishing the level of 'insight' the patient has regarding their symptoms, i.e. the level to which they accept a medical view that their symptoms are caused by an illness. Discussion of attempts at coping was a further area of closer alignment, with patients mainly describing strategies that were simple and accessible and did not rely on financial or social support, and included medication, and psychiatrists frequently validating these efforts.

In the absence of good practice guidelines for the psychiatric consultation, the present study offers some tentative points for consideration. First, when exploring the patient's understanding of their psychotic symptoms, open and exploratory questions give a real opportunity to the patient to express their view, which may strengthen collaboration and therapeutic alliance. Statements or questions that explicitly or implicitly offer an alternative medical perspective can be sensitively used to assess insight and to demonstrate the viewpoint from which the psychiatrist is working. Given the overwhelmingly negative emotional impact of psychosis, a second recommendation would be to routinely use open questions to explore emotional impact, and then follow this up with positive talk including empathy, normalising and reassurance. Whilst psychiatrists can feel that this is insufficient, and a solution is needed, research on the psychiatric consultation indicates that what patients often want is to feel

heard and validated, and do not expect easy solutions [23]. Given that patients described the emotional impact of psychosis as overwhelmingly negative, this is an area where empathy might be increased. Third, across all 86 extracts there were only ten instances of patients asking questions about their psychotic symptoms and none where a psychiatrist asked if the patient had any questions on this topic. Communication skills guidelines recommend offering opportunities for patients to ask questions during consultation in line with movements towards more collaborative care, and psychiatrists might further develop collaboration with patients by giving them the chance to ask questions about their psychotic symptoms. Last, where psychiatrists discussed treatment options this was predominantly medication, with occasional reference to daytime activities. Art therapy and cognitive behaviour therapy were mentioned in 3/86 extracts. Alerting patients to additional possibilities, even if only as options for the future, is in keeping with NICE guidelines and is likely to instil hope, a therapeutically powerful tool in its own right.

These findings should be considered within the context of the limitations and strengths of this study. First, inclusion required both the psychiatrist and patient to consent; it is possible that those who declined to participate were different in some way from the sample included in the study. Also, patients who did not speak fluent English were excluded. These factors limit generalisability of the findings. Second, data relate only to routine outpatient consultations –whilst this is a significant point of delivery, interactions in other settings (e.g. acute wards) are likely to

differ. Third, data on the length of the relationship between each patient and psychiatrist pair were unavailable – for some it was first meeting, for others the relationship spanned years. Whilst this variety is representative of clinical practice, and in this sense adds ecological validity, it was not possible to explore whether length of relationship exerted a significant impact on communication about psychosis. Fourth, qualitative analysis was undertaken only for the first time each positive symptom was discussed (although in practice the same symptom was discussed a second time in fewer than 5% of consultations). Last, participants were aware that the consultation was being filmed and this may have impacted on how both behaved (although recording equipment was very discrete, and anecdotally participants reported not being influenced by its presence).

The study has a number of strengths. The sample size of 143 consultations is large for a naturalistic, observational study, and combines qualitative and quantitative analyses. Collecting naturalistic mixed-methods data in a healthcare setting has value for assessing and developing clinical practice, not least because time-pressured psychiatrists rarely have an opportunity to observe the practice of others [23]. Data were collected in London in diverse and deprived catchment areas. Independent assessment of positive symptoms validated the presence or absence of positive symptoms. A further strength of the study was that the descriptions that patients gave of their symptoms were free of the influence of predetermined research questions, conferring validity.

Although the context of the study, i.e. psychiatric consultations, likely impacted on how patients described their symptoms, this is seen as a strength of the current study, as one aim was to explore what aspects of their experience patients would choose to share with the psychiatrist as well as considering the response of psychiatrists to these disclosures. Also, the data assess possible concerns held by psychiatrists that may needlessly discourage discussion of positive symptoms.

Coda

There is growing evidence to suggest that patients wish to talk about their lived experience of psychotic experiences. The findings of this study suggest that talking about psychotic symptoms in routine outpatient settings was neither time-consuming nor damaging to the therapeutic relationship and conversations in these settings may be therapeutic in their own right. Furthermore, when psychiatrists explore patients' beliefs, and are open and tentative about their own position, even disagreement about the meaning of psychotic symptoms need not have negative consequences on the consultation.

