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Shame and acute psychiatric in-patient care

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Aims and method   To investigate the complementarities of staff and service users' experiences of shame in psychiatric in-patient settings. Qualitative methods were used by means of focus group interviews in two compositions – staff and service users. Data were transcribed and thematically analysed.

Results   Service user group transcripts revealed four prominent themes: 'loss of value', 'loss of adulthood and autonomy', 'loss of subjectivity' and 'shaming or blaming of others'. Staff group transcripts also revealed two themes one of which overlapped with service users ('shaming or blaming of others') and one of which was distinct ('entrapment').

Clinical implications   Shame processes may be elicited by caregiving and impede treatment. Staff find themselves in the predicament of provoking the problems they intend to address. Suggestions are made as to how to respond to this dilemma and practically improve aspects of the in-patient care process to reduce shame.

Declaration of interest   None.

Concerns about stigma and the quality of psychiatric in-patient care are gaining international prominence on mental health agendas, yet comparatively less attention has been given to the related experience of shame. Stigma has been defined as a deep shame-provoking mark or flaw linked to being a member of a group that is devalued by society.[1] Although shame may have social origins and repercussions, it characteristically involves global evaluations about the self as unattractive and undesirable – to use Gilbert's phrase 'being in the world as a self one does not wish to be'.[2] As a result shame can correlate with a wide range of psychopathology and self-esteem measures.[3–5] In 1987 Lazare noted that people receiving treatment and healthcare sometimes fail to adhere to treatment or else neglect consultations because of shame.[6] Compared with other in-patient settings, psychiatric in-patients may not receive comparable levels of support from relatives.[7] Individuals may enter hospital vulnerable to feeling shame, influencing subsequent treatment and care processes.[6] To date, there are no published reports specifically addressing the global in-patient experience of shame comparing service users' and professionals' perspectives.[8] The aim of this qualitative research was to understand ways in which shame experiences are brought into, elicited by and dealt with in in-patient psychiatric care.

Method

Data were gathered using a focus group design. Focus groups are considered effective in gathering information

408

about a topic area. Focus groups can be carried out at less cost than individual interviews and researchers can correspond directly with the group members.[9] Focus groups also provide opportunities to clarify issues, explore deeper meanings, and ask for further detail to questions and they allow participants to listen and develop the responses in relation to other group members' comments.[9] Observing the group dynamics can also assist the researcher in gaining potentially important information from the non-verbal responses of group participants. However, because of the relatively small sample, generalisations to larger populations can be more difficult than with surveys with many participants. In addition, results may be subject to bias and may not be linear.[9] This investigation followed intra-personal and subjective methods of research[10] and so a descriptive phenomenological approach. We used a purposive sample in that all participants had experience of either receiving or providing healthcare in acute psychiatric in-patient settings.

There were 24 participants in total interviewed in six different groups. Each group discussion lasted 1.5 h. The participants were separated into three service user and three staff groups. All group discussions were audio-recorded and later transcribed. Local ethical committee approval was given.

Fifteen service users known to have in-patient unit experience were approached and invited following brief telephone contact. The researchers had no clinical involvement with the service users. Ten service users volunteered to take part in the focus groups, consisting of five men and five women with an age range of 30–63 years with diagnoses including schizophrenia, bipolar affective disorder, depression and personality disorder. The researchers also invited staff members to participate in the research study, A.C.J. provided information in more detail to interested staff members. The staff groups included six staff nurses, two occupational therapists, two consultant psychiatrists, three junior psychiatrists and a nursing auxiliary. There were six men and eight women in total (age ranges spanned from early 20s to 55).

Staff and service user groups followed a semi-structured format. The investigators asked what was understood by the term shame and then enquired about how this understanding related to their experience of in-patient care. Finally, the discussions explored ways that service users and healthcare professionals managed their experiences. The researchers have psychotherapy backgrounds and developed their interest in shame issues from working in a variety of statutory mental healthcare settings including publishing a study of shame experiences in older adults.[10]

Data analysis

Given their experience of the six groups and following a detailed review of the literature, the two investigators approached the transcribed texts with the supposition that shame is a relational issue in so far as it raises awareness about how one is in the mind of another. It is not therefore just a pure affect or behavioural set. They also recognised that being ashamed of oneself is not necessarily the same as feeling shamed by another. The investigators operationally defined this difference as internal v. external shame.[2] They

also considered the possibility of the group process actually evoking shame and documented this as process shame. Pragmatic solutions to shame were also recorded.

