CORE
Metadata, citation and similar papers at core.ac.uk
Provided by Canterbury Research and Theses Environment

CREATE
Canterbury Research and Theses Environment

Canterbury Christ Church University's repository of research outputs

http://create.canterbury.ac.uk

Copyright © and Moral Rights for this thesis are retained by the author and/or other copyright owners. A copy can be downloaded for personal non-commercial research or study, without prior permission or charge. This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the copyright holder/s. The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the copyright holders.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given e.g. Underhill, M. R. (2014) Threatening thoughts in first episode psychosis : the experience of content, emotional distress, change over time and context. D.Clin.Psych. thesis, Canterbury Christ Church University.

Contact: create.library@canterbury.ac.uk

Megan Rose Underhill
LLB Hons., Grad. Dip., MSc

THREATENING THOUGHTS IN FIRST EPISODE PSYCHOSIS: THE EXPERIENCE OF CONTENT, EMOTIONAL DISTRESS, CHANGE OVER TIME AND CONTEXT

Section A: A critical review of the evidence for the conceptualisation and mechanisms of threatening thoughts in psychosis
5500 (plus 375 additional) words

Section B: Threatening thoughts in first episode psychosis: An interpretative phenomenological analysis of experiential accounts of content, emotional distress, change over time and context
8000 (plus 9 additional) words

Section C: Critical Appraisal
2000 words

Overall Word Count: 15,500 (plus 384 additional words)

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

JUNE 2014

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

Acknowledgements

Firstly, I extend much gratitude to the eight study participants. For volunteering to give their time, and for reflecting on and discussing their experiences in such a thoughtful, detailed and open manner.

To Elsa Murphy for her calm re-assurance and support amid my recruitment problems, John McGowan for his ongoing suggestions and availability, and Kathy Chaney and her colleagues for unrivalled library knowledge. Much appreciated.

A huge thank you to my good friends on the course, for tirelessly keeping me going with this project, and for your humour throughout the training course and beyond.

And finally to my family and friends outside the course, thanks for bearing with me on this! I'm looking forward to catching up.

Summary

Section A is a critical review of literature on conceptualisation and mechanisms of threatening thoughts in psychosis. With regard to chronic and then first episode psychosis, key theories were addressed, and contrasted to findings in the empirical literature. Studies investigating the personal subjective experience of threatening thoughts in psychosis were also appraised. Methodological limitations were noted. The current position of extant knowledge of the area is summarised, and gaps in understanding are highlighted with suggestions for future research.

Section B reports an interpretative phenomenological analysis of personal experience of threatening thoughts in first episode psychosis, exploring content and distress, context and change over time. Eight participants took part. Five master themes and 16 sub-themes were identified. Results were discussed in relation to research questions and in the context of existing theoretical and empirical literature. Limitations and clinical implications were highlighted, while potential avenues for future research are proposed.

Section C is a critical evaluation of the experience of conducting the research study reported in Section B. Four set questions were answered reflexively, addressing research skills and abilities acquired and to be developed, possible changes to approaching the project in retrospect, alteration to clinical practice further to completing the study and thoughts about further research in the area.

Contents

Section A	**1**
Abstract	2
Introduction	3
Psychosis	4
Threatening thoughts	5
Treatment	5
Contemporary psychological theories	6
Bentall, Corcoran, Howard, Blackwood and Kinderman (2001): 'Delusions as defence' hypothesis	6
Freeman, Garety, Kuipers, Fowler and Bebbington (2002): Threat anticipation cognitive hypothesis	7
Cromby and Harper (2009): A social account	7
Summary and Synthesis	8
Exploration of process components	9
Cognitive processes	9
Theory of mind	9
Data gathering bias	9
Attributional style	10
Self-esteem	11
Negative schematic beliefs	12
Affective processes	13
Anxiety	13
Worry	14
Mood	14

Further Emotions 15
Contextual factors 15
Social environment 15
Life problems and goals 16
Summary and Synthesis 16
First episode psychosis 17
Cognitive processes 18
Data gathering bias 18
Self-esteem and attributional style 19
Affective processes 19
Anxiety 19
Mood 20
Anger 20
Contextual factors 20
Individual Experience 22
Chronic presentations 22
FEP presentations 23
Conclusions and implications for future research and clinical practice 24
References 27

Section B **41**
Abstract 42
Introduction 43
Threatening thoughts in psychosis 43
Modern psychological theory of paranoia and persecutory delusions 43

First episode psychosis 44
Empirical investigation 45
Exploration of subjective experience 46
Present study rationale 47
Study aims 48
Methodology 48
Participants 48
Ethical considerations 49
Design and procedure 49
Quality assurance 50
Data analysis 51
Results 52
Exposure of vulnerable self 53
Negative evaluation by self and others 54
Sense of transparency and defencelessness 54
Social distancing through rejection or withdrawal 56
Perceiving a need for impression management 57
At the limits of endurance 58
Overwhelming circumstances 58
Inadequate resources on which to draw 60
Anticipating death 61
Elusive sense of agency 62
Feeling powerless 62
Being attacked or intruded upon 63
Self-assertion and efforts to maintain control 64

The urge to explain it all 65

A need for certainty or logic 65

Identifying a suitable framework of understanding 66

Educating others 68

FEP as a finite experience? 68

Making a stand or managing better 68

Environmental and contextual modification 70

Lasting remnants 71

Discussion 72

Experiences of threatening thoughts content and emotional distress in early psychosis and the extent to which they are perceived as linked 72

Meanings assigned to the role of life events in delusions context 74

The estimation of change over time in experience of threat including content and related distress 75

Limitations 76

Clinical implications 77

Future research directions 78

Conclusion 78

References 79

Section C **85**

Question 1: Research skills, research abilities and future development 86

Question 2: Changes to be made if repeating the project 89

Question 3: Alteration to clinical practice as a consequence of the study 91

Question 4: Further research in the area 92

References 94

Section D **97**

Appendix 1: Literature review search strategy 98

Appendix 2: Research Ethics Committee (REC) ethical approval letter 99

Appendix 3: Host Trust Research and Development (R&D) department 100

Appendix 4: Participant information and consent sheet 101

Appendix 5: Semi-structured interview schedule 105

Appendix 6: Analysed and annotated transcript 107

Appendix 7: Theme development report 108

Appendix 8: Table of master themes, sub-ordinate themes and supporting transcript extracts 119

Appendix 9: End of study letters to REC and R&D with 145

Appendix 10: Summary of findings for REC and R&D 146

Appendix 11: Reflexive research diary 148

Megan Rose Underhill

Section A

A critical review of the evidence for the conceptualisation and mechanisms of threatening thoughts in psychosis

Word count: 5500 (375)

Abstract

This review evaluated the empirical and theoretical literature that contributes to current psychological conceptualisation and mechanism of threatening thoughts in psychosis. Firstly, key contemporary theories of paranoia and persecutory delusions were discussed and contrasted. Findings from relevant research into component processes and personal experience of threatening thoughts in chronic and early psychosis were then critically reviewed.

Regarding samples with chronic psychosis, evidence was appraised regarding cognitive and emotional components, and environmental factors surrounding threatening thought mechanisms. Methodological limitations were highlighted. Ambiguities were present in findings on cognition. Incomplete understanding was revealed of causal links, longitudinal change, data gathering biases, emotional processes and links between threatening thoughts and contextual factors. Far fewer studies were shown to have been conducted with early psychosis samples. However, evidence regarding data gathering biases, self-esteem, the role of anxiety, depression and context seemed to generalise between populations. A need for further research into the role of developmental stressors and the quality of delusional systems was revealed. Studies exploring subjective experience of threatening thoughts were critiqued, revealing a conspicuous lack of such research, especially in first episode psychosis. Avenues for future psychological research were highlighted.

Key words: psychosis; paranoia; persecutory delusions; mechanism; experience.

Introduction

The term psychosis "refers to some loss of contact with reality…" (Peters, Linney, Johns & Kuipers, 2007 at p.354), and typically involves positive symptoms, such as delusional beliefs, hallucinations and other perceptual abnormalities and thought and language disturbances. Negative symptoms may also occur, outlined by Morrison (2004) to include low mood and restricted emotion, anhedonia, withdrawal and decreased spontaneous speech. Psychosis most commonly forms part of a diagnosis of schizophrenia, a category which has been contested on grounds of validity, reliability and specificity (e.g. Boyle, 2002). Psychosis is alternatively conceptualised as an extreme point on a continuum of common human experience (van Os, Hanssen, Bijl & Ravelli, 2000).

Delusions were described by Jaspers as the 'basic characteristic of madness' (Peters et al., 2007), and are defined by the American Psychiatric Association (1994) as false, fixed beliefs, held on inadequate grounds, unaffected by contrary evidence and incongruent with ethnic, cultural or religious background. Gelder, Harrison and Cohen (2006) state that the term for one delusion sub-type, persecutory, is often used interchangeably with the term paranoia, and this practice will be followed in this project. Strictly, a persecutory delusion is characterised by a central theme of attack, harassment, cheating or conspiracy against the self or close other with the aim of inflicting physical, social or psychological harm (APA, 1994). Meanwhile, paranoia indicates a person's unfounded or exaggerated suspicion and mistrust of the motives of those around them (Boyden, Olendorf & Jeryan, 1998).

Additionally, proposals that research may be more accurately conducted by looking at the constituent parts of psychosis rather than psychosis as a synthesised whole (e.g. Bentall, 2003) have led to increased empirical efforts in recent years to define and understand the

details of delusional threatening thoughts in psychosis. So where are we now? What is the current evidence-based conceptualisation of these phenomena? What are their mechanisms? This review aims to answer these questions through a critical evaluation of extant literature.

Following further consideration of psychosis, treatment and threatening thoughts, key theoretical accounts of persecutory delusions and paranoia are introduced. Empirical findings about components and mechanisms involved are then appraised in light of theories, addressing in chronic and early psychosis consecutively. In conclusion, indicated gaps in the literature are summarised, with reference to clinical practice and future research. The identified literature was drawn from seven electronic databases. Included papers used English language, investigated clinical populations and contributed to the understanding of paranoia or persecutory delusions as objective phenomena or subjective experience. Appendix 1 details the full search strategy utilised.

Psychosis

Kirkbride et al. (2012) found the pooled incidence of affective and non-affective psychosis between 1950 and 2009 in the UK to be 31.7 per 100 000 and higher among men, young adults and in black and ethnic minority communities. Overall annual prevalence was estimated at 0.4%. Long-term psychotic experience has an extensive impact on cognition, functionality, relationships, employment and life expectancy (Green, Kern & Heaton, 2004).

The stress-vulnerability model (Zubin & Spring, 1977) of development accentuates the interaction of genetic or non-biological vulnerability with life events and environmental stressors to induce mental health problems. Empirical findings indicates that such stressors include high expressed negative emotion (Hahlweg, 2005); high levels of urbanisation in

early life environment (van Os, Hanssen, Bak, Bijl & Vollebergh, 2003); low socio-economic status (Cooper, 2005); migration (Bhugra & Jones, 2001) and second-generation status (Selten, Cantor-Graae & Kahn, 2007); discrimination (Cantor-Graae & Selten, 2005); lifetime traumatic exposure (Neria, Bromet, Sievers, Lavelle & Fochtmann, 2002); victimising experiences (Bebbington et al., 2004) and drug use (Arsenault, 2004; Bramness, 2012). Cumulative effects are evident (Myin-Germeys, Krabbendam, Delespaul & Van Os, 2003). Garety, Kuipers, Fowler, Freeman and Bebbington's (2001) psychological model of positive symptoms proposes the impact of these stressors on cognition and emotion in the development and maintenance of psychosis.

Threatening Thoughts

Persecutory delusions and paranoid ideation are among the most common psychotic characteristics (Jorgensen, 1994). In support of the theory that psychosis is on a continuum of human experience, Cromby and Harper (2009) note that 'irrational' supernatural beliefs are not unusual, while Freeman and Freeman (2008) observe that fear of others and of terrorism seems increasingly common. Non-psychotic populations demonstrate beliefs that could be labelled delusional (Verdoux et al., 1998) or paranoid (Ellett, Lopes & Chadwick, 2003). However, Cromby and Harper (2009) highlight that on engagement with mental health services, paranoia often comprises complex conspiracy beliefs, detrimentally altered perceptions and considerable distress.

Treatment

The primary treatment offered to people with paranoia and persecutory delusions is anti-psychotic medication (Gelder et al., 2006). Additionally, the National Institute for Health and Care Excellence (2014) recommend family therapy (Kuipers, 2006) and cognitive-

behavioural therapy (Tarrier, 2005). The 'recovery' approach recognises the need to address psychosocial issues (Peters et al., 2007). Singh and Fisher (2007) discuss early intervention services who offer youth-friendly, low-stigma support after first psychotic episode or during the prodrome, with the aim of improving prognosis across domains.

Contemporary Psychological Theories

Over the last 15 years, understanding of threatening thoughts in chronic psychosis has developed considerably. Current leading conceptualisations are explored below.

Bentall, Corcoran, Howard, Blackwood and Kinderman (2001): 'Delusions as Defence' Hypothesis

This reflects psychodynamic theory, explaining psychosis as an immature defence of the ego against unbearable affect and the anxiety of the intra-psychic conflict (Hingley, 1997). Bentall et al.'s (2001) cognitive theory updates the initial proposal by Bentall, Kinderman and Kaney (1994). It similarly advocates that persecutory delusions prevent negative self-representations and more specifically, low self-esteem from reaching conscious awareness in situations that would otherwise risk highlighting unmanageable discrepancies between self-representations and self-ideals. Through the mechanism of placing the blame for negative or threatening events outside the self (Lyon, Kaney & Bentall, 1994), negative self-esteem and self-representations remain latent (implicit) while ostensible (explicit) self-esteem is adequate. Malevolent internal representations of others maintain ideas of persecution.

Freeman, Garety, Kuipers, Fowler and Bebbington (2002): Threat Anticipation Cognitive Hypothesis

Freeman et al. (2002) suggest that emotion and low self-esteem have a direct, non-defensive role in the development of symptoms. In accordance with the cognitive principle (Garety et al., 2011), this multi-factorial model proposes that the appraisal of the experience causes distress, rather than the experience itself. Specifically, persecutory delusions are beliefs selected by the person to give meaning to internal and external arousal, confusion and anomalous experiences that have arisen further to a heightened state, in the context of stressful environmental events. Social isolation, the need for certainty and personal beliefs about illness may influence the meaning chosen. Arousal, confusion and anomalous experiences are also influenced by background emotions and emotional salience, pre-existing beliefs about the self, others and the world and cognitive biases associated with psychosis. Emotions, especially anxiety, may shape delusion content regarding impending physical, social or psychological danger. Well-established links between psychosis and anxiety exist (e.g. Tien & Eaton, 1992; Turnbull & Bebbington, 2001).

Subsequently, maintenance occurs through reinforcement (including the relief of having an explanation and consistency with pre-existing beliefs), the biased processing of belief-confirming evidence and the discarding of potentially disconfirming evidence. Emotional distress is conceptualised as being both a contributory and consequential part of the delusional process.

Cromby and Harper (2009): A Social Account

The authors critique individually-focussed models for treating paranoia and its potential components as problems in their own right. In comparison, they emphasise the predominance

of social, relational and material factors, and their role as interdependent with rather than supplementary or contextual to the origin and perpetuation of paranoia. The authors frame paranoia as co-constituted experientially of subjective socialised feeling, which is created through perceptions and impact of our interaction and relations with our socially, relationally and materially-structured world and our need to manage this. The continuum hypothesis is thus supported. Such socialised feeling is suggested to exist in trait and dynamic state forms, and flux of the latter can influence the content, affective texture and level and perceived salience of threatening thoughts at any given time.

Summary and Synthesis

Bentall et al.'s (2001) theory is interesting in its complexity and functional mechanism, but as indicated below has not been consistently upheld by research findings. One key problem in testing the theory has been accurately measuring implicit and therefore unconscious self-esteem. Freeman et al.'s (2002) hypothesis has greater empirical support, as demonstrated below. It is clear, relatively uncomplicated to test, and leads easily to psychological intervention using cognitive-behavioural therapy. However, the contemporary popularity of its cognitive underpinnings (partly because of their amenability to measurement), and the domination of the field by Freeman and Garety may facilitate this theory's prominence. Cromby and Harper's (2009) account is largely untested, but provides a useful challenge to perspective. The very interpersonal nature of paranoia logically corroborates a definition that advocates social, relational and material factors as focal co-constituents rather than contextual contributors.

Exploration of Process Components

Cognitive Processes

Theory of mind. It was originally proposed that difficulties with inferring others' mental states and intentions might link theory of mind (ToM) and mentalising deficits with paranoia. Freeman et al.'s (2002) model suggests that such deficits might reduce the ability to accurately ascribe meaning to an experience, though a persecutory inference would not necessarily follow (Freeman, 2007).

Several studies have concurred that ToM ability is poorer in people with paranoia than controls (e.g. Frith & Corcoran, 1996; Harrington, Langdon, Seigert & McClure, 2005). However, Walston, Blennerhassett and Charlton (2000) proved ToM to be unnecessary for paranoia to occur. Although their sample size (n = 4) limited generalizability, results highlighted the likely role of issues co-occurring with ToM in paranoid samples. This is addressed using correlational study designs which have occasionally yielded associations between ToM or mentalising and paranoia or persecutory delusions (e.g. Greig, Bryson & Bell, 2004; Craig, Hatton, Craig & Bentall, 2004). Such a link found in first-degree relatives indicated familial trait ToM deficits influencing paranoia development (Versmissen et al., 2008). However, ceiling effects of the mentalising measure might have affected ecological validity. Overall, methodological issues including sample size and inconsistency of ToM measures and symptom groupings complicate comparison and extraction of a complete representation of the role of ToM.

Data gathering bias. Freeman and Garety (2013) assert that the existence of the 'jumping to conclusions' (JTC) bias is substantiated in people with generic delusions. JTC means decisions are made based on limited evidence. Fear and Healy (1997) used

probabilistic reasoning tasks to demonstrate that the presence of JTC differed between clinical and control groups. However, regarding specifically persecutory delusions, McKay, Langdon and Coltheart (2007) highlight that most studies of JTC do not investigate exclusively persecutory delusions (e.g. Moritz & Woodward, 2005), which complicates analysis of specific associations. McKay et al.'s (2007) delusional sample was of solely the persecutory subtype, and JTC was not found, replicating Young and Bentall (1997). The JTC effect appears variable with such samples: only 50% of Startup, Freeman and Garety's (2004) participants demonstrated JTC. McKay et al. (2007) suggest that the greater wariness of those with persecutory delusions might extend to their decision-making.

A similar bias is the 'need for closure' (NTC): the preference for any answer over confusion and ambiguity (Kruglanski, 1989). Bentall and Swarbrick (2003) showed NFC to be significantly higher in groups with current and remitted persecutory delusions than in controls. Confirmation of NFC in a clinical group was provided by MacKay, Langdon and Coltheart (2005) but no relationship with JTC was identified.

Specific process elements of Freeman et al.'s (2002) model are further elucidated by findings of attentional bias (Bentall & Kaney, 1989) and recall bias (Kaney, Wolfenden, Dewey & Bentall, 1992) for threat-related information. Furthermore, biased processing of belief disconfirmation information, such as non-occurrence of the threatened event, is likely to promote maintenance (Freeman, Garety & Kuipers, 2001).

Attributional style. Findings are inconclusive regarding style of locating explanation for negative events among people with threatening thoughts. Lyon et al. (1994) and Fear, Sharp and Healy (1996) demonstrated a self-serving externalising bias, as Bentall et al.'s

(2001) theory might anticipate. Conversely, McKay et al. (2005) and Martin and Penn (2002) showed no difference between clinical and control groups. It is possible that greater specificity is required in classifying and comparing types of paranoia to elucidate disparities: Peters and Garety (2006) found high levels of depressive attributional style among those who believed they deserved the threat, but not among those who felt undeserving ('poor me' vs. 'bad me' paranoia, Trower & Chadwick, 1995).

A propensity to externalise blame to people instead of situations was noted (Kinderman & Bentall, 1997), but only replicated when participants' attributions were objectively rated (Martin & Penn, 2002; McKay et al., 2005; Randall, Corcoran, Day & Bentall, 2003). Differences may be partially accounted for by questionnaires failing to address the ambiguous social situations that delusional attributions commonly involve (Freeman, 2007).

Self-esteem. The role of self-esteem in paranoia and persecutory delusions is central to the difference between the conceptualisations of Bentall et al. (2001) and Freeman et al. (2002). If delusions are a (successful) defence then explicit self-esteem should be comparable to controls, as shown by Lyon, Kaney and Bentall (1994) and MacKay et al. (2007) (after controlling for depression). But if threatening thoughts directly reflect negative self-appraisal then explicit self-esteem should be lower in the clinical group, in accordance with MacKinnon, Newman-Taylor and Stopa (2011).

Two explanations for these mixed findings are proposed. Firstly, paranoia subtypes may denote self-esteem, which was found to be low in 'bad me' but preserved in 'poor me' individuals by Chadwick, Trower, Juusti-Butler & Maguire (2005). However, this simplistic division was not replicated by Bentall et al. (2008). Secondly, situations vary in terms of the

success of externally attributing defensively, which may lead to self-presentations and attributions interacting cyclically (Bentall et al., 2001). In corroboration, Melo, Taylor and Bentall (2006) showed fluctuation in perceived deservedness of persecution in 34% of participants over a two-week period.

Furthermore, empirical findings regarding implicit self-esteem measures are inconclusive. McKay et al. (2007) found it to be lower in clinical groups than control and remitted groups, supporting Bentall et al. (2001). Contrastingly, MacKinnon et al. (2011) found comparable positive implicit self-esteem in clinical and control groups. Methodological difficulties accessing covert processes are probable (Kinderman, 1994). Overall, such an equivocal overall picture indicates that low self-esteem is not a necessary constituent of threatening thoughts.

Negative schematic beliefs. Negative self- and other-schemas were more common in a group with persecutory delusions than controls (MacKinnon et al., 2011). However, the use of analysis of variance despite abnormal distribution of control group data might reduce the merit of results. Previously, Smith et al.'s (2006) results associated persecutory delusions with self- and other-evaluative beliefs independently of depression and low self-esteem. Also, Fowler et al.'s (2006) sample reported extreme negative beliefs about self and others, though only 55% of the sample experienced persecutory delusions, diminishing generalisability.

While negative other-evaluative beliefs support Bentall et al.'s (2001) 'delusions as defence' model, all findings align with Garety et al.'s (2001) proposal that underlying negative self-schemas can characterise a cognitive vulnerability to a sense of threat influencing the processing of anomalous experience (as detailed in Freeman et al.'s model, 2002), increasing

the likelihood of persecutory delusional explanations of phenomena. However, the mechanism is unclear: Fowler (2000) proposes that the triggering of these schemas catalyses the development of persecutory delusions; alternatively, negative self-beliefs may result from experience of psychosis, or causality may be circular (Freeman, 2007).

Affective Processes

Delusional distress is a key feature of clinical paranoia and persecutory delusions and has been associated with belief content (Freeman et al., 2001) and hypothesised to play a crucial role in the experience of perceptual abnormalities and selection of their meaning as threatening (Freeman et al., 2002).

Anxiety. Freeman et al. (2002) propose that "anxiety is ... the key emotion with regard to the formation of persecutory delusions" (at p. 335), ascribing a prominent function anxiety in leading to the anticipation of threat events in paranoia, including fear of psychological, social or physical harm. In support, meta-cognitive processes in anxiety (Wells, 1994) were found similarly in anxious and paranoid groups (Freeman & Garety, 1999). Furthermore, anxiety has been convincingly associated with paranoia (Fowler et al., 2006; Huppert & Smith, 2005), can predict paranoia (Freeman et al., 2003) and persistence of persecutory delusions (Startup, Freeman & Garety, 2007). Predisposition to hallucinations might predict persecutory delusions rather than simply anxiety (Freeman et al., 2003).

Using anxiety disorders terminology, 'safety behaviours' (Salkovskis, 1991) are common among people with threatening thoughts; usage correlates positively with anxiety levels (Freeman et al., 2001; Freeman et al., 2007). Freeman et al. (2001) found that choice of safety behaviour paired logically with high levels of specific emotions: avoidance with anxiety,

compliance with self-esteem and aggression with anger. Robustness of findings was reduced by the quantity of correlational analysis (Pearson's r) performed on the data set, risking Type 1 error and yielding multiple non-significant results.

Worry. People with persecutory delusions have typically been found to possess elevated levels of worry (Freeman & Garety, 1999), encompassing meta-worry (Freeman et al., 2001) and worry about matters unrelated to paranoia (Startup, Freeman & Garety, 2007). The latter study showed that catastrophising steps were larger in those with paranoia, reminiscent of the JTC bias. Perceived likelihood of an event occurring increased with length of catastrophising chain, indicating a role for this thinking style in threat belief maintenance. Additionally, higher levels of worry and catastrophising correlated with delusional distress experienced, which Startup et al. (2007) hypothesised to reflect a circular process. Together with anxiety, worry and catastrophisation predicted delusion persistence at three-month follow-up, suggesting that worry co-occurs with and predicts perpetuation of paranoia and persecutory delusions. However, design precluded investigation of causation; thus a further variable may mediate.