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Table 1. Therapeutic relationship scores for consultations with and without discussion of positive symptoms

| | With Discussion <u>n=52-65</u> | Without Discussion <u>n=70-78</u> | Differenc e <i>p</i> |
|--|---|--|-------------------------------------|
| PANSS Total Score | 68.16 | 52.97 | .001 |
| PANSS positive scale | 18.20 | 11.29 | .001 |
| PANSS negative scale | 14.57 | 12.69 | <i>ns</i> |
| PANSS general psychopathology scale | 33.74 | 26.48 | .001 |
| STAR Patient Total (0-48) | 38.04 | 38.96 | <i>ns</i> |
| Positive collaboration (0-24) | 19.41 | 19.90 | <i>ns</i> |
| Positive clinician input (0-12) | 8.48 | 8.73 | <i>ns</i> |
| Non-supportive clinician input (0-12) | 2.30 | 2.17 | <i>ns</i> |
| STAR Clinician Total (0-48) | 37.46 | 36.21 | <i>ns</i> |
| Positive collaboration (0-24) | 18.06 | 17.27 | <i>ns</i> |
| Emotional difficulties (0-12) | 2.33 | 2.57 | <i>ns</i> |
| Positive clinician input (0-12) | 9.65 | 9.44 | <i>ns</i> |

Note: *ns* = non-significant at the $p < 0.05$ level.

Table 2. Patient demographics.

| | N |
|------------------------|-----------------|
| | <u>65</u> |
| Gender | |
| Female | 16 <u>(25%)</u> |
| Male | 49 <u>(75%)</u> |
| Ethnicity | |
| White British or Irish | 25 <u>(38%)</u> |
| Other White Background | 3 <u>(5%)</u> |
| Asian or Asian British | 11 <u>(17%)</u> |
| Black or Black British | 17 <u>(26%)</u> |
| Chinese | 1 <u>(2%)</u> |
| Mixed Background | 4 <u>(6%)</u> |
| Other Ethnic Group | 3 <u>(5%)</u> |
| Not Disclosed | 1 <u>(2%)</u> |
| Marital Status | |
| Single | 48 <u>(74%)</u> |
| Married/ Partnership | 11 <u>(17%)</u> |
| Separated/ Divorced | 4 <u>(6%)</u> |
| Widowed | 1 <u>(2%)</u> |
| Not Known | 1 <u>(2%)</u> |
| First Language | |
| English | 50 <u>(77%)</u> |

Other 14 (21%)

Missing 1 (2%)

Employment Status

Unemployed 47 (72%)

Voluntary Employment 5 (8%)

Paid or Self-Employment 3 (5%)

Supported Employment 1 (2%)

Student 3 (5%)

Retired 4 (6%)

Other 1 (2%)

Mean Age in Years (Range/ SD) 44 (23-67/ 10.2)

Psychiatric Hospital Admissions

Mean No. of Previous Admissions (Range/
SD) 3.8 (0-50 / 7.1)

Mean No. of Compulsory Admissions (Range
/SD) 1.31 (0-8/ 1.67)

Mean No. of Weeks Spent in Hospital 29.46 (0-250, 51.12)
(Range/ SD)

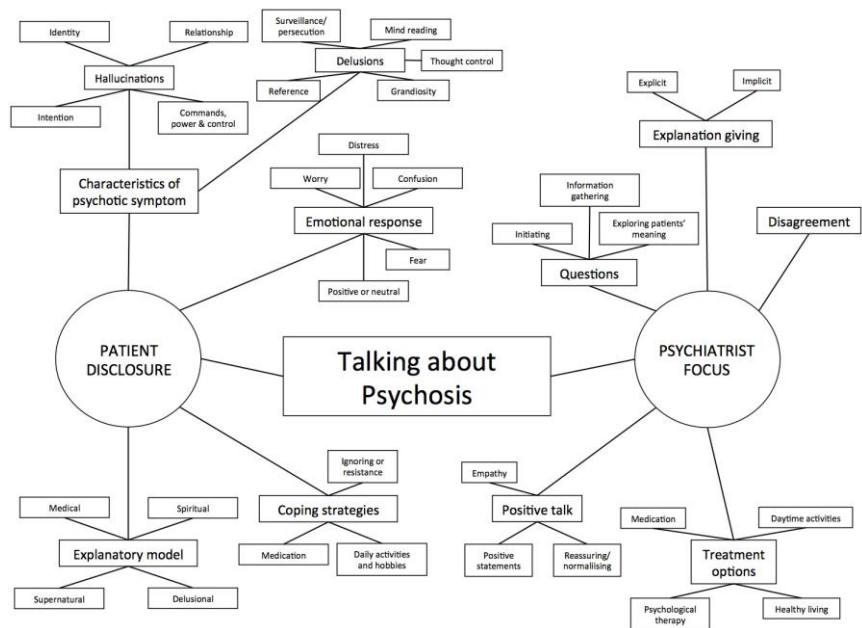


Figure 1. Thematic analysis network