The researchers met together, read over, discussed and thematically analysed all texts, identifying external and internal shame issues, noting both recurrence and commonality.[10] Differences between the investigator's views were negotiated to the point of mutual agreement. Both then aggregated salient themes into superordinate themes, judged by frequency of comments and evidence of affirmative responses. Qualitative computer software was not used for purposes of data analysis. A post-data analysis group was conducted with service users and staff to validate the findings. The findings of the study were made available to all participants before the meeting and the investigators encouraged detailed discussions concerning whether findings accurately represented the views of focus group members. All who attended the post-data analysis group agreed that the research study findings represented their stated experience.

Results

Mental health service users

Four superordinate themes were identified entitled 'loss of value', 'loss of adulthood and autonomy', 'loss of subjectivity' and 'shaming or blaming of others'. This last theme overlapped with the professionals group who also had a second theme entitled 'entrapment'.

Loss of value
The loss of value theme was composed of cluster statements in which participants identified themselves or other service users as failures, not being normal or different. For example, one group member remarked:

> 'And I remember when I was acutely unwell...I remember the girl on the till looked me up and down 'coz she must have known I was a, from, from the mental health unit and I wasn't a nurse obviously and I, and at that moment I felt ashamed then. 'Coz I thought she knows that I come from there. And we went to the till and she sort of looked at me and said am I staff and I was about to say no when the lad next to me said "no, we're actually in the madhouse" ' (M1, 15.17, group 1).

Contributors also noted that admission to hospital provoked an internal shame experience as a sense of having failed.

> 'I think feeling that you kind of let yourself down, deep down inside, by being admitted' (F2, 3.14, group 3).

Repeat admissions were reported as more shaming:

> 'You failed, you failed yourself. And I still feel like that and I'm not in hospital. I think it kind of suggested shame' (F2, 4.11, group 3).

Loss of adulthood and autonomy
All service users reported the consequences of feeling or being ashamed as having an effect on their senses of adulthood and autonomy. Discourse commonly revealed themes concerned with not being believed in or related to as adults as if they were incompetent children pressed into enforced inactivity and taking up unnecessary space. Others

spoke of having to seek permission for activities normally taken for granted outside of hospital.

'You don't intend to be rude, but you just feel, do you mind, I'm gonna go. It's kind of, I'm a grown adult here and I'm having to ask to go to the rest room' (F2, 35.44, group 3).

The following group member's comments reflect this discomfort:

'I'm an independent person. Having our meals wheeled up, it was all so easy. The whole time I felt guilty and shamed' (F1, 43.03, group 1).

'You've got to be escorted. Somebody forgot they had their badge on when they were accompanying me (in town)....It's like "why don't you stick a flag on me 'ed [then]"' (F2, 26.53, group 3).

Loss of autonomy is also captured in comments about medication:

'Demeaning, queuing up in a line that absolutely makes me feel ashamed. It's like mummy giving out to baby' (F1, 39.41, group 1).

A group member explained:

'I've been made to feel ashamed that I was wasting staff's time' (M1, 06.00, group 1).

Service users were typically sensitive to what they viewed as derogatory terms used by staff members, such as 'bed blocking' and 'revolving door patients'. Some group members spoke of feeling too unwell to leave hospital, yet feeling unworthy to stay as if fraudulent. The result was a sense of confusion and disqualification.

'You feel safe living in a bubble in the in-patient unit, but I felt ashamed of being in that bubble. I felt I was bed blocking. Others are worse than me. I'm bed blocking. I kept saying that to nurses' (F1, 20.38, group 1).

'I felt I had to justify a reason for being there. It makes you feel sort of shamed because you're like a, as though it makes you feel something of a fraud' (F2, 1.20, group 3).

Loss of subjectivity

The term 'loss of subjectivity' was a way of encapsulating a sense of being an observed other. Observation is a necessary part of assessment for treatment and care, but inevitably heightens feelings of self-consciousness.

'You felt all eyes are on you' (F1, 60.35, group 1).

The admission process was likened to interrogation with fears about unwittingly revealing information that may later be regretted.

'Sitting right in front of you with all everything happening and the head is down you know' (*gestures*) (M1, 6.00, group 1).

'The staff are doing their job, but they're going to write notes after the conversation, so it makes me think, did I say anything wrong that might lead to something else' (M1, 15.36, group 1).

Assessment procedures invited self-disclosure that could provoke feelings of exposure and loss of control.

'Telling people certain things, it makes you feel more paranoid. It makes it shameful' (F2, 14.53, group 3).