Mood. Freeman et al. (2013) showed high levels of depression in patients with psychosis, 85% of which reported paranoid thinking. Results linked depression with emotion-related cognitive biases such as negative interpretations of ambiguous events and negative ideas about the self, which might arguably maintain delusions. In support, mood and self-esteem have correlated positively in studies of persecutory delusions, in a potentially circular relationship (e.g. Chadwick et al., 2005). Smith et al. (2006) showed that depression, poor self-esteem and negative evaluative schemas were more strongly linked to distress and delusion pre-occupation than to belief conviction. Unusually, Fowler et al. (2012) used a

longitudinal cohort design, repeating initial measures at three and 12 months. Structural equation modelling identified plausible pathways from negative cognition and depressed mood to paranoid symptoms, with the link between the latter two being mediated by the former. Authors admitted that confounding by unidentified variables was possible.

Further emotions. Other affective influences on delusional content, development and maintenance have included anger (Chadwick et al., 2005), external shame (Matos, Pinto-Gouveia & Gilbert, 2013), elation (Freeman et al., 2002) and worthlessness, humiliation and helplessness (Fornells-Ambrojo & Garety, 2005).

Contextual Factors

Social environment. Freeman et al.'s (2002) individual contextualised theory explicates persecutory delusion development and maintenance sufficiently. Corroboratively, a deprived urban environment was shown to exacerbate current symptoms via increased negative thoughts about others, anxiety and JTC bias (Ellett, Freeman & Garety, 2008). The tendency to interpret neutral social signals as threatening (Freeman et al., 2005) was likely to mediate.

However, the commonly interpersonal nature of paranoid threat better endorses the emphasis of Cromby and Harper's (2009) social theory, on a focal role of relational factors in paranoia as a socialised feeling, evolved to manage interaction with the world. Fittingly, Harrop and Trower (2003) highlighted the role of immediate relational dynamics in the development and reinforcement of paranoia, including mistrust, inflexible rules, apprehension and mutual intrusion on actions and feelings.

Additionally, paranoid thinking has been linked with perceptions of low social rank and power (Gilbert, Boxall, Cheung & Irons, 2005) and submissive behaviour (Pinto-Gouveia, Matos, Castilho & Xavier, 2012).

Finally, Collip et al. (2011) demonstrated that unfamiliarity of social company resulted in greater momentary paranoia and perceived social threat in low and medium but not high trait paranoia groups, suggesting a disconnection from social context in highly paranoid people. The use of real-life social contexts for data collection increased ecological validity.

Life problems and goals. Following Forgus and DeWolfe (1974), Jakes, Rhodes and Issa (2004) used thematic analysis to show connections between delusional themes and surrounding beliefs and categories of participants' life problems and goals. Unfortunately, delusion sub-types were not reported while delusion content was only presented in one case study. Therefore the study's contribution to conceptualising threatening thoughts specifically is impossible to evaluate. However, the authors hypothesise possible relationships: life problem as indirect trigger of delusion; delusion as shaper of perspectives on life problems or involvement of an additional variable (e.g. trauma) leading to both.

Summary and Synthesis

To date, key research into cognitive process components of paranoia and persecutory delusions indicates a role for data gathering biases and negative schematic beliefs, while findings are inconclusive regarding attributional style. The evidence for the contribution of self-esteem and ToM is weak, and Garety and Freeman (2013) conclude that the ToM theory has not survived testing. In terms of affect, the influence of anxiety in the formation of threatening thoughts is robustly proven, and its part in thought maintenance is also supported.

Worry and mood are demonstrated contributory factors, with depression unsurprisingly linked to distress. Other implicated major emotions are anger and shame. Elements of social context are consistently linked to not only the development and maintenance of paranoia and persecutory delusions, but also the moment-to-moment fluctuation of the majority of threatening thoughts. Additionally, associations between delusional content themes and life goals or problems seem likely.

First Episode Psychosis (FEP)

The World Health Organisation (2004) state that a first experience of psychosis usually occurs between 16 and 30 years old The first three years after onset, termed the critical period, seem particularly open to intervention (Birchwood, Iqbal, Chadwick & Trower, 2000) but also particularly vulnerable to maximum decline in personal, social and occupational areas, setting a 'ceiling' for long-term recovery (Singh & Fisher, 2007). Depression and suicide risk is high (Birchwood et al., 2000), as is self-harm rate (Patel & Upthegrove, 2009) and substance use rate (Rajapakse, Garcia-Rosales, Weerawardene, Cotton & Fraser, 2011).

Given the existence and specific term of the critical period, it seems possible that experiences of FEP and more chronic conditions are qualitatively different. Harrop and Trower (2003) suggest that a novel experience of psychosis is likely to be particularly confusing and frightening: early adulthood indicates concurrent developmental issues, ongoing identity formation and individuation. There is increased likelihood of sensitivity to others' judgement, related self-consciousness and insecurity, de-stabling separation from families of origin and anxiety about transition to autonomy.

Additionally, the effects of institutionalisation, long-term anti-psychotic treatment and long-standing experiences of stigma comprising devaluation and rejection (Hayward & Bright, 1997), dissolution of roles and social status may be less present in FEP presentation. Birchwood (2003) proposed that emotional difficulties in psychosis could form part of a psychological reaction to it, thus chronicity itself might affect delusional belief systems (Fornells-Ambrojo & Garety, 2005).

Therefore, while theories of paranoia development are highly relevant to FEP, empirical findings using chronic samples should be drawn upon with caution. Exploration of paranoia and persecutory delusions in FEP is thus far a small but developing area. The studies evaluated below have begun to extend the above findings in relation to this specific group.

Cognitive Processes

Data gathering bias. Broome et al. (2003) investigated JTC in FEP. On the harder version of the experimental task, the clinical and prodromal groups presented clear bias, which therefore may pre-date delusional thinking. NFC may also be implicated in development of delusions: Colbert, Peters and Garety (2006) discovered a significantly higher score on NFC in FEP samples with current and remitted delusions than in controls. NFC remained high at one-year follow-up despite changes in delusional status, indicating its stable nature. Trait anxiety was related to NFC in control but not FEP groups, despite the logic that coming to a decision removes uncertainty and concurrently reduces anxiety. Colbert et al.'s (2006) longitudinal use of analysis of co-variance was informative. However, the small sample size decreased further at follow-up and only 76.7% of the sample had delusions defined specifically as persecutory, necessitating caution in interpretation and generalisation.

Self-esteem and attributional style. 'Bad me' paranoia was found in just 7.5% of a FEP sample (Fornells-Ambrojo and Garety, 2005), compared with 20% (Freeman et al. 2001), 27% (Trower & Chadwick, 1995) and 50% (Startup, Owen, Parsonage & Jackson, 2003) in chronic samples. Fornells-Ambrojo and Garety (2005) suggested that stigma and depression may contribute to the development of 'bad me' perspectives over time. Their exploration of 'poor me' paranoia in a FEP group indicated normal levels of self-esteem and an inclination to personal-external attributions for negative events (Fornells-Ambrojo & Garety, 2009), matching findings in chronic presentations. This supports Bentall et al.'s (2001) model. Nevertheless, cross-sectional design prevented a test of the stability of paranoia subtype.

Drake et al. (2004) discovered a negative correlation of self-esteem with insight and depression levels. Self-esteem was not seen to mediate relationships between paranoia and any variable. Longitudinal design allowed for several informative re-assessments.

Affective Processes

Mirroring findings in chronic psychosis, research to date has indicated a significant role for emotions in paranoid thinking.

Anxiety. Fornells-Ambrojo and Garety (2009) found elevated anxiety in a paranoid sample, as Freeman et al.'s (2002) theory would predict. Michail and Birchwood's (2009) results defined social anxiety (SA) in FEP as an independent co-morbidity rather than merely a derivative of persecutory delusions. While those with SA in FEP more often endorsed perceived threat from others; suspiciousness and ideas of persecution were unrelated to SA.

The authors suggested a division between types of anticipated interpersonal threat: generalised fear in SA and specific fear in persecutory delusions.

Mood. Fornells-Ambrojo and Garety (2005) noted severe depression in 'bad me' paranoia as expected, and depression ranging from minimal to severe in the 'poor me' group. This was significantly higher than controls (Fornells-Ambrojo & Garety, 2009).

Using a sizeable sample (n = 257), Drake et al. (2004) used structural equation modelling allowing examination of relationship direction over time. They showed that insight predicted depression at baseline, and paranoia level did so across follow-ups. Additionally, duration of untreated psychosis and substance use at baseline predicted depression 18 months later.

Anger. Fornells-Ambrojo and Garety (2009) found significant levels of anger in those with 'poor me' paranoia in contrast with controls. Anger intensity specifically in provocative situations was connected to external-personal attribution bias.

Contextual Factors

A large sample (n = 639) of records from first hospital admissions for psychosis with delusional beliefs, showed that women's delusions were principally persecutory while men's were commonly grandiose or jealous (Gutiérrez-Lobos, Schmid-Siegel, Bankier & Walter, 2001). Gender-based roles and experience seem relevant.

Raune, Bebbington, Dunn & Kuipers (2006) investigated the shaping of delusional themes by their context, through a rigorous assessment of life events over the year prior to onset using cross-examination and carer corroboration. Principal component analysis suggested a specific

association between persecutory delusions and experience of at least moderately intrusive events over the previous year. Intrusive events were defined as including receipt or threat of physical harm, and involving interference and attempted control of the person by someone without apparent relational closeness, often an authority figure. Raune et al. (2006) hypothesised that such events may impact on interpersonal schemata. However, life events' multiple attributes (e.g. humiliation, loss, danger, self-esteem impairment and intrusiveness) complicated the ascertainment of which element(s) of any given life event influenced delusional themes. Additionally, analysis did not account for the potentially cumulative effect of multiple experiences of a life event, while only 83% of the sample (n = 41) experienced specifically persecutory delusions. Nonetheless, theoretically, results emphasised the meaning in delusional content and highlighted the importance of social context in understanding delusions in FEP. Notably, Raune et al. (2006) operationally defined and objectified event characteristics leaving participants' interpretations of events unexplored.

Reflecting findings highlighting the role of anxiety in chronic persecutory belief development, Rajapakse et al. (2011) suggested that anxiety-provoking developmental life stressors in the typical FEP age group might explain their sample's preponderance of the persecutory subtype (53.7% of 143). The most frequently occurring themes depicted monitoring through hidden cameras or tapped phones. Reflecting on the imprecise, indistinguishable delusions found in adolescents compared to older participants by Hafner, Maurer, Loffler and Riecher-Rossler (1993), Rajapakse et al. (2011) suggested that the maturing personality of most FEP clients might contribute to an emergent, simpler and less bizarre delusional belief system, mirroring Larsen et al.'s (2006) findings. However, Rajapakse et al. (2011) omit to report details beyond delusion subtype frequency and broad information on correlating content themes, and mood and anxiety levels. A more illuminating

investigation could have been conducted with such a large sample of reportedly detailed medical records.

Individual Experience

Nomothetic, quantitative methodologies utilised in the literature reviewed have established essential and complex objective frameworks to conceptualise persecutory delusions and paranoia. However, deeper understanding of subjective experience and individual meanings attached to context is drawn from idiographic, qualitative findings (Camic, Rhodes & Yardley, 2003).

Chronic Presentations

Boyd and Gumley (2007) addressed the lack of experiential accounts of chronic psychosis through developing a social constructionist grounded theory of personal perspectives of persecutory paranoia. Results comprised a core theme of fear and vulnerability, sub-categories of confusion and uncertainty feeding into self under attack (from both external and internal sources), feeding into engaging the safety systems. Interaction of sub-sub-categories reflected a complicated, dynamic and frightening experience of paranoia as an evolved self-protective mechanism. Sensitivity to context, commitment and rigour, transparency and coherence (Yardley, 2000) was apparent. Clear and comprehensible themes were well-evidenced and agreed by multiple researchers, though lacked respondent validation. Reflexively, Boyd and Gumley (2007) considered whether interpretative phenomenological analysis (IPA) may have been more suitable for exploring participants' psychological worlds.

FEP Presentations

Boydell, Stasiulis, Volpe and Gladstone (2010) reviewed all qualitative studies of FEP to date, demonstrating a scarcity of subjective accounts of holding threatening beliefs in early psychosis. Two studies that do consider paranoia or persecutory delusions, though minimally, are addressed below.

Hirschfeld, Smith, Trower and Griffin (2005) developed a grounded theory of six men's perspectives on early psychosis and their related meaning-making. Sub-themes of the authors' first theme, experience of psychosis, portrayed paranoia as a sense of being unsafe, with altered perceptions present that others could not understand. Extreme emotions were described, namely anger, stress and unhappiness. Applying Mays and Pope's (2000) criteria for assessing quality of qualitative research, the study was limited by lack of a female perspective, but theoretical sampling was attempted, stages of the research process were clearly recounted, respondent validation and researcher cross-checking corroborated codes and themes which were well-grounded in literature. However, generation of the theme experience of psychosis in a study investigating experience of psychosis lacked interpretation.

IPA indicated that personal explanations and meaning were vital to maintaining hope and a sense of belonging during a first psychotic experience (Perry, Taylor & Shaw, 2007). Descriptions of paranoia contributed to a sub-theme about the confusion brought by the emergence of psychosis, with reference to misinterpretations and seeing and hearing horrible things. Quotes were efficiently used to support considered and well-validated themes. However, little researcher reflexivity was apparent in presenting or contextualising interpretation.

Conclusions and Implications for Future Research and Clinical Practice

This review evaluated the evidence for psychological conceptualisation and mechanisms of threatening thoughts in psychosis. Contrasting theories explain these phenomena using cognitive (Bentall, 2001; Freeman et al., 2002) and social (Cromby & Harper, 2009) approaches. Empirical evidence underlies and expands these theories to varying extents; seeming most supportive of Freeman et al.'s (2002) threat anticipation model.

Research into cognitive processes among chronic psychosis samples outlines a role for data gathering biases and negative schematic beliefs in the origin and maintenance of paranoia and persecutory delusions. Although established, further work is needed to confirm the presence of the JTC bias in persecutory delusions specifically. The importance of attributional bias as a process component is questionable, while consistent involvement of self-esteem and ToM is doubted. Attributional functioning may be better assessed in terms of 'poor me' and 'bad me' subtypes separately, and by using measures better suited to paranoid social concerns. Findings might inform the challenge and re-appraisal of thoughts in cognitive therapy. The discovery of fluctuating perceived deservedness of persecution can be built upon to investigate potential links between 'poor me'/'bad me' presentations and the success rate of external attribution as a defence at any given time.

Literature regarding affective processes highlights anxiety, worry and mood and implicates anger and shame in paranoid and persecutory delusional function. The potential circularity of relationships of delusional distress with worry and catastrophising and mood with self-esteem remains to be clarified. Recent evidence suggests a direction of effect from negative cognition and depressed mood to paranoia, with negative cognition as a mediator between the other two. Improved knowledge of the causes of emotions in paranoia (such as delusion

content) is needed given the role of distress in differentiating clinical and non-clinical presentations, and the consequent need to prioritise its treatment.

Studies' use of longitudinal measurement was limited. A focus on change over time in delusion content, its appraisal and related emotional and cognitive function could inform treatment design and promote recovery. Attrition rates would need to be considered and addressed.

A thorough approach is needed to investigate links between life problems or goals and persecutory delusional themes, appraisal and emotions. Relationship mechanisms must then be further defined. Research with different cultural groups possessing varying perceptions of and approaches to life problems could be informative. Approaching research and findings from Cromby and Harper's (2009) viewpoint that social and environmental factors are central rather than contextual to threatening thoughts could usefully change the focus. This could inform psychological therapy around the management of interaction and subjective socialised feeling. The possible caveat of disconnection from social context in highly paranoid people (Collip et al., 2011) needs further investigation.

Much of the above work requires replication with FEP samples. Early evidence indicates generalisation regarding data gathering biases, roles of anxiety and depression, self-esteem and context. Findings extend understanding of data gathering bias in suggesting that it may pre-date threatening thoughts, and that NFC remains stable notwithstanding reduction in paranoia. Additionally, 'bad me' seems particularly rare in FEP, although likely fluctuation of the 'poor me'/'bad me' paranoia subtype requires investigation.

Clarity is required regarding the role, impact and predictive capacity of anxiety-provoking developmental stressors on threatening thought development and content. Studies have omitted to assess the cumulative impact of multiple life event experience on delusional themes, and the mechanism of impact. Investigation of social context of threatening thoughts in FEP is lacking. Additionally, hypotheses that delusional belief frameworks in FEP might be simpler, non-specific or less unusual are unsubstantiated. Clinically, collaborative consideration of the influence of context could improve engagement and normalisation, thereby potentially reducing distress and feelings of powerlessness.

There is an absence of research exploring subjective experience of paranoia and persecutory delusions in FEP. Quantifiable measures can overlook important details of the process of phenomena on the participant's experiential level (Larsen, 2007). Clinical understanding of the area therefore remains biased towards the objective and generalised. Use of rigorous qualitative methodology could add nuances of personal insight to current conceptualisations of threatening thoughts in FEP, enhancing identification, engagement and intervention. Findings might also indicate new avenues for exploration.

References

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: American Psychiatric Association.

Arseneault, L., Cannon, M., Witton, J. & Murray, R.M. (2004). Causal association between cannabis and psychosis: examination of the evidence. British Journal of Psychiatry, (184), 110-117.

Bebbington, P. E., Bhugra, D., Brugha, T., Singleton, N., Farrell, M., Jenkins, R. & Meltzer, H. (2004). Psychosis, victimisation and childhood disadvantage Evidence from the second British National Survey of Psychiatric Morbidity. The British Journal of Psychiatry, 185(3), 220-226.

Bentall, R.P. (2003). Madness explained: Psychosis and human nature. London: Penguin Books.

Bentall, R., Corcoran, R., Howard, R., Blackwood, N., & Kinderman, P. (2001). Persecutory delusions: a review and theoretical integration. Clinical Psychology Review, 21, 1143-1192.

Bentall, R. P. & Kaney, S. (1989). Content-specific information processing and persecutory delusions: An investigation using the emotional Stroop test. British Journal of Medical Psychology, 62, 355-364.

Bentall, R.P., Kinderman, P. & Kaney, S. (1994). The self, attributional processes and abnormal beliefs: Towards a model of persecutory delusions. Behaviour, Research and Therapy, 32, 331-341.

Bentall, R.P., Rouse, G., Kinderman, P., Blackwood, N., Howard, R., Moore, R., Cummins, S., & Corcoran, R. (2008). Paranoid delusions in schizophrenia spectrum disorders and depression: The transdiagnostic role of expectations of negative events and negative self-esteem. Journal of Nervous and Mental Disease, 196(5) 375-383.

Bentall, R.P., & Swarbrick, R. (2003). The best laid schemas of paranoid patients: Sociotrophy, autonomy and the need for closure. Psychology and Psychotherapy, 76(2), 163-171.

Bhugra, D. & Jones, P. (2001). Migration and mental illness. Advances in Psychiatric Treatment, 7, 216-223.

Birchwood, M. (2003). Pathways to emotional dysfunction in first episode psychosis. British Journal of Psychiatry, 182, 373−375.

Birchwood, M., Iqbal, Z., Chadwick, P. & Trower, P. (2000). Cognitive approach to depression and suicidal thinking in psychosis: I. Ontogeny of post-psychotic depression. British Journal of Psychiatry, 177, 516–528.

Boyd, T., & Gumley, A. (2007). An experiential perspective on persecutory paranoia: A grounded theory construction. Psychology and Psychotherapy: Theory, Research and Practice, 80(1), 1-22.

Boydell, K. M., Stasiulis, E., Volpe, T., & Gladstone, B. (2010). A descriptive review of qualitative studies in first episode psychosis. Early intervention in psychiatry, 4(1), 7-24.

Boyden, K., Olendorf, D. & Jeryan, C. (2008). Gale Encyclopaedia of Medicine. The Gale Group Inc. Retrieved from http://medical-dictionary.thefreedictionary.com/Paranoia

Boyle, M. (2002). Schizophrenia: A scientific delusion? (2nd ed.). London: Routledge.

Bramness, J.G., Gundersen, O.H., Guterstam, J., Rognli, E.B., Konstenius, M., Løberg, E-M., Medhus, S., Tanum, L. & Franck, J. (2012). Amphetamine-induced psychosis: A separate diagnostic entity or primary psychosis triggered in the vulnerable? BMC Psychiatry, 12(1), 221.

Broome, M., Brett, C., Johns, L.C., Woolley, J., Peters, E., Garety, P. & McGuire, P.K. (2003). Reasoning styles and delusions in early psychosis. Presentation at International Congress on Schizophrenia Research, 2003.

Cantor-Graae, E. & Selten, J.P. (2005). Schizophrenia and migration: A meta-analysis and review. American Journal of Psychiatry, (162), 12-24.

Chadwick, P.D.J., Trower, P., Juusti-Butler, T.-M. & Maguire, N. (2005). Phenomenological evidence for two types of paranoia, Psychopathology, 38, 327-333.

Colbert, S. M., Peters, E. R., & Garety, P. A. (2006). Need for closure and anxiety in delusions: A longitudinal investigation in early psychosis. Behaviour Research and Therapy, 44(10), 1385-1396.

Collip, D., Oorschot, M., Thewissen, V., van Os, J., Bentall, R. & Myin-Germeys, I. (2011). Social world interactions: How company connects to paranoia. Psychological Medicine, 41, 911-921.

Cooper, B. (2005). Immigration and schizophrenia; the social causation hypothesis revisited. British Journal of Psychiatry, (186), 361-363.

Craig, J. S., Hatton, C., Craig, F. B., & Bentall, R. P. (2004). Persecutory beliefs, attributions and theory of mind. Schizophrenia Research, 69, 29−33.

Cromby, J. & Harper, D.J. (2009). Paranoia: A social account. Theory and Psychology, 19(3), 335-361.

Drake, R.J., Pickles, A., Bentall, R.P., Kinderman, P., Haddock, G., Tarrier, N., Lewis, S.W. (2004). The evolution of insight, paranoia and depression during early schizophrenia. Psychological Medicine, 34(2), 285-292.

Ellett, L., Freeman, D. and Garety, P.A. (2008). The psychological effect of an urban environment on individuals with persecutory delusions: the Camberwell walk study. Schizophrenia Research, 99, 77-84.

Ellett, L., Lopes, B., & Chadwick, P. (2003). Paranoia in a non-clinical population of college students. The Journal of Nervous and Mental Disease, 191, 425-430.

Fear, C. F., & Healy, D. (1997). Probabilistic reasoning in obsessive-compulsive and delusional disorders. Psychological Medicine, 27, 199−208.

Fear, C.F., Sharp, H. & Healy, D. (1996). Cognitive processes in delusional disorders. British Journal of Psychiatry, 168, 61-67.

Forgus, R. & DeWolfe, A. (1974). Coding of cognitive input in delusional patients. Journal of Abnormal Psychology, 33(3), 278 – 284.

Fornells-Ambrojo, M., & Garety, P. A. (2005). Bad me paranoia in early psychosis: A relatively rare phenomenon. British Journal of Clinical Psychology, 44(4), 521-528.

Fornells-Ambrojo, M. & Garety, P.A. (2009). Understanding attributional biases, emotions and self-esteem in 'poor me' paranoia: Findings from an early psychosis sample. British Journal of Clinical Psychology, 48, 141-162.

Fowler, D. (2000). Cognitive behaviour therapy for psychosis: From understanding to treatment. Psychiatric Rehabilitation Skill, 4 (2), 199–215.

Fowler, D.G., Freeman, D., Smith, B., Kuipers, E.K., Bashforth, H., Coker, S., Hodgekins, J., Gracie, A., Dunn, G. & Garety, P.A. (2006). The Brief Core Schema Scales (BCSS): Psychometric properties and associations with paranoia and grandiosity in non-clinical and psychosis samples. Psychological Medicine, 36, 749–759.

Freeman, D. (2007). Suspicious minds: The psychology of persecutory delusions. Clinical Psychology Review, 27, 425-457.

Freeman, D., Dunn, G., Fowler, D., Bebbington, P., Kuipers, E., Emsley, R., Jolley, S. & Garety, P. (2013). Current paranoid thinking in patients with delusions: The presence of cognitive-affective biases. Schizophrenia Bulletin, (39)6, 1281–1287.

Freeman, D. & Freeman, J. (2008). Paranoia: The 21st century fear. New York: Oxford University Press.

Freeman, D. & Garety, P.A. (1999). Worry, worry processes and dimensions of delusions: An exploratory investigation of a role for anxiety processes in the maintenance of delusional distress. Behavioural and Cognitive Psychotherapy, 27(1), 47-62.

Freeman, D., Garety, P. & Kuipers, E. (2001). Persecutory delusions: Developing understanding of belief maintenance and emotional distress. Psychological Medicine, 31, 1293-1306.

Freeman, D. Garety, P.A., Kuipers, E., Fowler, D. & Bebbington, P.E. (2002). A cognitive model of persecutory delusions. British Journal of Clinical Psychology, 41, 331-347.

Freeman, D., Slater, M., Bebbington, P. E., Garety, P. A., Kuipers, E., Fowler, D., et al. (2003). Can virtual reality be used to investigate persecutory ideation? Journal of Nervous and Mental Disease, 191, 509−514.

Freeman, D., Garety, P., Kuipers, E., Fowler, D., Bebbington, P. E., & Dunn, G. (2007). Acting on persecutory delusions: The importance of safety seeking. Behaviour Research and Therapy, 45, 89−99.

Frith, C. D. & Corcoran, R. (1996). Exploring `theory of mind' in people with schizophrenia. Psychological Medicine, 26, 521 -530.

Garety, P. and Freeman, D. (2013). The past and future of delusions research: From the inexplicable to the treatable. British Journal of Psychiatry, 203(5), 327-333.

Garety, P., Joyce, E., Jolley, S., Emsley, R., Waller, H., Kuipers, E., Bebbington, P., Fowler, D., Dunn, G. & Freeman, D. (2013). Neuropsychological functioning and jumping to conclusions in delusions. Schizophrenia Research, 150(2-3), 570-574.

Garety, P.A., Kuipers, E., Fowler, D., Freeman, D. & Bebbington, P.E. (2001). A cognitive model of the positive symptoms of psychosis. Psychological Medicine, 31, 189-195.

Garety, P., Freeman, D., Jolley, S., Ross, K., Waller, H. & Dunn, G. (2011). Jumping to conclusions: The psychology of delusional reasoning. Advances in Psychiatric Treatment, 17, 332-339.

Gelder, M., Harrison, P. & Cowen, P. (2006). Shorter Oxford Textbook of Psychiatry. Oxford: Oxford University Press.

Gilbert, P., Boxall, M., Cheung, M., & Irons, C. (2005). The relation of paranoid ideation and social anxiety in a mixed clinical population. Clinical Psychology & Psychotherapy, 12(2), 124-133.

Green, M.F., Kern, R.S & Heaton, R.K. (2004). Longitudinal studies of cognition and functional outcome in schizophrenia: implications for MATRICS. Schizophrenia Research, 72(1), 41-51.

Greig, T. C., Bryson, G. J., & Bell, M. D. (2004). Theory of mind performance in schizophrenia. Journal of Nervous and Mental Disease, 192, 12−18.

Gutiérrez-Lobos, K., Schmid-Siegel, B., Bankier, B. & Walter, H. (2001). Delusions in first-admitted patients: gender, themes and diagnoses. Psychopathology, 34(1), 1-7.

Hafner H., Maurer K., Loffler W. & Riecher-Rossler, A. (1993). The influence of age and sex on the onset and early course of schizophrenia. British Journal of Psychiatry; 162, 80–86.

Hahlweg, K. (2005). The shaping of individuals' mental structures and dispositions by others: Findings from research on expressed emotion. Interaction Studies: Social Behaviour and Communication in Biological and Artificial Systems, (6), 131-144.

Harrington, L., Langdon, R., Seigert, R. J., & McClure, J. (2005). Schizophrenia, theory of mind, and persecutory delusions. Cognitive Neuropsychiatry, 10, 87−104.

Harrop, C., & Trower, P. (2003). Why does schizophrenia develop at late adolescence?: A cognitive-developmental approach to psychosis. London: Wiley-Blackwell.

Hayward, P. & Bright, J. (1997) Stigma and mental illness: a review and critique. Journal of Mental Health, 6, 345 -354.

Hingley, S. M. (1997). Psychodynamic perspectives on psychosis and psychotherapy I: Theory. British Journal of Medical Psychology, 70(4), 301-312.

Hirschfeld, R., Smith, J., Trower, P., & Griffin, C. (2005). What do psychotic experiences mean for young men? A qualitative investigation. Psychology and Psychotherapy: Theory, Research and Practice, 78(2), 249-270.

Huppert, J. D., & Smith, T. E. (2005). Anxiety and schizophrenia; the interaction of subtypes of anxiety and psychotic symptoms. CNS Spectrums, 10, 72−731.

Jakes, S., Rhodes, J. & Issa, S. (2004). Are the themes of delusional beliefs related to the themes of life-problems and goals? Journal of Mental Health, 13 (6), 611-619.

Jorgensen, P. (1994). Course and outcome in delusional disorders. Psychopathology, 27, 79-88.

Kaney, S., Wolfenden, M., Dewey, M. E., & Bentall, R. P. (1992). Persecutory delusions and recall of threatening propositions. British Journal of Clinical Psychology, 31(1), 85-87.

Kinderman, P. (1994). Attentional bias, persecutory delusions and self-concept. British Journal of Medical Psychology, 67, 53-66.

Kinderman, P., & Bentall, R. P. (1996a). A new measure of causal locus: The internal, personal and situational attributions questionnaire. Personality and Individual Differences, 20, 261−264.

Kirkbride, J. B., Errazuriz, A., Croudace, T. J., Morgan, C., Jackson, D., Boydell, J. & Jones, P. B. (2012). Incidence of schizophrenia and other psychoses in England, 1950–2009: A systematic review and meta-analyses. PloS One, 7(3), e31660.

Kruglanski, A. W. (1989). Lay epistemics and human knowledge: Cognitive and motivational bases. New York: Plenum.

Kuipers, E. (2006). Family interventions in schizophrenia: Evidence for efficacy and proposed mechanisms of change. Journal of Family Therapy, 28(1), 73-80.

Larsen, J.A. (2007). Understanding a complex intervention: Person-centred ethnography in early psychosis. Journal of Mental Health, 16(3), 333-345.

Larsen, T.K., Melle, I., Auestad, B., Frii, S., Haahr, U., Johannessen, J.O., Opjordsmoen, S., Rund, B.R., Simonsen, E., Vaglum, P. & McGlashan, T. (2006). Early detection of first-episode psychosis: The effect on one-year outcome. Schizophrenia Bulletin, 32(4), 758-764.

Lyon, H.M., Kaney, S. & Bentall, R.P. (1994). The defensive function of persecutory delusions: Evidence from attribution tasks. British Journal of Psychiatry, 164, 637-646.

MacKinnon, K., Newman-Taylor, K. & Stopa, L. (2011). Persecutory delusions and the self: An investigation of implicit and explicit self-esteem. Journal of Behaviour Therapy and Experimental Psychiatry, 42, 54-64.

Martin, J. A., & Penn, D. L. (2002). Attributional style in schizophrenia. Schizophrenia Bulletin, 28, 131−141.

Matos, M., Pinto-Gouveia, J., & Gilbert, P. (2013). The effect of shame and shame memories on paranoid ideation and social anxiety. Clinical Psychology & Psychotherapy, 20(4), 334-349.

Mays, N. & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. British Medical Journal, 320, 50–52.

McKay, R., Langdon, R., & Coltheart, M. (2005). Paranoia, persecutory delusions and attributional biases. Psychiatry Research, 136, 233-245.

McKay, R., Langdon, R., & Coltheart, M. (2007). Jumping to delusions? Paranoia, probabilistic reasoning and need for closure. Cognitive Neuropsychiatry, 12(4), 362-376.

McKay, R., Langdon, R., & Coltheart, M. (2007). The defensive function of persecutory delusions: an investigation using the Implicit Association Test. Cognitive Neuropsychiatry, 12, 1-24.

Melo, S.S., Taylor, J.L. & Bentall, R.P. (2006). 'Poor me' versus 'bad me' paranoia and the instability of persecutory ideation. Psychology and Psychotherapy: Theory, research and practice, 79, 271-287.

Michail, M., & Birchwood, M. (2009). Social anxiety disorder in first-episode psychosis: incidence, phenomenology and relationship with paranoia. The British Journal of Psychiatry, 195(3), 234-241.

Moritz, S., & Woodward, T. S. (2005). Jumping to conclusions in delusional and non-delusional schizophrenic patients. British Journal of Clinical Psychology, 44, 193−207.

Morrison, A.P. (2004). Cognitive therapy for people with psychosis. In J. Read, L.R. Mosher & R.P. Bentall (Eds.), Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia (pp.291-306). Hove: Routledge.

Myin-Germeys, I., Krabbendam, L., Delespaul, P. A. E. G. & Van Os, J. (2003). Do life events have their effect on psychosis by influencing the emotional reactivity to daily life stress? Psychological Medicine, 33, 327-333.

National Institute for Health and Care Excellence (2014). Psychosis and schizophrenia in adults: Treatment and management. London: National Collaborating Centre for Mental Health.

Neria, Y., Bromet, E. J., Sievers, S., Lavelle, J. & Fochtmann, L. J. (2002). Trauma exposure and post-traumatic stress disorder in psychosis: Findings from a first admission cohort. Journal of Consulting and Clinical Psychology, 70, 246-251.

Patel, K. & Upthegrove, R. (2009). Self-harm in first-episode psychosis. Psychiatric Bulletin, 33, 104-107.

Perry, B. M., Taylor, D., & Shaw, S. K. (2007). "You've got to have a positive state of mind": An interpretative phenomenological analysis of hope and first episode psychosis. Journal of Mental Health, 16(6), 781-793.

Peters, E., & Garety, P. (2006). Cognitive functioning in delusions. Behaviour Research and Therapy, 44, 481−514.

Peters, E., Linney, Y., Johns, L. & Kuipers, E. (2007). Psychosis: Investigation. In S. Lindsay & G. Powell (Eds.), The Handbook of Clinical Adult Psychology (pp.354-373). London: Routledge.

Pinto-Gouveia, J., Matos, M., Castilho, P., & Xavier, A. (2014). Differences between depression and paranoia: the role of emotional memories, shame and subordination. Clinical Psychology & Psychotherapy, 21(1), 49-61.

Rajapakse, T., Garcia-Rosales, A., Weerawardene, S., Cotton, S. & Fraser, R. (2011). Themes of delusions and hallucinations in first-episode psychosis. Early Intervention in Psychiatry, 5, 254-258.

Randall, F., Corcoran, R., Day, J. C., & Bentall, R. P. (2003). Attention, theory of mind, and causal attributions in people with persecutory delusions. Cognitive Neuropsychiatry, 8, 287−294.

Raune, D., Bebbington, P., Dunn, G., & Kuipers, E. (2006). Event attributes and the content of psychotic experiences in first-episode psychosis. Psychological Medicine, 36(2), 221-230.

Salkovskis, P. M. (1991). The importance of behaviour in the maintenance of anxiety and panic: a cognitive account. Behavioural Psychotherapy, 19, 6-19.

Selten, J.P, Cantor-Graae, E. & Kahn, R.S. (2007). Migration and schizophrenia. Current Opinion in Psychiatry, 20, 111-115.

Singh, S.P. & Fisher, S.L. (2007). Early intervention services. Psychiatry, 6(8), 332-338.

Smith, B., Fowler, D.G., Freeman, D., Bebbington, P., Bashforth, H., Garety, P., Dunn, G. & Kuipers, E. (2006). Emotion and psychosis: Links between depression, self-esteem, negative schematic beliefs and delusions and hallucinations. Schizophrenia Research, 86, 181–188.

Startup, H., Freeman, D., & Garety, P. A. (2007). Persecutory delusions and catastrophic worry in psychosis: developing the understanding of delusion distress and persistence. Behaviour Research and Psychotherapy, 45(3), 523-537.

Startup, M., Owen, D. M., Parsonage, R. K., & Jackson, M. C. (2003). Anomalous experiences and the contents of persecutory delusions during acute psychotic episodes. Psychology and Psychotherapy: Theory, Research and Practice, 76(3), 315-322.

Tarrier, N. (2005). Cognitive behaviour therapy for schizophrenia: A review of development, evidence and implementation. Psychotherapy and Psychosomatics, 74, 136-144.

Tien, A. Y., & Eaton, W. W. (1992). Psychopathologic precursors and sociodemographic risk factors for the schizophrenia syndrome. Archives of General Psychiatry, 49(1), 37-46.

Trower, P., & Chadwick, P. (1995). Pathways to defense of the self: A theory of two types of paranoia. Clinical Psychology. Science and Practice, 2, 263−278.

Turnbull, G. & Bebbington, P. (2001) Anxiety and the schizophrenic process: clinical and epidemiological evidence. Social Psychiatry and Psychiatric Epidemiology, 36, 235–243.

van Os, J., Hanssen, M., Bak, M., Bijl, R.V. & Vollebergh, W. (2003). Do urbanicity and familial liability co-participate in causing psychosis? American Journal of Psychiatry, 160, 477-482.

van Os, J., Hanssen, M., Bijl, R. V. & Ravelli, A. (2000). Strauss (1969) revisited: a psychosis continuum in the general population? Schizophrenia Research, 45, 11–20.

Versmissen, D., Janssen, I., Myin-Germeys, I., Mengelers, R., Campo, J., van Os, J. & Krabbendaum, L. (2008). Evidence for a relationship between mentalising deficits and paranoia over the psychosis continuum. Schizophrenia Research, 99, 103–110.

Verdoux, H., Maurice-Tison, S., Gay, B., van Os, J., Salaman, R. & Bourgeois, M.L. (1998). A survey of delusional ideation in primary-care patients. Psychological Medicine, 28(1), 127-134.

Walston, F., Blennerhassett, R. C., & Charlton, B. G. (2000). Theory of mind, persecutory delusions and the somatic marker mechanism. Cognitive Neuropsychiatry, 5, 161−174.

Wells, A. (1994). A multi-dimensional measure of worry: Development and preliminary validation of the anxious thoughts inventory. Anxiety, Stress, and Coping, 6, 289−299.

World Health Organisation. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organisation World Mental Health Surveys. Journal of the American Medical Association, 291, 2581-2590.

Yardley, L. (2000). Dilemmas in qualitative health research. Psychology and Health, 15, 215-228.

Young, H. F., & Bentall, R. P. (1997). Probabilistic reasoning in deluded, depressed and normal subjects: Effects of task difficulty and meaningful versus non-meaningful material. Psychological Medicine, 27(2), 455-465.

Zubin, J. & Spring, B. (1977). Vulnerability - a new view of schizophrenia. Journal of Abnormal Psychology, 86, 103-124.

Megan Rose Underhill

Section B

Threatening thoughts in first episode psychosis: An interpretative phenomenological analysis of experiential accounts of content, emotional distress, change over time and context

Word count: 8000 (9)

For submission to:
Journal of Mental Health

Abstract

Background: The subjective experience of paranoia and persecutory delusions is largely overlooked in the extant literature, especially in first episode psychosis.

Aims: Exploration of the personal experience and understanding of threatening thoughts in first episode psychosis, guided by three over-arching research questions addressing: thought content and emotional distress; the role of life events and context; change in experience over time.

Methodology: Semi-structured interviews were conducted with eight participants. Transcripts were analysed using Interpretative Phenomenological Analysis.

Results: Five master themes were identified reflecting recurring characteristics of all participants' experiences: Exposure of vulnerable self; At the limits of endurance; Elusive sense of agency; The urge to explain it all and first episode psychosis as a finite experience? 16 sub-themes indicated elements of master themes that varied among individual narratives.

Conclusions: Findings indicated the highly interpersonal nature of threatening thoughts and their role as a key organising factor in people's lives. Emotional distress was often viewed as consequential to multiple types of thought content and overwhelming pressure, powerlessness and expectation of negative judgement. Difficult life contexts were often perceived to contribute to thought manifestation. Reduction of novelty was important to positive change. Several participants framed experiences as terrible but completed, rather than as the beginning of chronic difficulties.

Key words: first episode psychosis; paranoia; persecutory delusions; experience; interpretative phenomenological analysis.

Introduction

Threatening Thoughts in Psychosis

Threatening thoughts are among the most prevalent of the characteristics of psychosis (Jorgensen, 1994). The terms persecutory delusion(s) and paranoia are often applied interchangeably, and although strictly a delusion may be more fixed than a paranoid belief, both involve mistrust of others and their intentions and fear of physical, social or psychological harm, concerns which are objectively considered unfounded (Gelder, Harrison & Cohen, 2006). Psychosis is defined as forming part of the psychiatric diagnostic category schizophrenia (American Psychiatric Association, 1994). However, paranoid beliefs are also held in the non-clinical population; 47% of participants endorsing them in a study by Ellett, Lopes and Chadwick (2003). This supports the hypothesis that psychotic experiences exist on a continuum of typical human experience (van Os, Hanssen, Bijl & Ravelli, 2000). However, Cromby and Harper (2009) noted the distinguishing role of distress, reporting that those presenting to services are likely to be enduring considerable accompanying distress.

Modern Psychological Theory of Paranoia and Persecutory Delusions

Contemporary conceptualisation of the development and maintenance of threatening thoughts draws primarily on cognitive theory. The delusions as defence hypothesis (Bentall, Corcoran, Howard, Blackwood & Kinderman, 2001) also draws on psychodynamic theory (Hingley, 1997) in proposing that persecutory delusions have a defensive function in preventing negative self-representations from reaching conscious awareness, through externalising responsibility for negative or threatening events. In contrast, the threat anticipation cognitive hypothesis (Freeman, Garety, Kuipers, Fowler & Bebbington, 2002) advocates that persecutory delusions are beliefs selected to make sense of perceived anomalous experiences, and that negative self-esteem and emotions play a direct and non-defensive role with context

and pre-existing beliefs in forming threatening thoughts. Emotional distress is also a consequence. Critiquing these individually-focused approaches, Cromby and Harper (2009) define paranoia as constructed experientially of subjective socialised feeling, which arises through our awareness of and the influence of our interaction and relationships with the world around us. Thus social and relational factors are an inextricable rather than contextual part of the origin and maintenance of paranoid thinking. Theories of the development of threatening thoughts are particularly relevant to the early stages of psychosis.

First Episode Psychosis

The World Health Organisation (2004) cites the most common age range for first onset of psychosis as between 16 and 30 years old. In a review of first episode prospective studies, outcome predictors and patient appraisals, Birchwood, Todd and Jackson (2000) concluded that the first two to three years after psychosis onset, termed the critical period, was the time of maximum functional deterioration and openness to psychosocial, psychological and psychiatric intervention. Consequently, specialised Early Intervention (EI) services were established to accommodate this time-limited critical period, with the aim of improving long-term trajectories (Singh & Fisher, 2007).

Accordingly, a possible qualitative distinction between experiences of first experience and chronic psychosis can be considered. Given the typical time of life for the occurrence of first episode psychosis (FEP), Harrop and Trower (2003) discuss the potential role in psychosis development of developmental issues of early adulthood. These include ongoing identity formation, sensitivity to others' judgement, family transactional patterns and acclimatisation to autonomy. Moreover, the novelty of FEP may logically increase the confusion and fear

experienced. So how might threatening thoughts in FEP be understood psychologically given this background? The minimal empirical exploration to date is discussed below.

Empirical Investigation

Regarding cognitive mechanisms in FEP, jumping-to-conclusions and need-for-closure biases were observed in groups with predominantly persecutory delusions by Broome et al. (2003) and Colbert, Peters and Garety (2006) respectively, mirroring findings in chronic samples. 'Bad Me' paranoia was present in an unexpectedly small proportion of a FEP group compared to chronic groups (Fornells-Ambrojo & Garety, 2005). 'Poor Me' paranoia in FEP was characterised by normal self-esteem and frequent personal-external attributional bias for negative events (Fornells-Ambrojo & Garety, 2009).

Affect has been shown to play a key role in paranoid thinking in FEP as in chronic psychosis, and specific findings are broadly similar. Fornells-Ambrojo and Garety (2009) demonstrated elevated anxiety in a paranoid sample, elevated depression and significant anger levels in a specifically 'poor me' sample and severe depression in 'bad me' paranoia (Fornells-Ambrojo & Garety, 2005). Drake et al. (2004) found that insight predicted depression at baseline among 257 participants, while paranoia level did so across follow-ups.

Concerning contextual factors, Raune, Bebbington, Dunn and Kuipers (2006) showed an association between persecutory themes and recent moderately intrusive events. Events involved interference and attempted control by others without obvious relational closeness, and included physical harm or the threat of it. Rajapakse, Garcia-Rosales, Weerawardene, Cotton and Fraser (2011) found that the most common theme of persecutory delusions in FEP was of being watched, for example on hidden cameras or tapped telephones. The authors

proposed that given the role of anxiety in delusional belief development (Freeman, 2007) and the typical age of those with FEP, anxiety acquired amid developmental stressors might account for high proportions of persecutory delusions in the sample. Rajapakse et al. (2011) suggested that the maturing personality of the FEP age group might connote a simpler, less bizarre, emergent delusional belief system, in accordance with Larsen et al.'s (2006) findings. Belief systems may also be non-specific or poorly defined, as suggested by the findings of Hafner, Maurer, Loffler and Riecher-Rossler (1993).

Exploration of Subjective Experience

Investigation of individuals' subjective experience of these phenomena can complement and illuminate the above findings by adding detail of personal meaning (Camic, Rhodes & Yardley, 2003).

One grounded theory of persecutory paranoia in chronic psychosis has been conducted (Boyd & Gumley, 2007). However, out of 31 published qualitative papers on FEP identified by Boydell, Stasiulis, Volpe and Gladstone, none focused on threatening thoughts. Relevant allusions were made in just two studies.

Firstly, within a grounded theory of six men's understanding of their lives before, during and after FEP by Hirschfeld, Smith, Trower and Griffin (2005), paranoia was depicted within an identified sub-theme as a sensation of insecurity, with modifications to perception that others could not appreciate. Strong feelings of stress, unhappiness and anger were reported; fear was reported as implied. Secondly, Perry, Taylor and Shaw (2007) used interpretative phenomenological analysis (IPA) to explore hope in FEP, concluding that a sense of belonging and finding personal meaning in experiences were essential to hope maintenance.

Reference was made to misconceptions during paranoia, and to accompanying unpleasant perceived sights and sounds within a sub-theme expressing the confusion accompanying psychosis onset.

Present Study Rationale

Department of Health (2011) directives emphasise the need for greater consideration of what matters to service users. Clinically, a more detailed understanding of the complexity of individual perspectives could assist with empathic engagement, the facilitation of emotional shifts and normalisation and contextualisation of experiences. This might be of particular use to health professionals who are not psychosis specialists, given that psychotic experiences are not always readily accessible due to their apparently illogical underpinnings.

Academically, greater knowledge is needed of the key areas of enquiry cognition, emotion and context, including links between them and change over time. The disproportionate scarcity of studies investigating subjective experience of threatening thoughts in psychosis and particularly FEP indicates a need for research other than the nomothetic approach. Quantifiable measures can overlook details of the process of phenomena on the participant's experiential level (Larsen, 2007). The individual nature of idiographic enquiry maps well onto the intra-psychic foundation of cognitive theory on which models of threatening thought development and maintenance are primarily based. Thus qualitative work could add insights to the application of these theories to practice. Finally, results may also highlight areas for future research focus.

Study Aims

The present study sought to enhance knowledge of the experience of threatening thoughts in first episode psychosis, through the analysis of personal experiential accounts. Specifically, the study addressed the following questions:

a) What are people's experiences of thought content and emotional distress in early psychosis and to what extent, if at all, do they see the two as linked?
b) What meaning do people assign to the role of life events and context in delusion content?
c) What sense do people make of any change over time in experience of threat including content and related distress?

Methodology

Participants

Participants were drawn from the caseloads of three locality-based Early Intervention teams of a NHS trust. The sample was selected purposively (Smith, Flowers & Larkin, 2009), meaning that each participant was recruited for their ability to offer first-hand insight into the study topic. Inclusion criteria specified current or recent experience of threatening thoughts in the context of FEP as recognised by clinical teams, with the capacity to identify these thoughts. The terminology threatening thoughts was chosen over paranoia or persecutory delusions in order to include participants who do not consider their beliefs unfounded; a range of perspectives being expected to enrich findings. For ethical reasons, those experiencing extreme psychosis-related distress or functioning difficulties were excluded if their ability to undertake an interview seemed compromised. Eight people agreed to participate, see Table 1.

ID	Gender	Age	Ethnicity
Sarah	Female	26	Black British
Tom	Male	29	White British
Neil	Male	23	White British
Jason	Male	24	White British
Harry	Male	29	White Swedish
Ellen	Female	26	White British
Christopher	Male	32	Black British
Nina	Female	23	White British

Table 1: Demographics of eight participants

Ethical Considerations

Ethical approval to carry out the study was obtained from a NHS Research and Ethics Committee and the Research and Development department of the host Trust (see appendices 2 and 3 respectively). Vulnerability in interview was considered, regarding potential for both triggering a sense of social threat and for distress resulting from discussion of personal experiences with an unknown interviewer. To increase familiarity, the interview venue was participants' EI teambase. This also enabled participants' clinical team to be available should distress arise during interview. Full information was provided beforehand and informed consent to participate agreed. After interviews, I checked how participants felt post-discussion.

Design and Procedure

After identification and initial approach by care co-ordinators, interested clients gave consent for their mobile number to be passed on to me. On contact, I gave brief information and

arranged to meet those still interested. On meeting, the study information was given, questions were answered and written consent obtained (see appendix 4).

A single semi-structured one-to-one interview was conducted with each participant. This data collection method was chosen to facilitate the development of rapport and in-depth, personal conversation, and to permit participants to think, speak and be heard (Reid, Flowers & Larkin 2005). Interviews lasted 37 to 77 minutes, and were audio recorded using a Philips Voice Tracer LFH0862. The same interview schedule (appendix 5) was utilised for each interview, covering psychosis, treatment and threatening thoughts, emotions, life events, context and change over time. Questions were designed to prompt discussion around the three research questions. A draft information and consent sheet and interview schedule was comprehensively reviewed by a SAGE member; consequent changes to language were implemented to improve accessibility of documents.

Quality Assurance

To ensure the study's credibility, criteria defined by Yardley (2000) were met with guidance from Smith et al. (2009). Sensitivity to context was met through: the study's focus on the idiographic; sustained engagement with clinical teams during recruitment; negotiation of the interview interaction; engagement with the data and its shades of meaning at analysis stage; the grounding of findings in transcript data and extant literature. Commitment and rigour: Commitment was shown through attentiveness to participants; enduring engagement, perseverance and consideration regarding the project. Rigour was demonstrated though: purposive selection of a homogeneous sample; in-depth interviewing with awareness; meticulous and methodical analysis with a balance of phenomenological and interpretative components (see appendix 9). Transparency and coherence: Transparency was present

through an 'audit trail' (Yin, 1989) and clear presentation of research process stages, in this report and in appendices 5-8. Coherence with IPA principles was apparent: phenomenologically, the research concentrated on the experiential realm of threatening thoughts; hermeneutically, awareness of the influence of active researcher interpretation on themes' identification is noted. Additionally, themes and arguments are coherent. Impact and importance: the need for the study was evidenced by the lack of existing similar studies. The researcher, supervisors and ethics committees approved it as a worthwhile contribution to current understanding. Theoretical and clinical implications arose from findings.