'It's shameful when somebody's got to go with you to do this and you know it just depends on the observation level of how ill you are, how far you can trust yourself' (F2, 25.56, group 3).

'Shame is loss of control. You hand it over at the hospital as it were' (M1, 17.20, group 3).

Ward rounds featured as a particularly difficult forum for service users.

'You've got five or six people sitting there and they're all watching you and you know, how do you feel, you know you are crying' (F2, 20.36, group 3).

Shaming or blaming of others

As service users became more comfortable in discussing concerns, they also began to gain a sense of protest and increased self-worth.

'Other people should, ought to just feel ashamed. Not us!' (F2, 10.57, group 1).

Another statement reflects a sense of being at war and of dislocation from staff and services

'To me, patients should be awarded medals like people who fought in the war, not be looked down upon by people who haven't experienced anything' (F2, 12.32, group 2).

Although there were occasional criticisms, service users accorded respect to all staff but said it was difficult to establish mutual trust

'The staff are not on the floor enough to be trusted' (F1, 7.06, group 2).

Staff groups

Themes: shaming or blaming of others and entrapment

Staff group members' discussions concerned themes of shaming and blaming together with feeling entrapped by their professional roles. Staff attributed their concerns to some of the institutional processes concerned with the day-to-day organisation and frequently to attitudes held by other healthcare professionals.

'I used to feel I didn't want people outside work to sort of quite see some of the things I had to be doing in dementia work' (F, 151, group 3).

All group members spoke of critical incident reviews (for example following a suicide) as provoking a sense of being scrutinised and held to account in ways that resonated with service users' reported experience of admission processes.

'You pick yourself up and you have another meeting and another and another. Everything in there is scrutinised and taken out of context' (M, 128, group 1).

Another commented:

'Coping with other health professionals reactions to the burden of care can also provoke shame. Other staff says in relation to suicide "Isn't that part and parcel of the job? If you can't face it, you shouldn't be doing it"' (K, 36 group 1).

Some staff group members spoke of being caught up in, what they viewed as, shaming counter-attacks from patients. Sometimes censures were subtle, other times blatant.

'They [patients] think we lead a perfect life. One patient shamed me because I had such a perfect life' (K, 14 group 1).

'Another patient said, "You should be ashamed of yourself doctor. I was as happy as a sand boy until you came along"' (S, 27 group 2).

All staff voiced a sense of falling short of perceived service expectations such as preventing suicide or completing a full recovery. Several group members believed that this

The Psychiatrist

unintentionally provoked shame for themselves and for patients and families.

> 'It's like, if you don't recover how shameful is that' (S, 5, group 2).

Admission processes were also identified by all groups as potentially shame inducing.

> 'Both doctors and family feel as if we are letting people down by allowing admission to take place' (A, 9, group 1).

Various staff group members also reflected on their own potential to shame others by judging behaviours negatively.

> 'I think our idea of bad patients (not a term we would use) is the people we find difficult…who aren't motivated to help themselves' (S, 15.group 3).

All staff group members spoke of trying to be a caring presence while realising that shame could be provoked within themselves or others by their actions. We call this theme 'entrapment', a situation in which staff are ashamed of their potential to shame.

> 'I was supposed to know how to deal with shame and to prevent a patient from being ashamed. You definitely notice if a patient kind of reacts badly, I feel ashamed of it' (H, 9 group 3).

Entrapment occurs in a variety of ways linked to professional roles – enforcing treatment or feeling intrusive because of the need to observe. Sometimes staff reported feeling they were infantilising patients despite their desire not to.

> 'You get to the point and think, yeah, I've taken your autonomy away. I'm sorry. Look I don't want to give you an injection, but we can't go on like this because it's shameful isn't it [to let it go on]' (S, 15.group 2).

> '[Forcefully] injecting [medication] can be particularly humiliating, especially if it involves a woman holding a man down' (C, 27 group 1).

Various members of the staff group also told of being aware of ways clinical routines provoked shame. Sometimes it was considered that patients concealed their feelings by being overly cooperative:

> 'Even the patients not refusing medication, they come up and take it. It makes them shameful' (Z, 44 group 1).

One staff member spoke of an imposed loss of autonomy because of assessment and observation regimes:

> 'It's like a prison and the whole idea that you've got to get up at a certain time. You have to eat what you're told to eat, that can be shaming' (G, 22 group 3).

> 'Making observations about activities of daily living can also provoke shame like doing washing and dressing assessments' (S, 15 group 3).

Staff members were aware of the ways in which shame could provoke both passive and 'rebellious' behaviour or in some instances a mixture of both.