'Bracketing' (Fischer, 2009) was used to reflect on researcher pre-conceptions that may bias interpretation, so that awareness might enable temporary suspension of their impact (see Research Diary at appendix 10). A reflexive stance towards analysis aimed to reduce the risk of misrepresentation of participants' perspectives (Richards and Schwartz, 2002), while supervisor support was also drawn upon.

Data Analysis

After the verbatim transcription of interviews, interpretative phenomenological analysis (IPA) was employed to analyse data. IPA seemed the most suitable approach to meet study objectives, given its inductive focus on exploring subjective perceptions and meanings of events as they are lived, and of how individuals make sense of phenomena in their personal, psychological, social and cultural world (Smith & Osborn, 2008). A 'double hermeneutic' is recognised in IPA: findings are reflective of the researcher's interpretation of participants' expressed understanding of their experience, thus results are co-constructed. However, IPA's ontology is sufficiently realist to be compatible with applied psychology, so research findings can be legitimately linked to and inform real-world interventions (Reid et al., 2005).

Analysis followed Smith et al.'s (2009) guidelines, endorsed by Gee (2011). Each transcript was read five times, with a differently-levelled focus at each reading (see appendix 9). Transcripts were annotated accordingly (see appendix 8). Foci were: first impressions/initial notes; descriptive comments; linguistic comments; conceptual/psychological comments and emergent themes. Emergent themes were tabulated and grouped into abstracted super-ordinate themes and sub-themes for each transcript (see appendix 9). Comparing the clusters created across cases, connections, further abstractions and subsumptions were made, while frequency and possible function of themes and expressions were considered. Thereby, master themes relevant to all transcripts were identified, with sub-themes representative of some or all transcripts. Finally, transcripts were re-read to check the fit of themes to data.

Results

Five master themes and 16 sub-ordinate themes were identified through data analysis, see Table 2. Employing a 'case-within-theme' method (Smith et al., 2009), themes are explored below and illustrated by verbatim interview extracts[1]. Master themes indicated recurring characteristics of all participants' experiences. Sub-themes reflected specific elements of master themes that varied among narratives. The number of participants whose words contributed to each sub-theme is noted at headings. Pseudonyms are allocated to participants for anonymity and to allow readers to follow individuals' stories (Smith et al., 2009).

[1] … indicates elision of speech for clarity
[ ] indicates addition of words by researcher for clarity
Italics indicate speech of researcher in interview

Exposure of vulnerable self
Negative evaluation by self and others
Sense of transparency and defencelessness
Social distancing through rejection or withdrawal
Perceiving a need for impression management
At the limits of endurance
Overwhelming circumstances
Inadequate resources on which to draw
Anticipating death
Elusive sense of agency
Feeling powerless
Being attacked or intruded upon
Self-assertion and efforts to maintain control
The urge to explain it all
A need for certainty or logic
Identifying a suitable framework of understanding
Educating others
FEP as a finite experience?
Making a stand or managing better
Environmental and contextual modification
Lasting remnants

Table 2: Master and sub-ordinate themes identified in data analysis

Exposure of Vulnerable Self

This super-ordinate theme spoke to the recurrently intimated conceptualisation of a fragile internal self: uncovered, at risk and in need of protection.

Negative evaluation by self and others (6/8). Participants' negative self-portrayal was common, reflecting both self-judgement and perceived judgement by others.

Sarah's tone implied despair around her belief that everyone hated her. Christopher envisaged others "criticising…everything. The way I looked…the way…I'm dressed…the way I speak". Tom's self-perceived social rank is apparent from his comparison of himself to others who he perceived as "normal" and seemingly more valid, his anticipation of their perspectives and his use of the word freak, implying monstrosity.

> "…they are going to judge me…I mean literally think I'm some sort of freak or… mental case…'Cause at the time I knew that I was having problems…I believed that I was a freak."

Neil also drew unfavourable comparisons, between himself and his sister and friends, indicating the adverse impact on him of cultural commendation of social and career advancement.

> "…since I became ill, [my sister]'s started uni [and] finished…my mates have started moving on with their lives, getting jobs, meeting new friends and I've been…hitting a barrier!"

Sense of transparency and defencelessness (7/8). Participants' thought content and emotions indicated that the majority of the sample seemed to position themselves as metaphorically 'open' for all to read, criticise and potentially harm. Tom and his partner's long-term victimisation by their neighbour was central to Tom's narrative of threat:

> "Her homophobia made me…think…there were a lot of homophobics…I did have thoughts…that I would get bashed along the street…'cause she pointed us out, she named and shamed…they might take whatever you bought from the shop and take your money…they might see…being gay…as a weakness…"

Tom's reference to 'shaming' hints at internalisation of negative socio-cultural perspectives on homosexuality. Such internal threat may have intensified the perceived external danger to Dignity and safety. His assumption that discovery of a presumed "weakness" would increase the likelihood of attack might re-inforce fear about feeling uncovered.

Modern extension to means of social interaction via the internet concurrently increases the means by which social threat is discernable. Neil detailed the role that the networking website Facebook played in his thought processes:

> "the world was…out to get me…I put something on Facebook, and...straight away I'd be like "they know what I've put"…something in me said everything that I was doing…people knew…all the statuses were somehow indirectly aimed at me…People can see your photos and…the thing my mind was doing was like people knew…how I was thinking…"

Constrastingly, Christopher indicated perceiving no threat about feeling open to the young people he advised at work, suggesting they were outside his reference group:

> "…whatever thoughts or things I get off them, it only matters about 30%. The rest of it…just 'nah'…they're really immature…really not…clued up."

Social distancing through rejection or withdrawal (8/8). This situation was often framed as a consequence of others' perception or detection of a 'wrong' part of the self. Reduced socialising and trust issues were common.

Neil described a stigmatised response as part of conditional but meaningful friendships. His plan to meet conditions seemed to condone and re-inforce them:

> "…obviously my friends are now gonna…think twice before…letting me be in their lives…I should be able to…persuade 'em…if I can come back and start performing well again."

Nina emphasised her frustration and alienation created by others' disbelief of her account. She had reported a confusing time of assault and threat by individuals she believed to be guilty of a high profile murder. Nina said:

> "…you feel on your own with it…I'm rowing with people saying it did happen…but no-one believes me…it's stressful..."

Social distancing was also framed as a measure undertaken in anticipation of being misunderstood, in order to prevent rejection. Harry's fear was specific:

> "I was thinking [that my friends] were informants, because I was doing drugs…[to] the police…Yes, I tried to stay away."

Ellen recognised a more generalised stigma and discrimination prompting her withdrawal from confiding in people about her threatening thoughts and tactile sensations:

> "…it makes you sort of different to most people…it's something you can't share…if you want to develop a relationship…you might not be accepted if you tell them about it."

Perceiving a need for impression management (4/8). Distinct extracts corroborated this sub-theme, seemingly united by a motivating sense of wanting to be safe, accepted and well-regarded. Neil was determined to meet the challenges that would be presented by being constantly observed:

> "…despite what I was going through…I was thinking 'well, if everyone's looking at me, I'm going to be the best that I can possibly be'."

Tom preferred to conceal parts of his identity in order to stay safe:

> "I don't…put a label on me and say "look I'm gay, my name's Tom" or anything… and I feel safe…"

Harry added the following to one account, as though normalising his post-traumatic stress in case it portrayed him derogatively, perhaps as cowardly or lacking robustness:

> "…everyone I think…anyone could have…gotten post-traumatic from being in that situation."

At the Limits of Endurance

This master theme aimed to capture the devastating and all-consuming narrated experience of threatening thoughts in FEP. The impact of commonly reported co-occurring hallucinations and their intertwined relationship with threatening thoughts came to the foreground.

Overwhelming Circumstances (8/8). This was the most frequently endorsed sub-ordinate theme. Participants' discomfort and painful emotion was often inferred through tone, frequent pauses, filler words and stuttering (not reproduced for clarity). Sarah spoke for many in revealing that the experience had exceeded her personal limits of coping:

> "I just couldn't take it no more. I wasn't…looking after myself properly…I wasn't washing…I didn't have any motivation… I was…comfort eating. I've always been able to cope with things, but this…"

This sense of being overwhelmed was corroborated by Christopher who acknowledged "re-play[ing] the thoughts…24/7…I didn't know if I was human or not." Tom's use of simile and metaphor vividly portrayed panic and tension:

> "…I felt like I was stuck in a very small space…my air was going tighter and tighter if I didn't do what those voices were telling me to do…everything was building inside me to the point where there was no room left…like a ticking time bomb, I wanted to go bang..."

A comparable pressure was implied in Jason's account of his head seeming to be in a "vice" that was tightened by certain pitches of noise. The recurrence of Neil's auditory hallucinations was like:

> "…having a…kid in the room…It starts screaming…and you think arrgghhh… God… you can't just ignore it."

This analogy evoked a piercing relentlessness demanding a response. The use of the present tense was common among participants when describing intense experiences, as though recollection took them back physically.

The detailed and high-speed delivery of Nina's story corresponded with particularly disturbing thought contents:

> "they put on the news about [victim], telling me…she was dead and… they had her head in the fridge…the skull…with a bullet hole in the back..."

Ellen expressed the following:

> "I can only describe it as…energy going through my body. I remember… feeling quite distressed by the physical sensations…quite overwhelming… not pleasant. Because I was emotionally attached to her... I had feelings of upset… but… sadness as well at…the images, they were…sexually related…when it continues and doesn't go away…I get frustrated and annoyed."

Ellen's gentle disposition allowed a poignancy to emerge, around Ellen's affection for the woman with whom her thoughts and sensations were caught up, and her ambivalence about the involuntary images of intimacy with her.

Inadequate resources on which to draw (6/8). Although a lack of the resource of illicit and prescribed drugs was mentioned, extracts primarily represented a lack of other people, either literally or because others who were physically present could not or would not be mentally available or re-assuring. Jason re-iterated his wish for:

> "that one person…that I could speak to…who said 'be strong, you're going to be alright…you're having a bit of a bad time…ignore the voices…'"

Lack of support was exacerbated by further interpersonal problems:

> "It didn't help the fact that I was with someone who…was quite abusive towards me" (Sarah).

Harry's experiences of purported friends went beyond an omission to support and represented active disloyalty that clashed with Harry's principles:

> "I felt…betrayed by the…people that I knew…especially from him and he chose sides and not this side, I knew him longer."

Nina felt particularly unsupported by her dad and his disbelief in her threatening thoughts, compared to previous situations when he had become physically aggressive on her behalf. She said "that was the last straw" in their otherwise unstable relationship.

Anticipating death (5/8). The subject of death arose frequently. Annihilation by psychosis itself had seemed likely to Jason:

> "you genuinely think 'I'm not going to live until I'm 30' and… you have such apocalyptic thoughts about death and stuff…"

For Harry and Nina, death was a key element of ongoing threatening thoughts. Harry feared that the criminal gang he had fled his home country to escape might locate him or contact local allies to do so, and kill him. Nina also anticipated death threats to be acted upon:

> "…any minute now, every car that comes past…I think it's gonna be him, he's gonna shoot me…"

In contrast, three participants considered death as a potentially preferable option. For example:

> "I just couldn't take it no more and…I took a overdose. I just thought…at least I'd rest in peace" (Sarah).

Elusive Sense of Agency

This theme reflected an awareness of absent agency, coupled with a respondent mental and sometimes physical struggle to re-gain power. This played out in situations perceived as consequential to threatening thoughts, as well as in the situation itself of having thoughts and hallucinations.

Feeling powerless (8/8). Harry indicated a sense that his threatening situation had moved 'out of his hands':

> "…I was worried that the police would leak information about what I have said…I know [laughs]…some people got arrested…they're in prison [laughs]... if they found out that it was me then…they told me that it wasn't recording anything the police, and that they would censor it. So I really hope no-one understands…"

Possibly his laughter functioned to reduce the seriousness of the threatening situation, or to diffuse the intensity of it for him and between us in the interview. It was also possible that he enjoyed the temporary gaining of the upper hand over his persecutors.

Nina frequently recounted situations in which it seemed as though future day-to-day events and encounters were pre-determined. Examples included her fear of inevitably repeating her mum's deteriorating trajectory of schizophrenia and the expectation that others would never believe her.

The stress of having no control or warning regarding the abrupt infringement of voices and intimidating thoughts into the daily routine was also evoked:

> "…I was laying there…absolutely fine, I had some crisps, I had a drink, I had a sandwich. And then all of a sudden [clicks fingers]…they were back…" (Jason);
>
> "The fact is I'm getting all these thoughts and I can't do anything about it or say anything…" (Christopher).

Being attacked and intruded upon (7/8). For some, a key attacker was their 'voices'. Jason's became aggressively threatening, issuing commands under duress. He said:

> "you're hearing a voice…it's telling you to do something or…they're going to kill you, or…someone's going to…come into your bedroom at night and…slit your throat…I could have believed anything."

Threat appeared compounded by the internal thus intrusive source of the attack and the notion of such graphically depicted danger in a theoretically safe place at a time when the guard is down, i.e.) in bed asleep. This extract exemplified the tendency among participants to alter pronoun usage when describing particularly distressing events. The exchange of 'I' for 'you' might indicate a protective disowning or normalising of the experience.

Ellen used the indiscriminate 'they' when referring to the woman previously mentioned, perhaps to re-distance herself to re-claim some privacy from me, suggesting a fluctuating sense of comfort with openness:

> "…it felt as if there was some sort of connection between us. And…they were aware of it…and…purposely trying to control my emotions and upset me…put things into my…body…energy…I had a feeling of something invading me."

Contextually, this lady was Ellen's counsellor prior to becoming her manager. Coupled with Ellen's emotional attachment to her and hence susceptibility to her impact, Ellen's task of being professionally accountable to and therefore 'controlled' by someone who knew her and her vulnerabilities on a mentally intimate level might have influenced her experience.

Nina and Neil depicted a sense of intrusion into their private space via hidden cameras in their bedrooms, and for Nina via a chip implanted in her head.

Self-assertion and efforts to maintain control (8/8). Extracts constituting this sub-theme seemed to show an active and sometimes desperate self-protective response to the sense of powerlessness. A 'survival mode' was sometimes present, necessitating action only to secure safety in the foreseeable future. Sarah moved away from the area with temporary positive results. Others used drugs or alcohol, perhaps to escape mentally from the sense of being with their experiences and associated feelings:

> "…when I got that seven [sleeping tablets]…I took two…a night…though the doctor didn't prescribe it...It stopped it for that night…" (Tom);
>
> "every couple of months I go to a rave and take some drugs…I feel on top of the world. It's not often I feel like that" (Nina).

Aggressive towards persecutors was common:

> "…[when] paranoid, you're…in a very vulnerable state…you get aggressive…to protect yourself [or]…to see who's the bigger man..." (Jason);

> "I went through a stage where I was thinking about killing them…if they're going to get me…then I'll get them first" (Nina).

The prominence of online networking sites as an organising structure of real life was reflected in Nina's many thoughts indicating her relationship with online networking and trust in its reflection of fact. To increase safety amid threat from another, she advised "…you need to delete him off Facebook."

Harry's management of his experience-related emotions revealed his disregard for the underdog role:

> "I try not to…be sad because…you just feel bad for yourself the whole time and you become a victim after a while…"

The Urge to Explain It All

This master theme was inspired by participants' mutual search for meaning in their experiences, with differing levels of conscious effort, perhaps as a way of re-orientating themselves within their disrupted existences. The theme seemed to echo the discourse of modern Western culture of which participants were all a part, with its epistemological requirement for science-based 'truth'. The 'known' feels safe.

A need for certainty or logic (7/8). A pre-occupation with elucidating experiences in logical terms was inferred, possibly to allay the discomfort of doubt. "Why's my head like this?" Christopher had demanded. This was well-exemplified by Neil, a mathematician:

> "that idea [of threat] came to me the way my Maths comes to me. So…my instinct is telling me that that is what it's saying…I know 2 plus 2 is 4…But I'm trying to work it out, and…I'm getting the answer…Joe Bloggs down the road is…sitting watching me on the [TV] screen…"

Others identified the individual impact of not knowing why their experiences were occurring:

> "I think it was the fact that I didn't know why these people were doing this to me, that's what made it even worse…I believe that there's a logic for everything, and… like, I always want answers…" (Sarah).
>
> "You don't understand what's going on...And it's very …scary, 'cause you don't know what you can do..." (Jason).

Identifying a suitable framework of understanding (8/8). A range of frameworks was utilised by participants to make sense of elements of experience. Sarah revealed values of justice in explaining persecutors' actions as "criminal act…maybe it makes them feel better about themselves…that's what bullies…do." She also identified actions as part of human nature:

> "people do things to hurt people in this world."

The sense of ongoing threat from ostensibly different people was attributed by Nina to one man changing his disguise at intervals, and following the plot of a television show through his actions:

> "I thought… 'I swear he just took his wig off…' then he got back on the bus with me as [name]…" and "…it all made sense to fit in with that programme…"

Participants explicated the occurrence itself of threatening thoughts in various ways. Firstly, as a consequence of illicit and prescribed drug use or non-use. For example:

> "it's one of the side effects [of Ritalin]…" (Harry);
>
> "I was taking bucket loads of marijuana…alcohol …cocaine and…MDMA…sooner or later your brain is going to… collapse…" (Jason).

Jason described using marijuana as a "minefield", bringing to mind hidden dangers capable of devastating damage, striking parallels with his psychotic experiences.

Secondly, as connected to prior stress and contextual trauma:

> "I was living in…a rough area…there were stabbings, shootings…gangs…that made my condition worse…" (Tom);
>
> "I was so scared and…stressed out and the pressure…that's why I became psychotic…I saw someone being stabbed…in the head…and I stopped a murder…the heart and blood vessels and everything are there…" (Harry);
>
> "I was the victim of GBH…my jaw was broken and they re-wired it... that's…still playing on my mind" (Neil);

Thirdly, as a bi-product of engagement in activities with a spiritual component:

> "I was…practising some…meditation…spiritual practices at the time...mindfulness. So I don't know whether that was anything to do with it…" (Ellen).

Educating others (2/8). Tom and Jason wanted to convey their understanding and perspective of their experiences to others, to improve knowledge and treatment and people's ability to manage. It implied that they wanted something worthwhile to come out of their ordeal. Tom said:

> "I want to…upload on YouTube about…my own experience…and the help I've received…Hoping that someone out there...might understand a bit better what… people are going through."

Jason was keen that his account be heard by those providing and receiving mental healthcare:

> "…it can help doctors…it can help people that hear voices…Psychologists and nurses can listen to this."

FEP as a Finite Experience?

The final master theme spoke to the different concurrent stances present in participants' accounts of their standpoint at interview regarding threatening thoughts and psychosis. A clear message that these experiences were a closed chapter was interspersed with mentions of lasting impact and leftover occurrences.

Making a stand or managing better (8/8). This sub-theme reflected a newly shaped approach to experiences, that was measured, considered and had long-term possibilities. Four

participants corroborated the idea of difficulties associated with the novelty of FEP, and how learning from experience had improved their ability to manage. For example:

> "…because it's happened before…it doesn't have that psychological effect in me… if they wanted to hurt me physically they'd have done it by now" (Sarah);
>
> "…it's something I've built up inside…my coping strategy. You can't see it but it's there…something that I obviously didn't have before, when I fell really ill. Because… it was all new to me…and it was scaring me…" (Christopher).

Five participants referred to daily coping techniques, with admittedly inconsistent results. For example:

> "…talking to people helps…about anything, just having a chat…Watching TV ….reading…participating in sport…using my brain to do something tends to kind of…block it out" (Ellen);
>
> "Writing stuff down helps…when things get too much and you can't stop thinking about it…if you want to pick it back up then you can…but it's not there anymore. It's out your head" (Nina);
>
> "…go for a walk…even though you're scared…come home and think to yourself 'I made it'…go and do it again…" (Nina);
>
> "…perseverance is…a good thing…" (Neil).

Harry demonstrated enthusiasm about "the plan" for upcoming studies in Sweden under protected identity before leaving Sweden for good:

> "the plan was the best…I think that's what helps me the most…that's why I'm not so scared…I try to eliminate all the dangers…"

It seemed possible that Harry's plan provided a missing re-assuring structure to his immediate future.

Environmental and contextual modification (8/8). The recurrently-stated role of others in circumstantial change re-affirmed the interpersonal nature of paranoia. Sarah's story recalled above-mentioned fears of being judged:

> "…I've got a good support network now…I've got friends that…know the situation and understand…I can talk through things with them, knowing that they're not going to be…judgemental…"

Nina evoked the relief provided by others' support of her story:

> "…having a few people believe me…kind of gave me the break through the ice…I was otherwise just trapped underneath it…and everyone was pushing me down… then you felt like you could come up a bit and you felt like you had someone…to lean on…and they wouldn't backchat you…it was de-stressing…"

The therapeutic importance of finding an accepting or identifying other(s) in EI service staff or clients was highlighted by three participants, as was someone to "keep me on the right path" (Jason). Furthermore, the relief of understanding experiences was re-iterated through evaluation of a cognitive-behavioural therapy workshop (Tom) and of the provision by a

psychologist of useful explanatory suggestions about experiences (Ellen). Productive abstinence from illicit drug use was also reported.

Perhaps expressing mixed feelings about the loss of an identity coupled with the appeal of a new one, Neil began the interview saying that he wanted to "just get back to how it used to be", but ended contrastingly by explaining how he had changed his life goals:

> "…I don't want a stressful life, I just wanna wake up, do a nice job, get home, have a missus, get a few friends, do a few things I like...Before, I was a bit more "it's gotta happen today!...The future's not going to wait! [Laughs]."

Lasting remnants (8/8). This sub-theme represented the persisting unusual perceptions and their impact that were acknowledged by all. Residual reactive fear and voice-hearing was common, as well as intermittent low mood.

> "I think the paranoid thoughts are always going to be there…but they've lessened a lot. I still feel like sometimes I'm being watched…I still have trust issues, but it's getting better" (Sarah).

Jason reported voices "like 'don't shout at your sister'…'keep tidy'…which is very good..."" The tone of Christopher's voices had changed valence, from negative to positive. He noticed elements of "getting [his] old self back" but also now feeling "quite special" and "unique". Further long-term impressions left by experiences were discussed. Nina spoke for herself and Sarah when she said:

> "You'll never forget it. It doesn't go away like…But it's not like before, it used to be quite distressing…whereas now you just sit and think to yourself…"

Such extracts implied a permanent change in psychology post-FEP. This change was sometimes conceived of as a 'scar', but other times more neutrally, as an alteration in awareness and participants' conceptualisation of life and their relationship to their own.

Discussion

Similarity is evident between present findings and those of Boyd and Gumley (2007) regarding paranoia in chronic psychosis in which themes of fear and vulnerability, confusion and uncertainty, self under attack and engaging safety systems were identified.

As well as corroborating these aspects of the subjective experience, the present study adopted a differing focus and extended findings to an FEP sample through interpretation of the novelty and short-term of experiences. Discussion below is structured around the research questions.

Experiences of threatening thought content and emotional distress in early psychosis and the extent to which they are perceived as linked

Multiple kinds of physically and/or psychologically threatening thoughts were described by participants, including anticipation of criticism and negative social evaluation, psychological harm, physical injury and death. Supporting Rajapakse et al. (2011), a sense of being monitored was reported by several participants, with specific reference by two to hidden cameras. Perceived persecutors included neighbours, friends and acquaintances, family, users of social networking sites, police, employers and healthcare staff. Regarding complexity or

bizarreness of thoughts hypothesised by Rajapakse et al. (2011) to be less than in chronic psychosis, findings were mixed.

Emotional distress was highly prevalent in early psychosis; emotions experienced included fear, anxiety, sadness, stress, anger, frustration and aggression. This experiential data adds to Fornells-Ambrojo and Garety's (2005; 2009) finding of significant anxiety, depression and anger in paranoia using psychometric measures. Regarding explicit self-esteem, on the day of interview it appeared predominantly low among those six whose extracts illustrated the exposure of vulnerable self master theme, unsurprisingly. It was interpreted to be better preserved for the other two. This provides inconclusive comment on Bentall et al.'s (2001) delusions as defence theory.

Several findings spoke to the threat anticipation cognitive hypothesis (Freeman et al., 2002). Firstly, analysis indicated that participants saw a causal link from threatening thought content and its meaning to distress. However, no participant seemed to observe a connection between paranoia onset and the reported worry and stress present beforehand, highlighting a possible discrepancy between subjectively assigned meaning and objective formulation of mechanisms. Participants' accounts did appear to endorse the theory that thought content can result from trying to explain anomalous perceptions.

Stress and frustration was also described as resulting from the constancy and pressure of hallucinations and linked thoughts, and the lack of power to stop, alter or understand them or encourage others to acknowledge the thoughts and threat. This adds subjective detail to Hirschfeld et al.'s (2005) findings that others were unable to appreciate participants' perception changes. Such circumstances resonate with accounts of the pervasive sense of

stuckness, helplessness or victimisation among mental health service users, in personal relationships and those with services and society (Tew, 2006). Actual or anticipated negative judgement from others seemed to create social dissociation and a sense of aloneness through resultant exclusion or withdrawal. Consequential impact on a sense of belonging might have implications for maintenance of hope, given Perry et al.'s (2007) findings.

Meanings assigned to the role of life events in delusions context

Finding explanations for experiences was important for participants. Proposed to be essential for maintaining hope by Perry et al. (2007), it seems very human to want to make sense of our existence and give definition to our life paths. Frankl (1959) advocated that meaning in life facilitates both hope and resilience.

Life events and social contexts were commonly understood by participants to contribute to the development of threatening thoughts either as direct trigger or exacerbator. Transcripts suggested that some interviewees assigned causal roles to contextual drug and alcohol use, prescribed Ritalin use, omitting to take prescribed anti-psychotics, accumulation of stress due to work, vicarious trauma, prejudiced victimisation and threats of potentially fatal violence. Some participants seemed to allocate possible contributory and exacerbatory roles to romantic relationship breakdown, family relationships, local violence, recent and early life physical assault, long-term concern about relatives' health and activities with a spiritual component. Some but not all of these offered understandings were in keeping with Raune et al.'s (2006) identification of links between paranoia onset and recent intrusive events, however perceived persecutors did include those with relational closeness. Arguably, open questions revealed elements of subjective meaning that Raune et al.'s (2006) fixed questions could not access. Regarding anxiety-provoking developmental stressors proposed by

Rajapakse et al. (2011), participants' reports of difficult relationships with their family of origin and experimental drug use might fit this classification.

Cromby and Harper's (2009) proposal that paranoia develops in order to manage the encompassing social, relational and material world seemed to be supported in several ways. For some, life events appeared to create a non-specific atmosphere of insecurity and mistrust. For others, life experiences of specific prejudice and stigma, involvement with violence and online social contact was clearly reflected in threatening thought content. The contemporary role of online networking in two participants' accounts reflected observations by Hernandez (2011) that greater use of Facebook increases the likelihood of paranoia. Feasibly, the constant and effortless projection of the self to so many others simultaneously together with the monitoring of others' responses can raise self-consciousness, social comparison (Festinger, 1954) and fear of scrutiny and judgement.

The estimation of change over time in experience of threat including content and related distress

Although accounts were qualitatively different, reported change generally led to reduced distress, and with some exceptions it was gradual and uneven, often tentative and partial. Lessening salience of thought content was common rather than alteration of beliefs, often due to the passage of time since contact with persecutors. Therefore threat seemed less immediate so fewer distressing thoughts occurred. For others, as the experience of threatening thoughts and hearing voices became more familiar it seemed more manageable and people adapted, as discussed by May (2004). This indicated that novelty itself and concurrent uncertainty about what was being faced formed part of the overwhelming nature of experiences.

Additionally, change of tone and content of voices occurred so they were no longer threatening but quite bearable, and even welcome. Acceptance and support from others also seemed to reduce distress, as did participants' relinquishment of the need to be believed by others or accepted by everyone. This change re-iterated the interpersonal character of threat, as though the "socialised feeling" (Cromby & Harper, 2009) was re-defined and new ways to manage interaction with the world had concomitantly developed.

Positive change often involved a constructive change of circumstances, consistent with general recovery literature, e.g. Pitt et al. (2007). Daily coping strategies provided an alternative focus to thoughts and voices, while establishing a clarifying framework for experiences which facilitated new perspectives. Change appeared accompanied by the return to participants of some sense of agency, safety and stability. In this group, psychosis was largely framed as a finite episode to be recovered from in the prelude to resumption of normal life, rather than the beginning of a life-long course of psychosis. Such perspectives add to positive evaluations of the benefit of EI services (e.g. Singh & Fisher, 2007). However, some participants' expressed wish to return 'cured' to a lost pre-psychosis identity but simultaneously weave their experiences into their future approach to life might indicate ambiguous identification with both 'sealing over' and 'integration' recovery styles (McGlashan, 1975).

Limitations

IPA is not aiming to generalise but to improve understanding of human experience in a particular historically and demographically defined situation (Husserl, 1927). Therefore factors such as small sample sizes and limited transferability (Anderson, 2010) are irrelevant to credibility. However, researcher bias and novice-level skill set risked influencing findings,

which was addressed as far as possible. The study lacks data triangulation. Furthermore, the planned recruitment of participants across various stages of threatening thought experience did not happen, as those in earlier stages of FEP were usually not comfortable to take part in discussion, precluding representation of differently situated present-moment views. Additionally, the recruitment method meant that all participants had received clinical intervention; this impact on their perspectives was often apparent.

Clinical Implications

Findings support the use of cognitive-behavioural therapy for paranoid and suspicious thoughts (e.g. Freeman & Garety, 2006), to make sense of experiences collaboratively with clients when they are able to do so rather than just challenging paranoid thoughts. Results around change might be utilised clinically in terms of what improvement looks like from the inside, what helped and how. The intensity of distress that participants recalled from the most overwhelming times indicated a need for greater use of direct emotion regulation strategies, such as the combination of compassion, acceptance and mindfulness showed to be beneficial by Khoury, Lecomte, Comtois and Nicole (2013).

The present study also implied an advantage of a clinical operationalisation of the social account of Cromby and Harper (2009). Drawing on the interpersonal qualities of paranoia to frame experiences and intervene might involve incorporating more systemic work into individual therapy (e.g. Hedges, 2005).

Lastly, the insight gained about internal experience may help those clinicians who are not specialists in psychosis to meet clients ‘where they are’, engaging through clients’ own framework of meaning.

Future Research Directions

Themes suggesting a sense of lack of agency and exposed vulnerability need to be further explored. Given their nature, an investigation of the experience of how concurrent self-concept, social identity and perceived social positioning could be undertaken qualitatively. A similar study with a chronic psychosis sample is also warranted, given that identified themes appear at least partially transferrable.

The indicated impact of novelty on experience suggests that greater comprehension of the subjective detail and mechanism of this relationship could better support people with FEP. Longitudinal design would facilitate statistical comparison of measures of experience as the novelty of threatening thoughts reduces. Exploration of links between social networking usage and paranoia might also be achieved using quantitative method, investigating relationships between a range of relevant variables.

Conclusion

This research defines the sense of threat as a highly interpersonal and hugely influential organising factor in the lives of people experiencing threatening thoughts in FEP. As well as providing in-depth answers to research questions posed, IPA of participants' accounts provided a range of rich perspectives, often psychological, of the subjective personal experience. Findings complement and extend existing understanding, can contribute to the clinical treatment of associated distress and also indicate research recommendations to improve essential understanding of this complicated area.

References

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: American Psychiatric Association.

Anderson, C. (2010). Presenting and evaluating qualitative research. American Journal of Pharmaceutical Education, 74(8), 1-7.

Bentall, R., Corcoran, R., Howard, R., Blackwood, N., & Kinderman, P. (2001). Persecutory delusions: a review and theoretical integration. Clinical Psychology Review, 21, 1143-1192.

Birchwood M., Todd, P. & Jackson, C. (1998). Early intervention in psychosis: The critical period hypothesis. British Journal of Psychiatry Supplement, 172(33), 53-59.

Boyd, T., & Gumley, A. (2007). An experiential perspective on persecutory paranoia: A grounded theory construction. Psychology and Psychotherapy: Theory, Research and Practice, 80(1), 1-22.

Boydell, K.M., Stasiulis, E., Volpe, T. & Gladstone, B. (2010). A descriptive review of qualitative studies in first episode psychosis. Early Intervention in Psychiatry, 4, 7–24.

Broome, M., Brett, C., Johns, L.C., Woolley, J., Peters, E., Garety, P. & McGuire, P.K. (2003). Reasoning styles and delusions in early psychosis. Presentation at International Congress on Schizophrenia Research, 2003.

Camic, P. M., Rhodes, J. E., & Yardley, L. (2003). Naming the stars: Integrating qualitative methods into psychological research. In P.M. Camic, J.E. Rhodes and L. Yardley (Eds.), Qualitative research in psychology: Expanding perspectives in methodology and design (pp. 3-15). Washington, DC: American Psychological Association.

Colbert, S. M., Peters, E. R., & Garety, P. A. (2006). Need for closure and anxiety in delusions: A longitudinal investigation in early psychosis. Behaviour Research and Therapy, 44(10), 1385-1396.

Cromby, J. & Harper, D.J. (2009). Paranoia: A social account. Theory and Psychology, 19(3), 335-361.

Department of Health (2011). No health without mental health: A cross-government mental health outcomes strategy for people of all ages. London: Her Majesty's Stationery Office.

Drake, R.J., Pickles, A., Bentall, R.P., Kinderman, P., Haddock, G., Tarrier, N., Lewis, S.W. (2004). The evolution of insight, paranoia and depression during early schizophrenia. Psychological Medicine, 34(2), 285-292.

Ellett, L., Lopes, B., & Chadwick, P. (2003). Paranoia in a non-clinical population of college students. The Journal of Nervous and Mental Disease, 191, 425-430.

Festinger, L. (1954). A theory of social comparison processes. Human Relations, 7, 117–140.

Fischer, C.T. (2009). Bracketing in qualitative research: Conceptual and practical matters. Psychotherapy, 19(4-5), 583-590.

Fornells-Ambrojo, M., & Garety, P. A. (2005). Bad me paranoia in early psychosis: A relatively rare phenomenon. British Journal of Clinical Psychology, 44(4), 521-528.

Fornells-Ambrojo, M. & Garety, P.A. (2009). Understanding attributional biases, emotions and self-esteem in 'poor me' paranoia: Findings from an early psychosis sample. British Journal of Clinical Psychology, 48, 141-162.

Frankl, V.E. (1959/2004). *Man's search for meani*ng. London: Rider Books.

Freeman, D. (2007). Suspicious minds: the psychology of persecutory delusions. Clinical Psychology Review, 27(4), 425-457.

Freeman, D. and Garety, P. (2006). Helping patients with paranoid and suspicious thoughts: A cognitive-behavioural approach. Advances in Psychiatric Treatment, 12, 404-415.

Freeman, D. Garety, P.A., Kuipers, E., Fowler, D. & Bebbington, P.E. (2002). A cognitive model of persecutory delusions. British Journal of Clinical Psychology, 41, 331-347.

Gee, P. (2011). 'Approach and Sensibility': A personal reflection on analysis and writing using Interpretative Phenomenological Analysis. Qualitative Methods in Psychology Bulletin, 11, 8-22.

Gelder, M., Harrison, P. & Cohen, P. (2006). Shorter Oxford Textbook of Psychiatry. Oxford: Oxford University Press.

Harrop, C., & Trower, P. (2003). Why Does Schizophrenia Develop at Late Adolescence?: A Cognitive-developmental Approach to Psychosis. London: Wiley-Blackwell.

Hafner H, Maurer K, Loffler W, Riecher-Rossler A. (1993). The influence of age and sex on the onset and early course of schizophrenia. British Journal of Psychiatry; 162, 80–86.

Hedges, F. (2005). An Introduction to Systemic Therapy with Individuals: A Social Constructionist Approach. Basingstoke: Palgrave MacMillan.

Hernandez, D. (2011, August 6). Too much Facebook time may be unhealthy for kids. Los Angeles Times. Retrieved from http://articles.latimes.com/2011/aug/06/news/la-heb-facebook-teens-20110806

Hingley, S. M. (1997). Psychodynamic perspectives on psychosis and psychotherapy I: Theory. British Journal of Medical Psychology, 70(4), 301-312.

Hirschfeld, R., Smith, J., Trower, P., & Griffin, C. (2005). What do psychotic experiences mean for young men? A qualitative investigation. Psychology and Psychotherapy: Theory, Research and Practice, 78(2), 249-270.

Husserl, E. (1927). Phenomenology. Encyclopaedia Britannica, (R. Palmer, trans. and revised). Retrieved from http://www.hfu.edu.tw/~huangkm/phenom/husserl-britanica.htm.

Jorgensen, P. (1994). Course and outcome in delusional disorders. Psychopathology, 27, 79-88.

Khoury, B., Lecomte, T., Comtois, G. & Nicole, L. (2013, September). Third-wave strategies for emotion regulation in early psychosis: A pilot study. Early Intervention in Psychiatry. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/eip.12095/pdf.

Larsen, J.A. (2007). Understanding a complex intervention: Person-centred ethnography in early psychosis. Journal of Mental Health, 16(3), 333-345.

Larsen, T.K., Melle, I., Auestad, B., Frii, S., Haahr, U., Johannessen, J.O., Opjordsmoen, S., Rund, B.R., Simonsen, E., Vaglum, P. & McGlashan, T. (2006). Early detection of first-episode psychosis: The effect on one-year outcome. Schizophrenia Bulletin, 32(4), 758-764.

May, R. (2004). Understanding psychotic experience and working towards recovery. Retrieved from http://rufusmay.com/index.php?option=com_content&task=view&id=30&Itemid=33

McGlashan, T.H., Levy, S.T. & Carpenter, W.T. Jr. (1975). Integration and sealing over: Clinically distinct recovery styles from schizophrenia. Archives of General Psychiatry, 32(10), 1269-72.

Perry, B. M., Taylor, D., & Shaw, S. K. (2007). “You've got to have a positive state of mind”: An interpretative phenomenological analysis of hope and first episode psychosis. Journal of Mental Health, 16(6), 781-793.

Pitt, L., Kilbride, M., Nothard, S., Welford, M. & Morrison, A.P. (2007). Researching recovery from psychosis: a user-led project. Psychiatric Bulletin, 31, 55-60.

Rajapakse, T., Garcia-Rosales, A., Weerawardene, S., Cotton, S. & Fraser, R. (2011). Themes of delusions and hallucinations in first-episode psychosis. Early Intervention in Psychiatry, 5, 254-258.

Raune D, Bebbington P, Dunn G, Kuipers E. (2005). Event attributes and the content of psychotic experiences in first-episode psychosis. Psychological Medicine, 36, 221–230.

Reid, K., Flowers, P. & Larkin, M. (2005). Exploring lived experience. The Psychologist, 18(1), 20-23.

Richards, H.M. & Schwartz, L.J. (2002). Ethics of qualitative research: Are there special issues for health services research? Family Practice, 19(2), 135-139.

Singh, S.P. & Fisher, S.L. (2007). Early intervention services. Psychiatry, 6(8), 332-338.

Smith, J.A. & Osborn, M. (2008). Interpretative phenomenological analysis. In J.A. Smith (Ed.), Qualitative psychology: A practical guide to research methods (2nd ed.). (pp.53-80). London: SAGE Publications Ltd.

Smith, J.A., Flowers, P. & Larkin, M. (2009). Interpretative phenomenological analysis: Theory, method and research. London: SAGE Publications Ltd.

Tew, J. (2006). Understanding power and powerlessness: Towards a framework for emancipatory practice in social work. Journal of Social Work, 6, 33-51.

van Os, J., Hanssen, M., Bijl, R. V. & Ravelli, A. (2000). Strauss (1969) revisited: a psychosis continuum in the general population? Schizophrenia Research, 45, 11–20.

World Health Organisation. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organisation World Mental Health Surveys. Journal of the American Medical Association, 291, 2581-2590.

Yardley, L. (2000). Dilemmas in qualitative health research. Psychology and Health, 15, 215-228.

Yin, R. (1989). Case study research: Design and Methods (2nd Ed.). Beverly Hills: Sage.

Megan Rose Underhill

Section C

Critical Appraisal

Word count: 2000

1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to develop further?

Courses of study and employment prior to clinical training had equipped me with moderate familiarity with research procedures. However, holding the Principal Investigator role in the MRP was a considerably different experience.

Through proposing and designing the MRP I learned about the clarity, precision, thought and planning required to efficiently prepare and initiate a research project. In hindsight I observed my lack of forward projection regarding problems that may occur at later stages of the process. I believe my inexperience at being 'project executive' made it hard to conceive the sorts of difficulties that may arise, while juggling the multiple competing training demands concurrently impacted on the time and consideration that I could give to any one element.

The drawn-out and repetitive online IRAS ethics application forced me to think productively through the details and practicalities of the project. A particular ethical dilemma arose through my plan to interview people who were unacquainted with me about their private experiences of paranoid and persecutory thoughts. I was concerned about heightened vulnerability in this situation and potential distress that re-visiting these experiences might cause. I addressed this by accessing participants via care co-ordinators, who deemed each client clinically robust enough for interview, and as possessing capacity to consent to participate under the Mental Capacity Act 2005. Additionally, I was careful to explain to each participant what taking part would entail both verbally and in writing, so each could make their own informed decision.

Recruitment difficulties were ongoing and stressful, and their extent led to deferment of my MRP submission. On reflection, although essential, care co-ordinators inadvertently assumed a 'gatekeeper' role: I was relying on them to find time in their already pressured days to raise the project with suitable participants and obtain consent for me to ring them while staff likely felt uninvested in the project as it offered them no clear reward. Additionally, the nature of the area of investigation meant that potential participants more often felt uncomfortable and unsafe in general, thus the prospect of being recorded in discussion of such personal issues was often particularly unappealing. Approximately half of those who were approached declined to take part. In developing my project trouble-shooting skills, I considered the idea of applying to another NHS Trust's R&D department to increase my recruitment chances, but rejected this due to time constraints, settling for renewed efforts and perseverance with the teams with which I was already engaged. I found the psychologists including my external supervisor to be supportive, perhaps because they had personal experience of the pressure I was under.

Transcribing early interviews before completing data collection allowed me to appraise and alter my interviewing technique as I progressed. I acknowledged the difficulties of striking a balance between impartial researcher role and demonstrating rapport-maintaining empathy as people discussed their distressing experiences. While wanting to hear rich details of experience, I also wished to avoid intrusiveness, given broader ethical implications regarding the apportionment of power in the interviewing encounter (Richards & Schwartz, 2002). As I gained more practice at interviewing, I discovered that I handled these conflicting demands more intuitively, shifting the priority based on my interpretation of the interaction at each moment. I also worked hard to avoid slipping into my seemingly default 'therapeutic clinician response style' during interviews sometimes.

As a newcomer to IPA, I became absorbed during analysis in the emic/phenomenological/ insider vs. etic/interpretative/outsider (Reid, Flowers & Larkin, 2005) combination. Guided by Gee's (2011) experiential account of using IPA, I followed Smith, Flowers and Larkin's (2009) valuable steps through analysis for novice researchers. Breaking the process down into smaller tasks helped me manage the potentially overwhelming amount of transcribed data. I appreciated the many different levels within participants' accounts, and enjoyed stepping between phenomenological and interpretative viewpoints. Listening to interview recordings occasionally during the analysis process was useful to add intonation and volume to meaning conveyed.

Through this 'learning by doing' approach, I appreciated the double hermeneutics of IPA more fully than would be possible through didactic teaching. I more explicitly recognised its distinction from and overlap with Grounded Theory that I had used previously. I thereby furthered my overall knowledge of qualitative methodologies.

The thoroughness of approaches to quality assurance documented by Yardley (2000) and Mays and Pope (2000) significantly developed my understanding. As well as providing helpful and practical ways to ensure the quality of findings, these papers encouraged me to think about the paradigm upholding qualitative enquiry. I spotted and tried to address my culture-bound epistemological inclination to evaluate qualitative research in quantitative terms. Additionally, understanding bracketing (Fischer, 2009) improved and helped specify my knowledge of reflexivity in qualitative research.

Areas for further development of my research skills and abilities are multiple, and seem paradoxically to increase the more I learn. Progress on all the areas discussed above would be

useful. A key area to work on is my overall project management style, especially time apportionment and foreseeing potential pitfalls. Regarding my interview technique, it would be useful to improve my ability to maintain differentiation between researcher/therapist roles according to context.

I would like to have the opportunity to use other qualitative methodologies with different approaches to analysis, such as narrative and discourse analysis. Additionally, though I am familiar with the rationale of quantitative analysis and have first-hand experience of several specific methodologies, this remains limited to relatively simplistic analyses. It would be beneficial for me to work on more complex and probably larger-scale projects to address this gap and to develop more sophisticated analysis techniques.

2. If you were to do this project again, what would you do differently and why?

In doing this project again I would focus primarily on improving two areas. Firstly, I would concentrate on overall management. Addressing the relative enormity of the task with all its constituent components would benefit from more specific planning. Using the more realistic ideas that I now possess of how long project elements take to complete, I would factor in starting and finishing schedules for each stage accordingly while bearing the project as a whole in mind, and then adhere to mini-deadlines set. I would think through potential setbacks more carefully in advance and take time to devise back-up options in case of need. Ideally, I would do this project outside the clinical training course, as the context of such a quantity of simultaneous demands made it difficult to prioritise the MRP sufficiently.

Secondly, I would adjust my recruitment process. I would broaden the participant pool by applying at the start to the R&D department of at least one other local Trust for permission to

work with their Early Intervention in Psychosis teams. I (seriously) considered this too late in the process of the current project and so I used the time available to persist with teams already involved. Frustratingly though, it meant that I could not take up the offers of colleagues in my final placement with EI connections in the Trust to assist with my recruitment. Additionally, if repeating the project I would be more assertive in recruitment. I would attend more team meetings, re-arrange placement days more frequently if necessary to do so, and while remaining courteous and appreciative, I would be less timid about potentially annoying clinical staff with continued recruitment efforts. I would try to change the dynamic between us such that it felt more like a joint venture, through which they might benefit more directly than through improved knowledge about the client group which they might have felt they already possessed. Alternatively, in re-conducting research I might recruit from a the service where I worked clinically, which would facilitate recruitment by increasing the 'presence' of my project, and my familiarity with teams structurally and personally. The common expectation that trainees come into these situations 'cold' is problematic.

The final area I would modify is the interviewing process. I would send reminder text messages to participants from the start, and find interview locations that can allow room bookings to be extended time-wise for when participants arrive late. In interview I would ask more follow-up questions and be more confident to utilise participants' moments of apparent discomfort with sharing to ask about possible presence of threatening thoughts at that time, to learn more about the experience in the moment of its occurrence. With more time to allow for refusals, I would try to increase the representative sample of people at an earlier stage of FEP. I also wonder if a narrower overall research question would help to focus the research, but given the scarcity of experiential research in FEP, there are few foundations to build it on.

3. Clinically, as a consequence of doing this study, would you do anything differently and why?

Two participants fed back on research interviews, one directly and the other indirectly via her psychologist. They highlighted the benefit of talking through experiences openly but free of the agenda of improvement present in sessions with healthcare staff. Consequently, I am reminded of the therapeutic value and possible distress alleviation of having a space to talk about experiences that may be considered unusual or delusional or cause discomfort in regular social interaction, with minimal fear of judgement. I would therefore be more comfortable to let this unfold in sessions if I gauge that it's needed and if service timeframes allow, rather than feeling the need to always be more actively intervening.

In direct work and in discussion of clients with colleagues, I would want to draw greater attention than I did prior to this study to the impact on people of constant socialisation, and to focus as much on the interpersonal as the intrapersonal. This could entail more systematically incorporating systemic perspectives in therapeutic work with individuals (e.g. Hedges, 2005). Furthermore, study findings indicated the potential key significance and root of distress among participants of the sense of defencelessness and vulnerability, lack of agency and unmet need to explain. In light of this, I would consider incorporating intervention around these difficulties in clinical work.

On a different note, research with a FEP population has re-inforced and increased my interest in working clinically in the field. While wishing that I had requested to undertake my supplementary placement in an EI service, I am considering possible routes to gaining related experience through qualified work, and possibly moving into EI services at a later date.

4. If you were to undertake further research in this area what would the research project(s) seek to answer and how would you go about doing it?

Given the explicit lack of qualitative research into FEP (in favour of research into aetiology, risk factors, treatment and outcomes, Rajapakse, Garcia-Rosales, Weerawardene, Cotton & Fraser, 2011) I would be keen to follow up this study with further exploration of individuals' experience. Drawing on themes resulting from this completed study, specifically those indicating a felt sense of depleted agency and the exposure of a vulnerable self, the development of a grounded theory (Glaser & Strauss, 1967) around self-concept and social identity in FEP could assist understanding of development and maintenance of these themes. This might focus on how their development occurs in FEP and in conjunction with which contextual factors, and themes' interaction with threatening thoughts in psychosis. Results could inform psychological treatment with prioritisation of service users' perspectives.

Furthermore, social identity in terms of the 'lack of agency' and 'vulnerable self exposed' themes could be further understood by conducting a Foucauldian discourse analysis (Foucault, 1969/2002). This would explore participants' linguistic and behavioural expressions of their perceived social positioning within societal power hierarchies.

I would also be interested in verifying if and how the same themes transposed to a chronic sample, using IPA (Smith et al., 2009) again. Alternatively, given findings of discrepancies between early and chronic psychosis populations (e.g. Fornells-Ambrojo & Garety, 2005), it could be useful to draw statistical comparisons between the two groups. For example, a between-groups ANOVA could be used to compare scores on measures of sense of agency and perceived vulnerability, or elements of these, in early and chronic psychosis samples.

Finally, I would like to look further at identified links between paranoia and use of social networking sites, which seems such a current issue. It could be useful to start with quantitative analysis of correlation between variables such as time spent on websites, type of activity undertaken and details of feelings held at what point.

References

Fischer, C.T. (2009). Bracketing in qualitative research: Conceptual and practical matters. Psychotherapy, 19(4-5), 583-590.

Fornells-Ambrojo, M. & Garety, P.A. (2005). Bad me paranoia in early psychosis: A relatively rare phenomenon. British Journal of Clinical Psychology, 44, 521–528.

Foucault, M. (1969/2002). The Archaeology of Knowledge. Abingdon: Routledge.

Gee, P. (2011). 'Approach and Sensibility': A personal reflection on analysis and writing using Interpretative Phenomenological Analysis. Qualitative Methods in Psychology Bulletin, 11, 8-22.

Glaser, B. & Strauss, A. (1967). The discovery of grounded theory: Strategies for qualitative research. New Jersey: Transaction Publishers.

Hedges, F. (2005). An Introduction to Systemic Therapy with Individuals: A Social Constructionist Approach. Basingstoke: Palgrave MacMillan.

Mays, N. & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. British Medical Journal, 320, 50–2.