> 'They tell us what they're doing all the time or, on the other hand, you haven't got a clue because they've disappeared' (M, 43 group 1).

Group members spoke of concerns about the effects of breaking bad news and diagnoses:

> 'Conveying bad news and disappointment can also give rise to shame on the part of staff. Then it makes it even more shameful and you have to say things like "You'll never go back to university now you know"'' (G, 34 group 2).

> 'When we discussed the diagnosis with the patient, sometimes I feel shameful. I can't put it across' (Z, 19, group 1).

A number of practical suggestions were made (Boxes 1 and 2).

Discussion

Shame involves power and relative social attractiveness.[2] There is an inevitable power difference between the roles of professional carer and those cared for. Three factors come together to make in-patient care particularly problematic from the shame perspective. First, patients may have had past shame-provoking experiences of trauma and disordered

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Box 1 Service user group ideas

- Beware medication side-effects making patients 'look different'
- Beware visitors invoking shame
- Avoid enforced passivity
- Having a post-admission group
- Sensitivity about literacy levels
- Social hierarchy of self-disclosure – it's easier talking to cleaners ('I think a lot of people end up going into hospital again because they've spoken to the wrong people the first time')
- Slowing the admission process
- Having money to spend
- Having an evening group to process the day's interactions
- Having a maximum number per ward round to reduce self-consciousness
- Be particularly sensitive around readmission protocols ('we're not revolving door patients')
- Not having questionnaires that are too personal or intrusive
- Never being 'threatened' with the Mental Health Act
- Environmental shame – dirty surroundings
- Having clear and open information given on admission around routines and facilities

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Box 2 Staff group ideas

- Interview slowly
- No repeated interviews to elicit the same information
- Having an intermediate care ward to help step down from levels of heightened dependency/observation
- Length of admission (neither too short nor too long)
- Awareness sessions concerning shame issues
- Matching 'autonomy with capability' (knowing how much responsibility to give to service users and how much to take)
- Enable staff to talk about the shame about feeling ashamed
- Avoid anything that promotes regression of patients – rigid policies that are disempowering (e.g. being unable to make food)
- More discreet observation techniques (avoid 'goldfish bowl' offices)
- Recognise that carers may feel ashamed for failing to prevent admission

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attachments. Such issues are typically brought into the professional care relationship and often reawakened. Second, widespread stigma of mental illness discourages individuals and families from seeking help. Finally, patients may struggle to develop a trusting relationship with staff because self-shaming (internal shame) is a core feature of their mental ill health. Primed in these ways, taken-for-granted procedures concerned with the provision of psychiatric in-patient care may inadvertently intensify self-stigma and so amplify underlying shame.

Psychiatric in-patient care inevitably focuses on two particular areas of interpersonal functioning that can provoke shame – dependency and intimacy.[11] The sick role may help to provide a form of managed regression that shames neither staff nor patient. That is to say it minimises risk to personal self-esteem. For our service users degrees of personal intimacy and dependency between patients and professionals are essential to recovery yet make boundaries less easy to define. Service users may already have had shame-provoking experiences in relation to dependency and intimacy (e.g. childhood abuse).

Gilbert suggests that shame tends to be self-managed in three ways: by hiding, by overcompliance and by projection.[2] Self-reports from this research study confirmed evidence of all three. There may be subtle signs of activated shame (for example when the therapeutic alliance seems to be poor or clinically important issues are hidden or misread as anger). Particular vigilance is needed around boundaries of care: admission and discharge processes invoke attachments and separations that can activate shame.

Limitations

Generalisability is limited by qualitative methods of research including small sample sizes, researcher bias and the use of a single National Health Service trust site.[12] Although contributions were predominantly based on the experience of care in the local acute admission unit, some members of both the staff and service user groups had experience from other admission units too. However, focus groups have the advantage of helping contributors develop ideas, hypotheses and inferences as they are reported that then enables memories to be recollected in a supportive respectful atmosphere.

Implications

This research study suggests that staff are acutely aware of a cognitively dissonant role of provoking the problem they wish to address, although this may then give rise to therapeutic opportunities. Many healthcare professionals may wish psychologically to distance themselves from the task of coping with their own activated shame states. Professional supervision processes therefore need to reflect this.[13] Understanding ways that shame-related experiences are already primed and activated within care programmes could improve clinical outcomes, reduce treatment failures and help staff. Careful monitoring of therapeutic alliances within in-patient care linked to measures of activated shame would be an initial focus. Further knowledge would allow organisations to address shame at all levels of planning and delivery.

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The Psychiatrist