Rajapakse, T., Garcia-Rosales, A., Weerawardene, S., Cotton, S. & Fraser, R. (2011). Themes of delusions and hallucinations in first-episode psychosis. Early Intervention in Psychiatry, 5, 254-258.

Reid, K., Flowers, P. & Larkin, M. (2005). Exploring lived experience. The Psychologist, 18(1), 20-23.

Richards, H.M. & Schwartz, L.J. (2002). Ethics of qualitative research: Are there special issues for health services research? Family Practice, 19(2), 135-139.

Singh, S.P. & Fisher, S.L. (2007). Early intervention services. Psychiatry, 6(8), 332-338.

Smith, J.A., Flowers, P. & Larkin, M. (2009). Interpretative phenomenological analysis: Theory, method and research. London: SAGE Publications Ltd.

Yardley, L. (2000). Dilemmas in qualitative health research. Psychology and Health, 15, 215-228.

Megan Rose Underhill

Section D

Appendices

Appendix 1

Literature review search strategy

1. Literature searches were conducted via Search It using the following electronic databases: EBSCO host; Ingenta; Medline; PsycINFO; PubMed Central and Science Direct. No time period was specified in order to capture all pertinent papers.

   Paranoi* entered firstly as a title and secondly as a subject was combined with each of the following as a title and as a subject using the AND function:- persecutory delusion*; psychosis; first episode; early psychosis; chronic; thought*; threat*; belief*; schizophreni*; theor*; conceptualis*; understand*; mechanism*; role*; factor*; component*; process*. This procedure was repeated with persecutory delusion* as the primary term entered as a title and secondly as a subject.

   Paranoi* was then entered firstly as a title and secondly as a subject, combined with the following as a title and a subject using the REFINE option: psychosis; first episode; early psychosis; chronic; thought*; threat*; belief*; schizophreni*; theor*; conceptualis*; understand*; mechanism*; role*; factor*; component*; process*.

   A search was then performed entering Freeman as author combined with each of the following as a title and as a subject using the AND function: psychosis; persecutory delusion; paranoia. This was procedure was repeated with Garety and then Bentall as the primary term as an author. These three names were chosen as key authors in the field.

2. Duplicates were deleted.

3. Abstracts of relevant returned titles were appraised. Inclusion criteria were: theoretical or empirical papers informing current understanding of persecutory delusions and paranoia in psychosis, such as those addressing concept, mechanisms, process and components. Exclusion criteria were: non-English language papers and dissertation abstracts.

4. Reference lists of included papers were manually searched for further titles using the same criteria.

5. Given the requirement for Section A to be focused and word limits on Sections A and B, where abstracts indicated that papers were making the same points, the most recent was chosen and others were excluded from the final total. Relevant books already known to the author were also included.

6. 102 papers were identified. 97 of these papers were included in Section A, while the remainder contributed to Section B where their detail was more relevant. A further 30 papers, books, guidelines and policies were included, 22 of which were previously known to the researcher, and the other 8 of which were identified further to very specific literature searches around findings after analysis.

Appendix 2

This has been removed from the electronic copy.

Appendix 3

This has been removed from the electronic copy.

Information for participants about the research

Exploring people's experience of thoughts about others harming them, in the context of early psychosis

Hello. My name is Megan Underhill and I'm training to be a clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether you want to take part, it's important that you know why I'm doing the research and what it would involve for you. Feel free to talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what it will involve if you take part. Part 2 gives you more detailed information about the conduct of the study.

Part 1

Purpose of the study

The aim is to investigate views of people currently receiving support from the early intervention in psychosis service on the distressing thoughts they have or have had. I would also ask about feelings, events in life and any changes people have noticed in these three areas over time. From looking at what people say in the interviews I expect to improve knowledge of individuals' personal experiences of thoughts about others wanting to harm them. I hope to gain a better understanding of any connections that people see between these experiences and their emotions, and events in their life. Findings could enhance treatment in the future. Specifically, findings might help therapists to identify and engage with people who have these experiences. Findings regarding any change that happens over time might point to which parts of these experiences could be worked with to help relieve difficult feelings.

Why have I been invited?

One of the staff at the early intervention team who knows you thought that you would be a suitable person to take part in the study, because you have or did have thoughts about people wanting to harm you. My research is about this type of experience.

Do I have to take part?

No, participation is voluntary so it is up to you to decide to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

What would happen to me if I take part and what would I be asked to do?

We would make just one appointment for a convenient day and time for you to meet me at the team base. We will then talk about your views and experiences of threatening thoughts, guided by a series of questions that I would ask. Our discussion would be recorded and then I would type it up so I can look at what you have said more closely. The interview would last about an hour.

Expenses and payments

Travel expenses to the interview would be reimbursed up to the value of £10.

What are the possible disadvantages of taking part?

It is possible that you might find it difficult or distressing to talk in detail about some of your experiences, especially if they have happened quite recently and you are still trying to make sense of them yourself. Also, you might not feel comfortable talking about things with me

since you haven't met me before. It's important that you read the information about the project carefully so that you are able to make a fully informed decision about whether you would feel at ease with taking part and talking about your experiences. Of course we would be able to have breaks in the interview or stop it if you needed to do so. Since interviews would take place at the team base, members of the team would be available to talk with you if you felt distressed after the interview.

What are the possible advantages of taking part?
I cannot promise this study would help you directly, but I hope the information it provides will help improve the treatment of people experiencing threatening thoughts about others wanting to harm them.

What if there is a problem?
Any complaint about the way I conduct the research with you or about any possible harm you might suffer would be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be confidential?
People at the team base would know you were taking part but I would not share the content of our discussion with them, except in the special circumstances mentioned in Part 2.Yes. We would follow good practice guidelines and all information about you will be handled in strict confidence. The details are included in Part 2.

This completes part 1. *If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.*

Should you decide to take part, you would be given a copy of this information sheet and the signed consent form to keep.

Part 2

What would happen if I didn't want to carry on with the study?
You would be free to withdraw at any time. If you did decide to stop, we would like to keep and use the information collected up to the point you withdraw if you agreed to this. If you stopped, this would not affect the care you receive from services.

What if there was a problem?
If you had a concern about any aspect of this study, you could call me via your [EI team name removed] on [telephone number removed] or email me at university at mru1@canterbury.ac.uk . I would do my best to answer your questions and would address any complaint you had about your involvement in the study. If you remained unhappy and wish to complain formally, you could do this by contacting Paul Camic, Professor of Psychology & Research Director at: Department of Applied Psychology, Canterbury Christ Church University, Broomhill Road, Tunbridge Wells, Kent TN3 0TG. Tel: 01892 507 773.

Would my taking part in this study be kept confidential?
Only myself and people at the teambase would know that you were taking part. **I would get your contact details from your keyworker.** All information collected about you during the research would be kept strictly confidential, unless information that you gave me suggested that you or someone else is at serious risk of harm. In this case I would need to follow this up. Interviews would be recorded and then uploaded to a password-protected PC audio file. They would be typed up word-for-word with all details that would identify you removed. Typed up interviews would be stored as an electronic password-protected PC document.

Any print-outs would be kept in locked drawers. Content would only be used for this research project. Recordings would be erased once research is finished. Two copies of anonymised extracts from interviews would be stored electronically on password-protected CDs in locked cabinets for ten years after the study is completed, after which it would be disposed of securely. One copy will be at the university's clinical psychology programme office and I would keep the other copy.

Only myself and my research supervisor Dr Elsa Murphy would have access to interview extracts that could be identified as your's. Any information about you which leaves the team base would be anonymised so you cannot be recognised.

What will happen to the results of the research study?
Results will form part of a research report which will be submitted to Canterbury Christ Church University as part of my coursework. It is intended that results will also be published. If so, participants will not be identified in any report or publication without consent but anonymised quotes from interviews will be used. You are welcome to request a copy of research results which will be supplied upon completion of research. Either ask at interview or by contacting me using the details given above.

Who is organising and funding the research?
Canterbury Christ Church University, with organisational support from the Early Intervention in Psychosis teams of [Trust name removed].

Who has reviewed the study?
To protect your interests, all research in the NHS is looked at by an independent group of people, called a Research Ethics Committee. **This study has been reviewed and passed by the City Road and Hampstead Research Ethics Committee.**

Further information and contact details

Further information about research or this research project
If you would like to speak to me to find out more you can call me or leave a message at the [EI team name removed] on [telephone number removed] or email me at university at mru1@canterbury.ac.uk .

Advice about whether or not to participate
You are welcome to contact me or Dr Elsa Murphy about this, at the [EI team name removed] on [telephone number removed]. Elsa is supervising me on this project and is also part of the team there. You could seek independent advice from Service Users in Research at the Mental Health Research Network at www.mhrn.info .

Appendix 4

Consent to take part

Participant information number for this study:

Title of project: **Threatening thoughts in first episode psychosis: perceptions of content, context and emotional distress**

Name of researcher: Megan Underhill

Please initial boxes:

1. I confirm that I have read and understand the information sheet dated July 2012 (version 4) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	☐
3. If I withdraw, I am willing for the information I have given beforehand to be kept and used confidentially for the project by researchers.	☐
4. I am aware that my interview will be recorded and then typed up with all details that would identify me removed. All data will be stored securely.	☐
5. I agree that anonymised quotes from my interview may be used in published reports of the study findings.	☐
6. I freely consent to take part in the research study.	☐

Participant's name:

Participant's signature:

Researcher's name:

Researcher's signature:

Date:

Appendix 5

Interview schedule

Ice breaker

1. It would be great to hear a little bit about you to start with, can you tell me a bit about yourself?

   Prompts: what you like doing, personality like, most important characteristics

A. Psychosis, treatment history and threatening thoughts

2. When did you first start getting support from the early intervention team?

3. Could you tell me a bit about what led to you coming to the team?

4. I understand that you have thoughts about others wishing to cause you harm or having ill feeling towards you – would you tell me about that?

   Prompts: what sort of threat have/had you picked up on? type (physical, social, psychological? target of harm, timing of threat), content of belief(s), interpretation (what did you make of that thought/experience?), relationship to identified persecutors, and timing of threat, target of harm

B. Life events and context

5. What do you remember about the time when you first started having the types of thoughts you talked about?

   Prompts: internal and external events/situations

6. What do these events mean to you?

7. Does the situation you're in have any impact on the thoughts you talked about? (If yes, what sort of impact?)

   Prompts: where you are, what you're doing, who else is around

8. Could you tell me about any times when you haven't had these thoughts? Or when you have had different thoughts? What do you make of that?

C. Emotions

9. How do you feel when the thoughts about other wanting to harm you are in your mind?

   Prompts: how did/do your thoughts about threat make you feel or how did/do your feelings influence your thoughts about threat?

10. How would you describe the connection between the thoughts and these feelings (if there is one)?

    Prompts: what was it about the belief or its content that made you feel that way or what part of your feelings influence the belief in that way?

11. a) Are there any times when the thoughts don't create these feelings in you?

    b) What's that like?

D. Change

12. a) Have the thoughts changed over time in any lasting way?

    b) If so, how?

    c) What sense do you make of that (whether change or not)?

    Prompts: content changes? Change in aspects of content in relation to each other? different explanations for events? Importance of occurrences that seem to have changed? Process of change?

13. a) Have there been any lasting changes in your feelings?

    b) If so, could you describe them?

    c) What sense do you make of that (whether change or not)?

Closing

14. Is there anything else you would like to tell me about, that might be relevant?

Appendix 6

This has been removed from the electronic copy.

Appendix 7

Development of themes

Excerpts of notes made after interviews

Sarah – lack of support, nobody believes her and this is a recurring complaint. – emphasises the value to her of being believed. Feels rejected, leads to her distancing herself/being distanced from others – unshared thoughts and fears. Alienated? Hard for her to move away from searching for explanation vs. difficulty with holding both the knowledge that there's no logic to her experiences and the belief that it did happen. Her perception of persecutors' intrusion into her flat/life/personal possessions. Re-attribution of blame reduces hurt to her of their taunting words? She has resilience.

Tom- attack from the inside by voices – battle with voices and thoughts. Desperation. Crying himself to sleep – regression. He was an "easy target" for attack by neighbours – self-positioning in society. Change in self-concept with psychosis, or positioned himself like this before? "Can't understand if not experienced it" – ostracising or making self special? Freak/mental case – connotation. No help from those who should help – mum, police, council – powerlessness – parentified, cares for others and dislikes being burden. Intrusiveness of experiences – not safe in own home – neighbourhood like a village where everyone knew about each other. Problem with me – meant to pick up poisoned food, if I'm psychotic he'll leave me, if I'm gay I'll get attacked. Wanting to use experience to help others – to create some positive identification with it? Active recovery – need to do things as well as take meds.

Neil – endorsing EI approach – "nip it in the bud" now or it'll be worse later. Drinking a bit to be expected as student – partly avoiding responsibility and partly asserting membership of sub-culture – combat isolation caused by being uncomfy to tell people about thoughts/voices? Threatening thoughts come to me the way my Maths comes to me – A Beautiful Mind, John Nash?? Can't step out of experiences and take on different viewpoint, living it. Positive of barrier being down - found it easier to chat up girls! Urge to impress and idea of needing to be good enough, conditional acceptance comes up recurrently.

Jason – novelty of experience – part of his fear/confusion is not knowing what to do/where to go with it, how to understand it. Huge overlap between his perception of sectioning and inpatient stay/common ideas about prison – he uses much of the same discourse: punishment for misbehaviour, disobeying rules and trying to escape ward; being sent to a 'worse' ward so you know you've misbehaved; being taught a lesson for taking drugs; doing your time, being sensible and you'll be out of here- suggests lack of felt power. Behaviour used as gauge of mental health in hospital. Big focus in speech on drugs and voices. Things much less overwhelming now.

Ellen – participant's anxiety and tentativeness almost palpable, her presence seems fragile, she doesn't seem to fill half of the interpersonal space between us, so I feel pressured to fill it. I also feel too 'large' at times, like I could damage her and very easily be intrusive -> exacerbated by needing to prompt/follow up frequently due to her non-expansive contributions, feel like I'm drawing her out of her hiding place unfairly. Does this speak to her sense of self and entitlement, how safe she feels to be seen? Wonder whether others feel like this with her and whether she feels over-

shadowed, either with or without her control. Does she ever tire of it and put her foot down? - occasionally her sentences seem more assertive.

Analysis

I have offered examples of work with Neil's transcript throughout the analysis process below, to provide some continuity of analytical development with one particular case. Additional examples from others are also provided.

Having transcribed interviews complete with ums and ers and pauses etc, I went through each transcript 5 times based on guidance by Smith et al. (2009) and Gee (2011) for novice IPA users, with a different focus on each reading, though insights from other perspectives often came up too. Thoughts for each reading were noted on the transcript as follows (the annotated transcript of Neil's interview is shown as an example at Appendix 6 above):

1) First impression/initial notes – pencil
2) Descriptive comments – purple pen
3) Linguistic comments – blue biro
4) Conceptual/psychological comments – black biro
5) Emergent themes – red pen in capitals in left margin

While doing this, I kept the 3 initial research questions on a sheet of paper nearby for reference. I tried to remain open-minded and treat each transcript on its own terms to do justice to individuality of each case, using the "dual bracketing process" described by Fischer (2009.) Ie) firstly identifying prior assumptions and interests re: a topic, and recognising them and consciously setting them aside/questioning them during analysis to try to avoid imposing meanings on the data via their filter, and secondly continuing to do this but re prior assumptions that have arisen from findings/ understanding of the data earlier in the process of analysis which have changed/set up my "fore structures" (Smith et al. 2009, on Husserl and Heidegger's opposing positions on the nature of interpretation).

It was common for short passages to illuminate the meaning of the whole interview, and vice versa as Smith et al. (2009) indicate, exemplifying what Gee (2011) frequently calls the *hermeneutic circle*. For example, Neil described being stuck within his threatening thoughts despite knowing that he 'shouldn't' be thinking them: "It's like swimming against the tide, d'you know what I mean? Like, you try to but at the end of the day it's going to come back". The quote seemed to reflect a more holistic aspect of Neil's interview, about trying relentlessly to understand things and change things, to no avail, and feeling powerless about it. At the same time, the interview as a whole re-inforced the meaning and significance of this one quote.

I was interested initially in looking for patterns to understand participants' social relationships based on the 'reciprocal roles' of cognitive analytic theory (Ryle and Kerr, 2002). But I abandoned this plan on reading that Smith et al. (2009) advocate not reading extant theories from outside into passages, but to focus on what's already in the passage and elsewhere in the interview, using fresh eyes.

I typed emergent themes for each interview into a table, the one produced from Neil's interview is shown as an example below, see Table 1.

Appendix 7

Table 1: Emergent themes from interview with Neil

How I come across	Taking control	All that stress/Contextual stress
Longing for past way of being	Engagement with support	Lack of agency
Lack of agency – reduced responsibility	Taking control – abstinence from drugs	Contextual drug use
Need to explain/ understand	Belonging to student sub-culture	No agency
Psychosis not playing fair	"Nip it in the bud" – psychosis as finite episode	Hyper-vigilant
Unclear thought process	Clouded judgement	Poor decision-making
Low concentration	Self-conscious	Discomfort discussing
Feeling transparent	Role of modern technology	Rational 'knowledge' vs intuition – internal struggle
Nowhere to hide	Change in social behaviour	Traumatised
Pushed to limits	Unsure how to cope	How can I fix this?
Non-adaptive fear	Process of thought occurrence	Certainty without explanation
Low mood due to thoughts	Overwhelm	Targeted
Thoughts taking over life	New practical approach	Feeling exposed
No privacy	Protective barriers broken down	Experiences challenge values
Performance mode as spotlight on	No acknowledgement of effort	Negative social evaluation of self
Vicious circle of social judgement	No escape/no way out/no options	Self-evaluation
Self-control	No point in trying	Experimenting with coping strategies
Doubtful of support	Conditional friendships	Self-assertion

Appendix 7

Self-evaluation	Journeying	Asserting achievements
Negative comparison of self to others	Low social rank	Vulnerable self protected
Now vs then	"Living it"	Rather not exist/ suicidal thoughts
No enjoyment	Trapped	Logic not working
Trying to rationalise	Trying to find evidence for beliefs	Hiding exposed self
Too open to intrusion	Self-evaluation	Logical self-talk
Stigmatised understandings	Voices	Relationship with voice-owner
Voice taking over	Battle with voice	Thwarted efforts to be productive
Trapped attention	Obstructed life progress	Need to know where you are
Making definite decisions	Barriers to social interaction down	Exposed = known
Self-chastisement	Desire to change reputation	Easily provoked
Physical assault	Past incident very present in current thoughts	Contextual event heightening aggression
Self-protective/ Vulnerable self protected	Jealousy-provoking life consequences	Raised intensity of day-to-day feelings
Admission of non-ideal self	Comparison to ideal self	Passed test under scrutiny
Standing out	Positive influences on experiences	New less pressuring ambitions
Complexity of change/improvement	Improvement means life might be worthwhile	

I printed each table out and cut it up into segments so that each emergent theme was on its own small piece of paper. I then arranged themes into clusters by similarity of concept and glued or stapled each cluster on a separate post-it notes

attached to an A4 sheet. I labelled post-it notes with respective concepts/abstracted themes, as demonstrated in Figures 1-5 below. The more simply descriptive or slightly obvious of the emergent themes were discarded at this stage of cluster creation, for example, from Nina's A4 sheet I removed 'feeling unsafe', 'suspicious', 'contextual drug use', 'physical attack', 'step-mum left home', 'not being believed' among others.

Excerpts of notes from this stage are as follows.

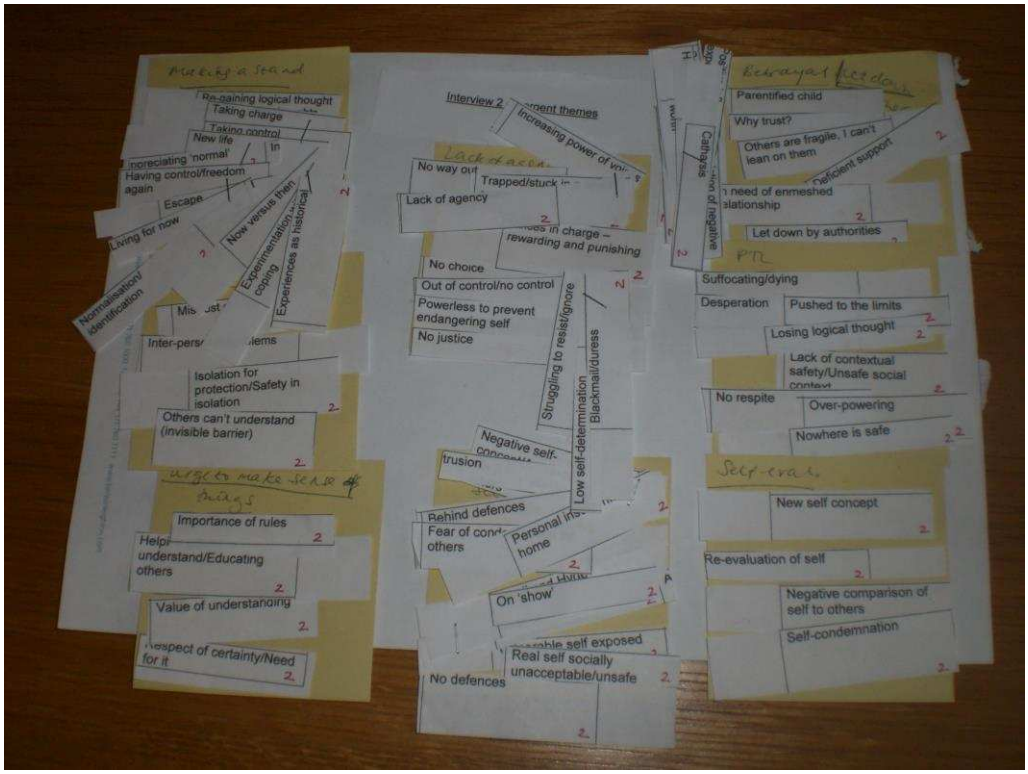
Sarah's interview - master themes on post-it notes comprised: Making a stand/Self-assertion; Alienation; Urge to make sense of things; Betrayal; lack of agency; Exposing vulnerable self; Survival mode; Overwhelm/Pushed too far; Self-evaluation.

Ellen's interview – master themes on post-it notes comprised: Alienation; Lack of agency; Urge to make sense of thing; Making a stand; All-consuming; Pushed to the limits; Role of meaningful close relationships (positive and negative); Hindsight; Exposure of vulnerable self.

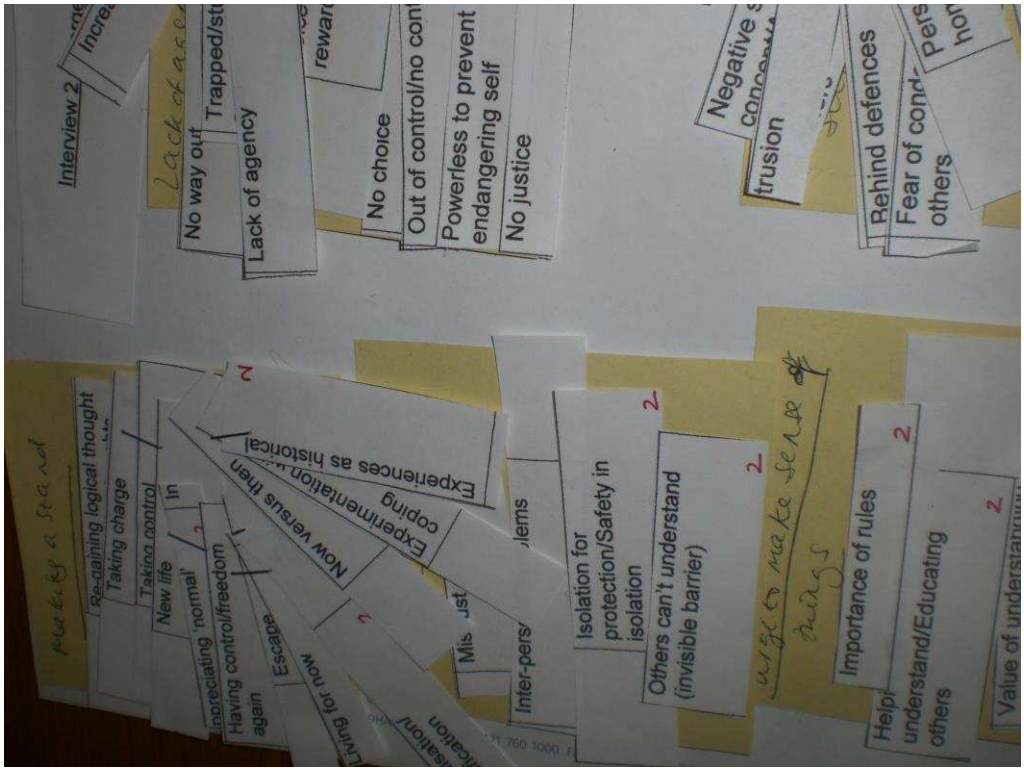
Neil's interview - master themes on post-it notes comprised: Exposure of vulnerable self/Self-evaluation; Urge to explain it; Personalisation of experiences by life history; Pushed to the limits; Elusive sense of agency; Efforts to maintain control; Attempting to 'package up' experiences.

Figure 1: Work in progress - going up a level of abstraction, themes for each interview were organised by similarity of concept and became 'working' sub-themes (on white paper sections) and an over-arching name was ascribed to each group. These names formed draft/working super-ordinate themes (as labelled on post-it notes).

Appendix 7



Figures 2 and 3: Close-up example as described in Figure 1. This shows analysis of Interview 2 (Tom).



Appendix 7

Figures 4 and 5: Another close-up example as described in Figure 1. This shows analysis of Interview 3 (Neil). As I refined the process the products clearly became a bit neater!!

To look for patterns across cases I laid the 8 completed A4 sheets containing post-it notes of attached themes out, and considered the following:

Which themes matched across cases– the sense of huge pressure and being pushed to the end of their tether during the most overwhelming of experiences, often with insufficient support, was mentioned by everyone in individual contexts. The search to understand what was happening and how to do this was also discernible in one way or another in everyone's interviews. These became the draft master themes *At the limits of endurance* and *The urge to explain it all.*

Which themes linked up across cases despite being slightly dissimilar and might therefore be grouped together under an even higher order concept – prior drug use was mentioned by four participants, three of which used quite heavily sometimes. The role of close relationships was endorsed by all, good ones and less good ones. Prior trauma was mentioned explicitly by two people, and implicitly by one. Modern technology also seemed to affect experiences, most explicitly in two cases. These themes were all linked initially under the higher order master theme of *Personalisation of experiences by life story* which had already formed part of initial themes for Neil.

References to loss of control of life were made by everyone, with varying idiosyncratic emphases across cases. Some referred to powerlessness in the face of forced intrusion or attack. Asserting oneself against the lack of agency when possible was also often reported. For some, assertion led to a sort of 'survival mode', kicking in at the time of the worst experiences. This survival mode seemed to overlap with perspectives in the working theme title *Pushed to the end of their tether* (where it was eventually subsumed). Participants also often talked about current ways of taking control when things no longer felt at crisis point, likened by some to relapse prevention. These initial emergent themes were initially abstracted into the themes *Environmental modification, Making a stand and Experimenting with coping strategies.* Placing together these stories of coping during different types of time felt problematic as there was a qualitatively different tone to the calmer, better thought-through and more long-term coping techniques of current times compared to the desperation, grabbing at straws and short-term thinking that characterised earlier attempts to get control. To account for this, the master theme *the elusive sense of agency* was created to contain polarised themes of powerlessness and self-assertion and trying to keep control (in overwhelming times), as well as an intrusion theme. The more considered coping techniques were moved to the master theme *FEP as a finite experience?*, discussed below.

The abstracted themes *Attempting to package it up* and *Hindsight* came out of participants' reports of new perspectives and their current temporal location seeming very different to being in the midst of things. While in contrast, participants often talked about remaining anomalous experiences and the longer-term impact of threatening thoughts and voices as a whole, there was still a sense among all that the worst was behind them, it was indeed an 'episode' that was now over, or nearing over depending on individual perspectives. The master theme *FEP as a finite experience?* was developed to capture moving on, but ambiguously in some cases.

Which abstracted themes contained the most emergent themes thus indicating frequent referencing by participants and so perhaps key importance to them – a common theme of a vulnerable sense of self that needed more protection than it was getting, and was often too exposed for comfort seemed to resonate in unique ways

for everyone and formed an abstracted theme in all 8 cases. For 3 people there was a suggestion that they actively tried to address this by 'managing' the way they came across. Some emergent themes originally classified under the abstracted theme *Betrayal/Let down by others* (in 3 cases) described the creation of vulnerability by these interactional problems or responses to them that revealed vulnerability, such as *Why trust, Can't lean on others, Can't rely on others to be loyal, Abusive relationship.* Additionally, abstracted themes for 3 participants were labelled *Self-evaluation*, which in general contained quotes that were quite self-condemning, negatively comparing the self to others or seeing the self as excluded from the group. *Self-evaluation* also contained re-evaluation of the self in the present, which actually seemed to fit under the above-discussed theme about FEP being over (and quotes were subsequently transferred to that theme). Criticism by others, social withdrawal and alienation was also commonly mentioned, which implied the creation of vulnerability through being rejected, directly or indirectly, from the group/society. Drawing all these linked expressions of experience together, a lot of emergent themes and therefore supporting quotes became involved, strongly endorsing the over-arching master theme that was named *Exposure of vulnerable self.*

Sub-themes were created using similar principles. A lot of subsumption and abstraction of working themes occurred with the aim of highlighting those expressions that I interpreted to be the most important for participants and the most comprehensive in answering research questions. Following up the emergent themes already mentioned above, the large master theme *Exposure of vulnerable self* was assigned 4 sub-themes, *Why Trust?* was placed in the sub-theme *Alienation through rejection and withdrawal* to connote the withdrawal from social connections involved in withdrawing trust from others after being let down. Other emergent themes from which this sub-theme was abstracted included *Others can't understand, Isolation for safety, Mistrust of friends, Unusual experience as social taboo, Impact of cultural beliefs about psychosis, madness and normality, Excluded from group, Them vs. Me (Outside vs. Inside), Not being believed.*

The emergent theme *Abusive relationship* was categorised within the sub-theme *Sense of transparency and defenceless*, reflecting the sense of being defenceless and vulnerability being preyed upon. Other emergent themes constituting this sub-theme included *Feeling exposed, Performance mode as spotlight on, Passed test under scrutiny, Self-conscious, Transparent for social judgement, Exposed = 'known', True self needs to be hidden, Tracked down/pursued, On show, Personal insults hit home.*

Emergent theme *Self-evaluation* and a range of expressions of criticism by others were placed together in a higher order sub-theme called *Negative evaluation by others and myself.*

Emergent themes *Can't lean on others* and *Can't rely on others to be loyal* were subsumed under the sub-theme *Inadequate resources on which to draw* under the *Limits of Endurance* master theme.

Those emergent themes that seemed to be a mere reflection of the question I had asked were discarded completely, such as a theme named 'then vs. now' when I had asked about change over time.

Consideration of the possible function of themes was helpful in interpreting the way depictions of experiences might reveal meaning behind the literal words. For example, in discussion of the remaining impact of his psychotic experiences which eventually formed part of the sub-theme *Lasting remnants* under the master theme *FEP as a finite experience?,* Christopher said "I feel quite special actually. I feel quite unique. And it's something that only I can really understand." There was a stark contrast between this and his earlier accounts of feeling overwhelmed with distress and not being able to escape thoughts and voices, and thinking that he might seem "a bit nuts". Noting this, I wondered if Christopher might have developed and advocated this new perspective to himself and others as a means to accept his remaining voices and create a preferable sense of himself as different in a valuable, sought after and special way. As though he was 're-branding' the voices/ experiences.

Eventually, 6 draft final master themes and 20 sub-ordinate themes were produced. However, further changes occurred. Word count limits did not allow me to sufficiently explain and discuss so many themes in the Section B Results section so some had to go. Additionally, the master theme *Personalisation of experiences by life story* seemed to be a direct reflection of questions I had asked about life events as context of experiences, rather than being particularly explorative. Some of the themes subsumed under the sub-themes (which were *Substance Use*, *Modern Technology*, *Trouble and Disillusionment in Specific Relationships* and *Past Traumatic Incidents*) were distributed to other relevant sub-themes.

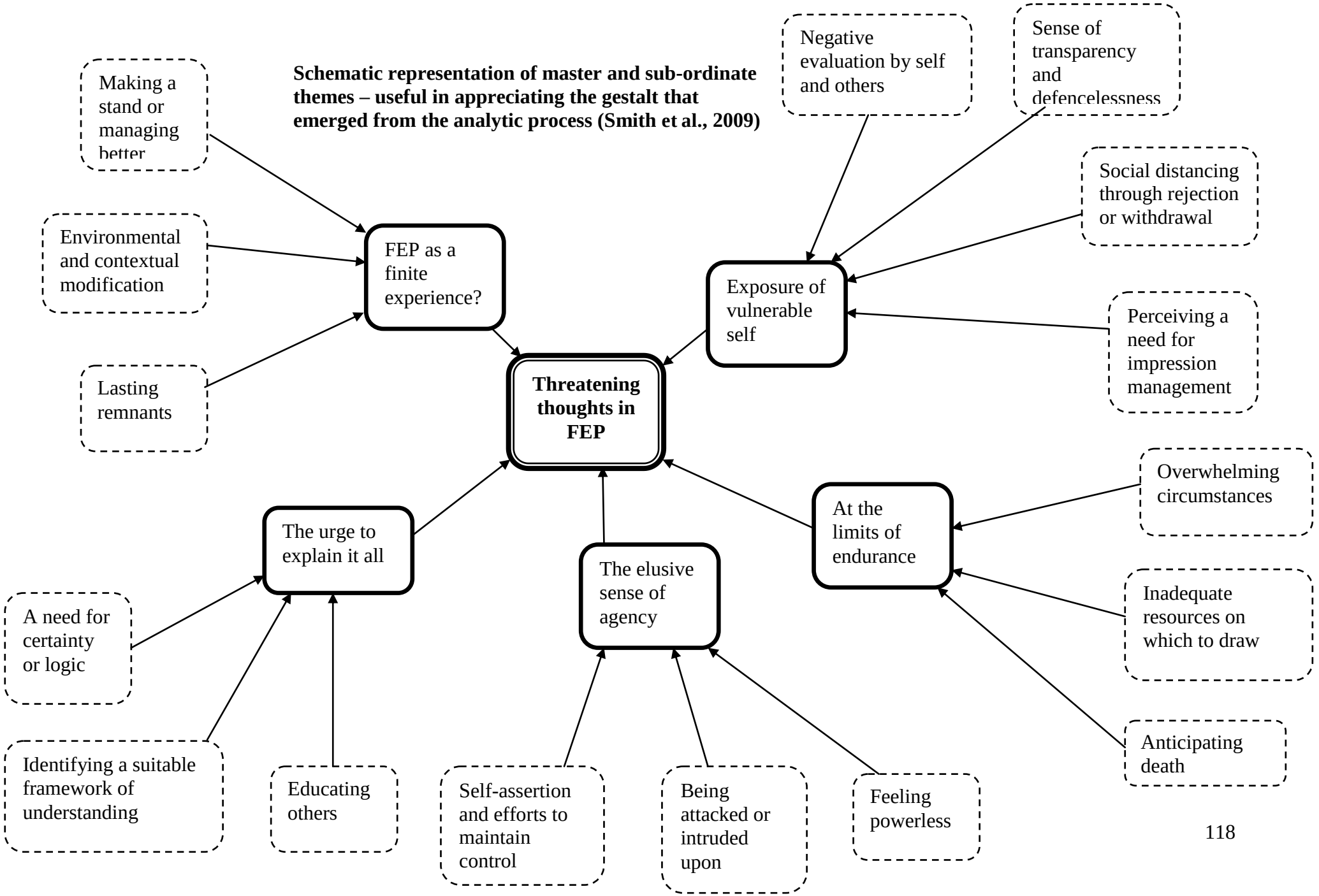
Once finalised…
Referring back to transcripts and initial emergent themes in the margins, I used green highlighter to mark quotes in each that I felt represented the final master and sub-ordinate themes. Using these, I then created a table of master themes, sub-ordinate themes and samples of supporting quotes from participants (see appendix 8). I drew on this table when writing up Section B Results section.

One final concern: I wondered whether the inherent nature of a research interview is about finding out and looking for answers, and wondered whether this atmosphere might have influenced participants to produce the quotations that made up the *Urge to Explain It All* category. However, I was satisfied that relevant quotes were too often initiated unprompted by participants to be a mere effect of my questioning or of the interview context.

Lastly, when my supervisor read over my analysis he suggested that 'alienation' was perhaps an exaggeration of what quotations indicated. I therefore softened the sub-theme name to *Social distancing through rejection or withdrawal.*

Appendix 7

Schematic representation of master and sub-ordinate themes – useful in appreciating the gestalt that emerged from the analytic process (Smith et al., 2009)



Appendix 8

Master-themes, sub-ordinate-themes and samples of supporting quotes from participants

Master theme: Exposure of vulnerable self		
Sub-ordinate themes	**Participant**	**Supporting quote**
Negative evaluation by self and others	1	I just felt like, ohhh, everyone hates me...
	1	…at first I thought it was me, I thought I was the problem, I thought… you know I was the one with the issues, and…they do, 'cause of the way I am as a person and…
	2	The voices were, at first it was just, they were insulting me, um… calling me um… a fat cunt to be precise. Um, I was getting a lot of you know, fat comments and… just sort of like, saying I'm ugly, I'm no good for no-one, I'm just… I'm nothing.
	2	The voices were making me feel that low, made me feel worthless, and it just… it made me feel like I'm a weak, weak person, um… telling me that I may be a big person but I ain't strong.
	2	I guess I was a mental case but… to them, to a normal person that… hasn't got a clue what I went through, it would be just literally a mental case, a freak… what's going round in my head, the thought was there that you know, that they are going to judge me and they are going to hate me, um… And when I say judge me I mean literally think I'm some sort of freak or… or… a mental case.
	2	'Cause at the time I knew that I was having problems, and I knew that I was not normal to, you know, to say… um, that people would literally think I'm a freak and that I, I believed that I was a freak.
	2	I thought being gay was a weakness to er, to everyone else.
	5	…a couple of months after I started taking, I started becoming stranger and stranger and my friends said that there was something wrong with me and… I was speaking and was saying weird things…
	4	And you can't talk to anyone about it really 'cause, you know, they'll think you're crazy and they'll probably be, they'll probably be, you know, right, thinking about it.
	4	…when you stand up for yourself when you're taking drugs you just get known as a pushover. Like, I don't know, he don't even know what he's talking about, he's not even speaking straight, he's bent you know, he's taking marijuana, and like, drinking alcohol so what's he got a right to tell me what to do. You know, you just get brushed aside.
	3	But for me, it was like, I'm turning up… and everyone's doing their own, they're… living their lives, and um… if anything I'm 'intrusing' on them. Because all they're doing is putting a picture up, and I'm thinking it's something to do with me… that makes me look bad, feel bad, like…
	3	She's at university. Yeh. So… I mean she's…I...uh, I started before her and she's finishing this year. So, in that… space of time, while… since I became ill, she started uni, she's now finished and I… I'm in a no better position than I was before.
	3	Yeah, really just… grounded to a halt do you know what I mean? All my mates have started moving on with their lives, getting

Appendix 8

		jobs, meeting new friends and I've been, been hitting a barrier! [Laughs slightly].
	7	Paranoia about anything that you could be paranoid about. At that point I was…It was mostly what they thought of me and stuff… The way that I'm dressed. Criticising… The way I look, the way I speak. Everything.
	7	…there was a really bad voice and it would just say things like "Oh, this person don't like you. Oh, they're taking the piss…
	7	If I hear something bad it makes me feel a bit low. Even though it might not be true, but it just does.
Sense of transparency and defencelessness	1	I used to dread coming back home 'cause I'd know that I'd be open to whatever was gonna go on.
	1	I'd be thinking, like, someone's at the door ready to attack me.
	1	…early in the morning, about just after four o'clock in the morning, my door was kicked down.
	2	I did, I did, I did have thoughts. I did have thoughts. I had thoughts of, you know, people watching me as well and um… thoughts of you know, anyone out there in the world harming me, um… I just looked at everyone and thought they were going to mug me or something, or… I, I believed in myself that I was an easy target for someone to approach and just, start on.
	2	I did have thoughts about my own personal friends… um, were out to get me, like they were all talking about me, uh mainly because of what I was going through.
	2	Her homophobia made me feel like, or made me think shall I say, that there were a lot of homophobics… And, just walking the streets alone, you would, you would see one of these boys that she had brought to our door. Erm… the thought, I did have thoughts that these people were literally going to be homophobic or… that I would get bashed along the street if I see one of these guys again, 'cause she pointed us out, she named and shamed us sort of thing… They might say "oh look, you queer boys", take whatever you bought from the shop and take your money. That was just all going through my head.
	2	You know, that they might see queer, being gay sorry, er…as, as a weakness, and… I just thought, "do you know what, I, I am going to be mugged or beat up because of what I am.
	2	I could not go into big supermarkets because I thought everyone was watching me, talking about me and…Erm, thinking things were going to happen to me. I even thought I was going to be poisoned if I went into the supermarkets… I would just look at food and think 'do you know what? This food was, I was meant to pick this product up, and I'll know that this product's poisoned.
	5	I became so strange with my friends… because I started saying… started thinking about other people, speaking about within my party [laughs] At first I was er… wondering, I was thinking about if they was informants, because I was doing drugs… [to] the police.
	4	…you're giving off the bod… wrong body language and…your body suggests that you don't like him and then like [laughs], he… he thinks 'oh, he's being a bit weird, like why is he being a bit weird, is he stoned?' Or 'oh my God, I don't like people that do that'. You know, you considered that.
	4	I didn't start off having aggressive thoughts. I had voices talking to me, and then they became aggressive when I felt lonely, when I felt at my most vulnerable stage.

Appendix 8

	3	I was a bit paran… like pa… I don't know, just like a bit um… like um… like the world was… was out to get me sort of thing. I was having problems with like, computers and stuff and the TV, television. Like, I was thinking like people on the TV, like 'knew about me'… I didn't know how to handle it, to be honest like… it's hard to know exactly when it happened but, like I was putting, I put something on Facebook, and then... straight away I'd be like "they know what I've put on Facebook"… do you know what I mean? I just, you know, there was something in me that said everything that I was doing… people knew… it didn't really give me much leeway to… to get away with anything basically… People… can… interpret that, they can see it in people, do you know what I mean? ...my friends would say like, that they would… they noticed a, a change in me and er… there would probably be a physical, er… it would manifest itself.
	3	at one point I thought like the, the webcam in my… in my laptop could… could see me, and there was a live feed, and that… there was a website that everyone logged on to and watched me… and then I thought if it, if it, if it isn't the webcam, then… someone's put a camera in my room. Because there's definitely someone, wat… there, people are watching
	3	Er… a lot, a l… a lot of my time was pre-occupied with what was going on on Facebook. Like I started thinking like, all the statuses were somehow indirectly aimed at me. If not directly. And the pictures as well… People can see your photos and… they want to know what you're thinking. I mean like, it's very difficult, I mean I know nobody's a mind reader… but the thing my mind, the thing my mind was doing was like people knew how I, how I was thinking as well… Do you know what I mean? If I think about someone, like they're going to know…
	3	Broke down the barriers a bit, sort of… the thing is we need those barriers to survive…We all need private space, we all need secrets… I found it a bit easier to get the girls, because obviously the barrier… was, was gone.I knew they didn't know about me but I thought that they did. Know what I mean? So, I'm like, I'm a nice guy, why can't I just try it?
	3	…sometimes it felt like if I was watching the news, then the person on the news, I know that it's their job to talk… to the audience, that is their job, I know that's their job. But it felt like they was talking directly at me… Not necessarily specifically. I think that… the concept that they was talking at me, through the TV is what really got me…I couldn't switch off from it. It's very hard to snap out of it like, I was focused so much on the TV… talking at me… I can't have a conversation with it, but like… I don't know, it just felt like people were out to get me sort of thing [laughs slightly]. *Yeh, yeh. Did you find the same with the radio?* A bit, yeah… It's very difficult to get on with your life…
	3	I remember um… that defining moment where things changed, and er… I was playing chess on the computer? And I said to my mate like, "I'm going to play this … against the highest level, and I'm going to win". And I won... And it's just, the way I was thinking then was like, the whole world was watching me, and I beat it... The fact that I, that I done it, I won, only added on to what I was thinking, which was 'everyone's watching me'.
	7	*Only in specific situations:* If it was adults, I probably would be a bit more funny, but they're all younger, so whatever thoughts or things that I get off them, it only matters about 30%. The rest of it just, "Nah." They're only young people ain't they, so let them think what they think. Because I hear what they say and I think they're really immature and they're really not, they're not clued up at all, they're quite stupid.
	8	For the first few months I was really scared. I didn't like to go outside that I felt like I was a target every time I was walking down the road…

Appendix 8

Social distancing through rejection or withdrawal	1	[The police] weren't willing to listen to me… which I think, you know is quite, that's not fair at all. Just because someone's got a mental health problem doesn't mean that they don't know what they're saying. Or that, they don't know what's going on around them.
	1	I felt like I was all alone. It made me feel like I was on my own, because it only happened when I was on my own.
	1	I sort of isolated myself away from people because of it, um…I didn't go out. I stopped socialising. I stopped talking to people that I considered as friends because I, I had, I started to have trust issues as well.
	2	I ended up just shutting myself off. I ended up, I mean, I had a partner at the time. Erm… I had to shut myself off from him. Erm, I was just in the bedroom 24/7, I didn't even go to the shop in case I heard voices. And the only way I could do it is I could just sit and focus on… a box set of DVDs, which was just continually going on. Or listening to music or putting headphones in my ear to the point where it, it's really loud, and I can't hear anything.
	2	…thoughts of you know, anyone out there in the world harming me, um that was part of me shutting myself off as well.
	2	I was shutting myself off, 'cause I weren't answering my phone or my texts.
	2	Unless someone's experience it themself no-one can understand.
	2	…telling [my partner] what I'm thinking and what I'm hearing. And… it was really hard because… again I was thinking that he's going to judge me, he's going to leave me for it.
	2	…it got the point sometimes where I just went on, online and did all the shopping online.
	2	I didn't want even my own family to think I was a freak. I would speak to [my sister] on the phone and stuff, but…um, again I just, I didn't really go too deep 'cause…I don't know whether it was embarrassment or, or anything like that.
	6	I left working for her… didn't really speak to her or explain… the situation… I wasn't entirely comfortable about talking about it.
	6	Erm… yeh, 'cause it makes you sort of different to most people and…it's sort of something that you can't share with people like friends… if you develop, or if you want to develop a relationship with someone, you can't really, it's more difficult to… you feel like you're, you, you might not be accepted if you tell them about it.
	5	To me it's not that strange… from someone one that doesn't know what they might be doing, how dangerous they are so… they might not understand but for me…
	5	I was thinking about if [my friends] was informants, because I was doing drugs… [to] the police… Yes, I tried to stay away.
	4	I was so paranoid, so paranoid that you, you know… I would like… I would like cower away from people, I'd be like "ahh, I can't talk to you like", [laughs], "I can't really talk to you" [sniffs].
	4	…you can't talk to anyone about it because you're afraid that they're going to think 'this guy's fucking, he's crazy'. And, do you know what, they would be absolutely right! [Laughs].
	4	[people with psychosis who don't know about it are] going to wrap themselves up in a bit, in, in… a state of not wanting to talk about it just in case they get the wrong reaction or in, in… actual fact they might still be doing that because they might get the right reaction and they have to stop taking drugs, because they are so addicted to it they… they wouldn't think about not living without it, you know.
	4	'Cause I never really spoke to people about it. I can't really speak to my friends about it, because they don't really know what I… what I went through. And, you know, some of my friends are quite arrogant you know, they think they're well… this, that

Appendix 8

		and the other. So I don't generally talk to my friends about it…. I don't talk to my family about it.
	3	I stopped… being that person that goes out and meets people and has a good time. I was very much… er, fearful, traumatised.
	3	I didn't particularly watch much TV. Er… I didn't have any internet at home, so… I didn't have to worry too much about Facebook then.
	3	But obviously my friends are now gonna… are now gonna… think twice before… well, letting me be in their lives sort of thing. Do you know what I mean? They're, once you… there's a bit of a stigma towards it, do you know what I mean?...I should be able to… to persuade 'em, if I can…"well, you didn't want me around when I was being a bit depressed and a bit paranoid and… I mean I wasn't doing particularly well at school or… all the activities that I used to be good at, I, I wasn't doing as well… But… if I can come back and start performing well again, then… surely they will, I can win 'em over sort of thing, do you know what I mean?
	7	I wanted to just go home all the time. I wouldn't stay around people for too long. I hated being in crowded places…it was too many voices, too much.
	7	My friends just thought I was just stressed out. My baby mother knew something was wrong with me and so did my mum. They didn't know what was happening inside my head. They still don't know. I wasn't telling them everything… Because I felt like it makes me look a bit nuts.
	7	I stayed inside. I didn't socialise too much.
	8	…you start to think about well everything's happening, like maybe he is actually going to kill me and then you start … then no one believes you and then you feel on your own with it. And then like everyone thinks you're going mad…It's very stressful because you're going up against a lot of people on your own like and no one's there to back you up.
	8	Like if I'd kept it a secret, I could have lived with it better I reckon, like it might have broke me every now but at least I wouldn't have every one looking at me thinking I'm mad and making things up and telling me that I'm wrong.
	8	I started thinking like the only person that knows the truth are the people that are watching over that ain't there. And then I just wanted to go and be with them because I wanted to be with people that would believe me in knowing the truth…It started frustrating me to be around these people like, like I was getting annoyed with them. Every time they spoke to me I thought I just wanted to disown everyone…I don't want anyone else's support when it's not the support I want and I'm after.
Perceiving a need for impression management	2	I don't, I don't… put a label on me and say "look I'm gay, my name's Tom" or anything. No-one needs to know anything as far as I'm concerned. I mean I can just act like a normal person… And… yeh, I feel safe. Yeah, I mean people know my name and that's about it. That's all they need to know.
	5	All of… they, everyone that, I think if… anyone could have been, get, gotten post-traumatic from being in that situation.
	4	I don't really fear anything now…. I don't fear, you know whether I lose or gain. Not really… I'm very fearless, always have been since I was a little child… you know no-one really bothers me. And if you do, you, I'll let you know about it.
	3	I was drinking a bit but like… that's, that's er… to be expected as a student…. I thought I'd go out and enjoy myself with my friends… Like everyone else, yeh.
	3	I was very intent on trying to be the best I could be, despite what I was going through… I was… I was thinking 'well, if everyone's looking at me, I'm going to be the best that I can possibly be'.
	3	…every day I was, I was worrying about what I might say, what I might do... d'you know what I mean?

Appendix 8

	3	But… if I can come back and start performing well again, then… surely they will, I can win 'em over sort of thing, do you know what I mean?
	3	on Facebook, they've got this thing called um, an activity log… and it stretches for 4, 5, 4 years?... I've gone through it, I've undone everything, so everything that I've 'liked', everything that I've commented I've deleted. I don't really want to leave any prints, d'you know what I mean?... I don't like that idea that someone else can…in… intervene, erm... intrude sort of thing. I'm feeling people are intrus… being intrusive on me.
	3	I don't know, I just wanna be a bit more respected by my friends… I don't want them to think 'he's a joke,' sort of thing. I just wanna be a bit more, "wait a minute, I might have a, I might have something to say that you might wanna listen to".
	3	I'm not a runner, particularly, I'm a fighter… sometimes I've been in trouble and there'll be like one person, and... they'll… they'll have like 5 mates… but it don't make no difference to me... I'm not being bullied, basically… it's easier to live with myself, for me…
Master theme: At the limits of endurance		
Sub-ordinate themes	**Participant**	**Supporting quote**
Overwhelming circumstances	1	I just couldn't take it no more. I was actually, you know, not even looking after myself properly, I wasn't washing, you know I didn't have any motivation, I couldn't get, and people at work were noticing.
	1	…it went on… I'd say for about… [long pause]… two, two years? And then erm… I got, I got admitted into hospital. I've been admitted into hospital about four times.
	1	You know, I've always been able to cope with things, but this was just…
	1	I wasn't looking after myself. And you know like… I was gaining weight because I was over-eating, comfort eating. Um…and I felt like I was all alone. It made me feel like I was on my own, because it only happened when I was on my own.
	1	It affected my work, and to be honest I don't even know how, like, I kind of got through everything.
	1	I mean, before [the thoughts] were really intense, they were like, sometimes I couldn't even leave the house because I was so paranoid about things.
	2	I started um… experiencing hearing voices, and um… which were getting stronger and stronger as the time went by. Uh, I think it took about a year for them to get really demanding and… very very strong to the point where I just needed help.
	2	It got louder, it got stronger, it just got more demanding to the point where… I felt trapped, sort of thing, I felt like I was just stuck in a very small space, and it just felt like my air was going tighter and tighter if I didn't do what those voices were telling me to do.
	2	It was, it was, and it got to the point where that was, it was getting me down. And I was just getting very very down and depressed.
	2	It is… oh, it's tough.
	2	It got to the point where it was literally all the time… nothing was working anymore.
	2	*Does it affect your sleep as well?* Oh God yeh, oh God yeah. I weren't sleeping at all. It got to the point where I was on sleeping tablets and…um, sleeping tablets just weren't working anymore and it got to the point where I was just immune to sleeping tablets… the doctor here prescribed me, um… seven sleeping tablets just for the week, he said this was go… going to be his final lot, and I was very

Appendix 8

		stupid enough to add a zero… to that prescription.
	2	I mean I was really tired and it got to the point where I was so tired that I was just literally physically crying. I would just lay on the sofa and… I don't know. Just, I couldn't get myself to sleep and I would cry… I would, I… to the point where I would literally cry myself to sleep… even when I did get to sleep it would be a couple hours, every night. And I, I was just very very drained.
	2	…me and my partner had a next door neighbour who was very homophobic...she would be pointing us out, "oh they're, they're the gay neighbours I've got". And… it just got to the point where… I went… it just got to the point where I started shouting and I was literally telling her to fuck off and please leave us alone… She was banging on the wall, calling us queer and every homophobic name you can think of… She was even going into her garden, which we could see into her garden, with her boyfriend, kissing him, um getting her boyfriend to touch her, her breasts and… shouting through our window, saying "this is how it should be done".
	2	it got to one night where she, um… she phoned up the police, she had self-harmed, cut her wrists and cut her face with a razor blade and she phoned up the police and said I did it.
	2	So I was arrested, I was in a police cell for the first time in my entire life. Um, I've never even spoke to a police officer before. So I was in that police cell, the door was locked, and I was just, I think from then, I was just frightened…And all that was going through my head at the time was panic…
	2	[It] was just…I can't keep handling all this… It just, it just felt like everything was building inside me to the point where there was no room left, there was no more room to take it all in and I just wanted to explode. Just like a ticking time bomb, I wanted to go bang.
	2	I think it was just… a feeling of sickness really, whether it was just in my head or not, I mean I had constant headaches and I just, my stomach was turning all the time, and I was literally being physically sick in the toilet. I think it was just the fear, um… definitely the fear. And especially when the voices were demanding.
	2	I mean I got my mum's health as well, I mean she's had bad health from when I was a very young kid. So, all my life I've just been worried about my mum anyway…me moving away sort of like, kind of worried me more, 'cause I wasn't there as the extra support.
	6	I was getting like, kind of like, I can only describe it as like, energy going through my body. I do remember being, feeling quite distressed by the physical sensations I was getting.
	6	…and it felt quite overwhelming sometimes, erm… so…yeah it was… sometimes it was kind of, like, not particularly… pleasant sort of… sensation.
	6	I, I, I guess… kind of sad… in relation to the first lady I mentioned… because I was quite emotionally attached to her... 'cause I was also getting kind of like, imagy, images … which I found distressing. So that was, kind of made me sad, because I felt I had sort of feelings, feelings towards her I'd say. So yeh, I had feelings of upset because of, because of the… feelings of being con, being controlled… but just like, sadness as well at… at the images, they were kind of like sexually related things.
	6	…the distress usually comes when… when it continues and doesn't go away, and then… then I get frustrated and annoyed, I start getting angry sometimes... Erm, 'cause it's not going away. If it lasts for like a whole day or something, then… then I will get distressed by it.
	5	I don't know if I have suppressed it… I am sad that I, I had to go through it… I'm gl… happy that I don't remember it [laughs].
	5	…people that I was with… Er, they… they'd done a lot, er… attempted murder, stabbings, torture, and robberies, and a lot of

Appendix 8

		things. Drugs as well.
	5	… I noticed that I were becoming… now, I know that I was probably psych… becoming psychotic, or the pressure was too much so I was a lot of… I was under a lot of stress and pressure so it became too much for me. [Because of] the criminals… that they might come and chase me here.
	5	…yeah there was an incident back in Sweden… that made me really scared. And I had just witnessed a stabbing or two stabbings and er… I said that I didn't want to join the gang and I did too much drugs and don't want to live in Sweden anymore and the gang got angry with me… it's a famous motorcycle gang… they have done a lot of crimes in my country.
	5	I was unemployed… under… unemployed… I didn't have any money, so the financial situation was also bad.
	5	I was really, yeh really scared and I could feel a… feeling [indicates his chest], and I got… physical sometimes also, so I was so scared that I started shaking and I had cold sweats, yeh… So I had difficulty breathing and I, it was like… panic… I started sleeping worse afterwards.
	4	I had completely gone right down the wrong path, and it's weird because at the time I thought it was the right path, it was the right thing to do, it was a good thing to do… and now it's just… you know… yeah, it's just horrid…
	4	I was in the hospital… and I…I totally lost… lost the plot really. I erm… started hearing voices, erm… noises were really irritating me, giving me a massive headache. I felt like I had them… my head was in a vice and certain things would make the vice tight and really hurt my head, and give me a headache [sniffs]… I can remember… that certain pitch of that electrical motor was driving me crazy, I couldn't, I couldn't focus. …there's other things that lead to more aggressive thoughts if someone… keeps on moving… they look agitated and that makes you feel agitated… bad manners as well, if someone snorts their nose and you think 'oh my God, like what are you doing? That's disgusting'.
	4	I went there with my mum and I ran off, left the hospital, smashed my phone… erm… left my mum in a state, in an absolutely terrible state. And… ran off, er… and then the police caught up with me and then I started hallucinating… I would hallucinate police cars… I would walk past a… road… where a police car was parked and then… I would walk past it again. It's like, you know in The Matrix when he sees that black cat… he goes you know, "ahh I just had déjà vu". It's exactly like that, but you are freaking out, you are like, you're shaking your head going "what's going on? You know". So it turned bad w… it turned really bad within… a day, erm…
	4	I was hearing um… mostly my dad's voice… which was, you know he was saying some… you know, crazy things…
	4	So I thought 'I'll rip the mirror off the wall', luckily just as like… just when I was you know, about to cut myself the um… the nurse came in and said "what are you doing? What are you doing?" and me like, as crazy as, like I'd totally lost my marbles by now, I um… I said it was an act of God! [laughs]. I didn't even admit to it…
	4	I can remember going to work and I… having the biggest headache. It felt like I had two metal plates in my brain either side, and I couldn't even focus at work…
	4	It's the most frustrating thing I have ever ever encountered.
	4	he probably doesn't even think 'oh, you know this is crazy, why am I doing this?' You know. You, you, you generally just think you're doing whatever you need to do to get by, day by day.
	4	I was mentally unstable and I didn't really know what was going on in my head at the time you know, and it affected me, home, work, socially. It affected my life entirely, you know.
	4	… I've been through, you know, traumas, my nan dying and stuff. But that was… that was by far the… the most… worse thing that I… I went through. You know, you consider everything you know, everything to... get you out of that situation.

Appendix 8

	3	I can't do my work, I can't read properly… like, I've got, I've got a lot worse.
	3	…very paranoid, very on edge… I was taking notice of everything around me, but I wasn't very… thinking very clearly… judgement was quite clouded… I probably made a few bad decisions… I didn't have much concentration.
	3	And… I don't know, I j… I didn't know how to handle it…I g… I, I was just… And I was just like "what can I do?"
	3	…it just seemed never-ending… it's like you're living it. But… you know what paranoia is, but it's like you're living it. And it's very hard to… to realise. I mean, you sort of realise. You sort of realise that, this, this is, is stupid, you're being paranoid, it's nonsense. But at the end of the day that's, that's your life, d'you know what I mean? This is the way you're feeling and thinking, this is, this is your life. So it's very hard to just, well, think like this but… that's why it's, sometimes I was thinking it's better if, better I don't exist.
	3	Sometimes I can… I just think I don't want to think a thing. I mean I've had a lot of… a lot of pain in, in my head. It's like a shooting pain, like um… like lighting a sparkler in my brain sort of thing. Yeh it's quite um…unsettling, I don't like it…
	3	if I was thinking something, a name or… a certain thing, then that, that word would be said to me… usually a girl's voice. I mean I was having problems with, er… these problems …arose, around the time I was seeing this girl… her voice imprinted on my brain quite heavily. And I was having problems like, I was reading… and, her voice was like… I would read a couple words fine, and then… the next word bang, it would like have her voice say the word in my head, sort of thing… it was very disruptive….So I'm trying to do my work and then… it's like having a… kid in the room do you know what I mean? It starts screaming. I can compare it to that sort of thing, like. You, you're getting along and doing what you're doing and then there's, the baby's in the room and it starts crying sort of thing and you think arrgghhh… God… you can't just ignore it, you have to… I don't know, acknowledge…
	7	I was really in a bad way and I was just … I wasn't really coping well in public and social situations at all.
	7	I was doing a really stressful job and I was breaking up with my baby mother. Yeah. And the voices was just overpowering everything and I had to quit my job. And then I felt rubbish about that and then just ended up getting worse.
	7	Twenty four/seven. Even when I'm on my own, I'd replay the thoughts and everything that's happened throughout the day, so I was never getting away from it…it was quite a really strong voice…really horrible and angry about everything and everyone…it was like it was making me believe that I could feel peoples' thoughts and emotions.
	7	I wasn't sleeping. I wasn't eating. I was just awake all the time and really stressed.
	7	I get confused. I get confused. I have to try and reassure what's happened.
	8	And then fuckin', when I got to the … I left there and I went to the police station, I went to Bexleyheath police station and I was trying to tell them that he wanted to start a war with Russia as well. And do you remember that Russian banker that got shot? That was him. And I tried saying that was him. No one believed me that it was him and that. And then they tried telling me that they killed … do you remember that girl that died, Gemma McCluskie?
	8	But then anyway, got to his house and he offered me this wine. He had put MD in it though. I didn't know there was any MD in it at the time. And he was … like so I was drinking that. And then he went upstairs and his friend turned round and said to me, "You've gotta leave." And I said "Why." And he goes "He's gonna rape you and then he's gonna kill ya." And I was like, what am I meant to do like.
	8	… they put on the news about the Gemma McCluskie thing, telling me like that she was dead and that and that they had her head in the fridge and that. And then they said … what they said they'd done was that they the skull in the fridge with a bullet hole in the back of it. And then when I went upstairs to get some socks from the drawer they said only look in the top drawer.

Appendix 8

		So I looked in the second drawer as well. And in the second drawer there was a gun on top of a yellow cardigan. And when she went missing she was wearing a yellow cardigan wasn't she?
Inadequate resources on which to draw	1	And at the time, my partner at the time didn't really… He wasn't really there for me as such. Um… he kind of made things worse.
	1	It didn't help the fact that I was with someone who, you know was quite abusive towards me as well.
	1	My family were supportive. But the thing is they didn't really know what was going on, 'cause, like I said it only happened when I, to me. So… there was little that they could do really.
	2	When I went to the chemist they, they kind of thought 'do you know what? Seventy [sleeping tablets] doesn't sound right.' They, they phoned up the doctor straight away, and that kind of stopped me from having any kind of erm… sleeping tablets at all. So I did that to myself really… I had no thoughts of suicide at the time. That was purely to have extra.
	2	…my actual partner… he did try his very best… it got to the point where he, I didn't want to put it all on him. So... I, I left him… I had him there… as erm… as s, small, small support. I would go to him, and I would go to him you know, telling him what I'm thinking and what I'm hearing… he was a support but only when I went to him. He, he kind of didn't really know how to… how to deal with me, or he kind of didn't know what to say.
	2	The council weren't helping, they were like, "do you have any witnesses?" "Of course we don't have any, no witnesses." Erm… so the council weren't no help whatsoever… even the council guy was a bit homophobic himself.
	2	I would say "look Mum, just things are kind of difficult at the moment." And… that's as much as she would know. Because she had her own problems, I never wanted to speak to my mum about my problems. I kind of told her "look Mum, things are a bit out of control. Um, to the point where I can't control things that are going on, and that I need help". And, I told her, I just sort of reassured her, that I was getting the help and that the help is working and…
	2	Er… my mental health and [my brother's] Tourette's syndrome sort of, didn't mix…. I definitely wouldn't speak to my brother. My sister… was just always busy with her two kids.
	5	… [my family]… they don't really understand, so…
	5	I felt a little betrayed by the… people that I knew… Yeah, especially from him and he chose sides and not this side, I knew him longer.
	4	I couldn't, didn't want to speak to [Dad] about it more than anything.
	4	…at that stage I was still having arguments with my mum and dad which piled on more stress for me, 'cause like I would go back to my bedroom just thinking about things… I was even… having big arguments with my dad because, you know… erm...
	4	If someone says "look, you're having a bit of a bad time at the moment, you know, you know, constant headaches, um… constant voices in your head, like… what you need to do is actually, you know. If they just said to you, you know, ignore the voices, you… you know. Not one person whilst I was sectioned, or you know, the couple of days that I was out beforehand hearing voices, no-one… you know, it's difficult because I didn't really speak to anyone about the voices… I wish that I had that one person there that I could speak to… who just said "look, be strong, you're going to be alright".
	4	I sort of blamed my dad a little bit for me, like…for… you know, I thought he knew that I was taking drugs and that, you know… apparently he didn't and there was a lot of tension there, a lot of friction there.
	3	it's got to a point now where I, I th… I think, if they were really my friend they'd want me, to see me get better, and then there could be a future… friendship… And as I'm getting better, I'm looking back at my friends there, and I'm thinking…'do you

Appendix 8

		know what, you weren't particularly there for me.'
	8	…my dad's really a hard person to live with. Like he's constantly moaning and stressing and slamming and banging…He's very hypocritical, like…I started thinking my dad was involved. And that he planned this all and he knew this was going to happen.
	8	[My dad's] one of them people like, I've got problems too you know, like that. And it's like, but hold on a sec, your problems are years old. Mine's just come up today and you haven't got the time of day to take out of it and put it into place for me. And it's one of them things like, the way I've grown up he would always threaten to beat people up like, if you do this, I'll do this. If they do this, I'll do that. Then some guy comes and does this and what does he do? Nothing.
Anticipating death	1	I just couldn't take it no more and… I tried, I tried to take my life… Erm… at my last admission, I actually took a overdose. I just thought it would be easier just to go, and you know at least I'd rest in peace, than having to go through… like, having to leave your house and be tormented by random people that you don't know.
	2	And my mood was coming lower and lower, and it got to the point where do you know what? I can't live like this. And it just got the point where… I didn't want to live anymore and… just, it weren't a way of living.
	5	[Because of] the criminals and that I knew that I will… I was… I thought I was going to die… So I was thinking about it, well it's probably only one phone call and I… might die… Er, scary.
	5	I thought that I was going to be killed, murdered.
	4	'Cause I thought I was going to die, I thought I was going to die, I didn't even… I was living my life like I didn't give a… a sod, you know, about anything…
	4	you genuinely think 'I'm not going to live until I'm 30' and… you have such apocalyptic thoughts about death and stuff, that… you know, you think, you think 'this is what's going to actually going to kill me, psychosis'.
	8	And he goes "He's gonna rape you and then he's gonna kill ya."… I was just sitting there, thinking like what am I meant to do, like there's two of them and there's only one … if I get up and run … he had a baseball bat down the side of him.
	8	Well when someone says he's going to kill you, you sort of think well that's it isn't it? What are you meant to do? You just start … you don't, you don't really think about it like, it just goes blank… you kind of accept it as well at the same time, you just think to yourself, well this is it like. Especially like, when you're not like 100% satisfied with life, it's not such a bad thing if someone says to yah "I'm going to kill you." It's like well, you might be doing me a favour mate.
	8	Anyway, they said to me that I had 13 months to live.
	8	…like someone one minute, any minute now, like every car that's come past I was like someone's gonna do it … it's like it's gonna to be him; he's gonna shoot me…
	8	I mean … mixed emotions like I've started thinking to myself maybe like the only way out would be like suicide.
Master theme: Elusive sense of agency		
Sub-ordinate themes	**Participant**	**Supporting quote**
Feeling powerless	1	I went to report what was happening but the police, they didn't do anything, 'cause I didn't have any evidence that this was going on.
	1	…when I talked to people about it no-one believed me. They would think that, you know, this isn't happening because obviously there was no logic to it, and there's still no logic to it.

Appendix 8

	1	You know, I was scared to leave the house…
	1	I don't know how they found out where I lived but… it started happening again and, it was the same people.
	1	I guess the low mood had to happen, well the reason why I stopped taking the medication was because, you know… I always insisted that I didn't really need, I, I, well OK fair enough the anti-depressant because I was depressed, because of the situation. …but the anti-psychotic, I felt like I didn't need to be on it because, you know I wasn't imagining these people, they were actually… they were real, and it was making, that's, what they doing to me was making me paranoid.
	1	[The police] tried to make it out because I was on um, medication, that you know I was, I was just unwell. That maybe I'm just imagining, maybe it's my illness. So they weren't, weren't willing to listen to me or anything.
	1	I felt every time I'd go out people would be laughing at me and sniggering and stuff like that, and… being taunted, and… I… I just… I, I just put up with it I guess 'cause… there was nothing else to do, I couldn't do anything about it.
	2	I was walking through the high street one time and erm, someone in front of me spat on the floor. And the voices just strongly come to my head, and say 'call that person a dirty, dirty so-and-so, bastard'…. Um… and… it was, it was that strong, it was that demanding… As, as hard as it was, I only did it because I knew the voices would go on, if I didn't do what, what I was told to do. And… straight away the voices kind of just went away, there and then….and um… it kind of got me to, into a situation where this person that spat started an argument and... was in my face and um… was literally nearly ready to hit me, basically.
	2	somewhere deep inside me, I didn't want to do what these voices were doing. And I..I..I know that it was there that I didn't want to do it, but it just kind of overtook everything… I would sit there, it was almost like straining really, sort of like, my head was hurting 'cause I was thinking so hard, trying to control it but… it was just, too over-powering. And it just felt like it… it was inside that I didn't want to do it, and I knew it was inside, I could feel it inside, but I just couldn't get out, I couldn't be strong enough sort of thing. Um… so… yeh. I wanted it to come out, I did, and I…I think that's why I was just literally feeling sick all the time. Because it was there, but I couldn't do nothing about it, and I was just sick because… I just didn't know what to do, really.
	6	It didn't happen when I was actually around the person, just when I was not with them. Er, for some reason.
	6	And feelings that I'm kind of like connected to people when I'm not… when they're not there with me…that kind of makes me anxious. Just the feeling that someone's there when [laughs]… when there's no-one there… Yeah, that I'm not alone when I'm… alone sort of thing.
	5	… I was worried that the police would leak information about what I have said so… and I know [laughs]… some peoples, some people got arrested… they're in prison, I think [laughs] thanks to me... if they found out that it was me then… they told me that it wasn't recording anything the police, and that they would censor it. So I really hope no-one understands… if the motorcycle gangs find out, I'm probably on… ah like, most-wanted list.
	4	I had to be carried to… by the police to the hospital.
	4	So in the hospital I was sleeping, I was relaxed, I felt a lot better. I wasn't hearing voices… I was laying there, I was absolutely fine, I some crisps, I had a drink, I had a sandwich. And then all of a sudden [clicks fingers], you know, they were back but they were aggressive, they were really really aggressive. And… they told me to do things in the alley, like to shout out erm… certain things…
	4	I felt that I had to because they might, you know, they might not go away, might continue driving me insane.
	4	I'm trying to escape the place, you're not, not realising that actually if you play by the book at that place and you keep yourself

Appendix 8

		to yourself and you… if you're on good behaviour I would have been out a lot quicker.
	3	I… stayed, ab, ab er.. abstained from drugs and er… I tried to do my work and I just… didn't get any better… it was very gradual but I, I got worse and worse, week on… month on month. And erm, I just couldn't see a way of getting any better.
	3	…thinking that way, you cannot do your work.
	3	It's like swimming against the tide, d'you know what I mean? Like, you try to but at the end of the day it's going to come back.
	3	It's very, very much like I lost control of who I was.
	3	I was trying so hard to do Maths and it just wouldn't work, so…
	7	I get anxious, because I don't know how I'm going to be in certain situations, with certain people.
	7	The fact is that I'm getting all these thoughts and I can't do anything about it or say anything. And just having them there in my head as well.
	8	So I went to [XX] Unit and then they said I either stay voluntary or they'll section me and that was it.
	8	I couldn't show them the message because the other police officers had my phone.
	8	And then I went to see Dr Love that he named and she didn't mark down any of my injuries… I said Dr Love's like she's doing, specifically she's working with him. I said like, she's getting paid to do it.
	8	And then [the police] deleted the picture on my phone that was covered in blood. They deleted that off my phone.
	8	I tried to explain to him, I said the police officer that's dealing with my case is corrupt. He's not going to do this for me. And they said I had to make a complaint to the ICPS or something.
	8	And I thought maybe they're going to kill someone and set me up for a murder somehow. Like and I thought they was going to kill this guy, Jack.
	8	It makes you feel like, was there any point in telling anyone it happened because it's got me nowhere and it's just made my life worse.
	8	Well my dad threatened to kick me out if I didn't take my … if I didn't go on the Depot injection… I thought well, hold on a sec, I didn't ask for any of this. I'm only saying what I've been told and I'm only telling you what's happened. And you's are all the ones that are choosing not to believe me…
	8	I said I was just generally scared. I've been manipulated and like, tormented by these people.
	8	…he thinks like I'm going to end up like my mum. My mum's a paranoid schizophrenic as well. And she's really bad.
	8	And she's … but then I thought to myself, if I keep sitting there thinking to myself they're going to kill me, they're going to come and get me, I'm going to end up like her, like paranoid every day and not leave the house.
Being attacked or intruded upon	1	…basically… I was really… depressed and stuff. Because of what was going on around me……basically, it affected my self-esteem and my self-confidence, and stuff like that.
	1	It all started, erm… with people calling me… names and insulting me…
	1	It was my neighbours yeah, that were doing it. Like, I'd come out the house, and they'd insult me. But they'd do it in a way that…I wouldn't know who it was. Because it'd be someone from, like someone shouting from… like… the window, or something like that, or the door, through the door.
	1	I was also being followed by people, in cars and…
	1	…it just really… affected me mentally.
	1	I'd think that someone was in my house, moving things about, things went missing. And I'd start panicking, you know… And it got to a point where, I was turning, because of what they did, what they were doing, it was making me ill. And therefore I was

Appendix 8

		getting more paranoid… about the littlest things.
	1	I'd leave my house, I'd get insulted, taunted, laughed at. Spreading rumours about me to other neighbours, neighbours were insulting me…
	1	they'd gone through my bins. They had, I've had my car window smashed. I had… you know, just things that… you know, just things pertaining to me.
	1	It affected me very badly in the sense that… I felt like… [pause]… you know, I felt worthless, I felt useless, I felt… That's how they made me feel you know, and like… I changed as a person. I changed… and it wasn't just mentally, it was sort of like physically as well.
	2	It felt like there was so much pressure with these voices in my head, to the point where my head was literally hurting. And my head was in pain and… even that was draining.
	6	… the physical sensations I was getting. And… as if something was sort of being, pushed into my body, almost. That's what it felt like.
	6	… I can't remember specific thoughts, but I remember feeling quite distressed, upset by it, as if someone was trying to do something to me. Erm… and I remember it was in relation to one person specifically… the lady I was working for. Erm, in…in the main. Although there were other people involved, like other voices, people that I knew… They were people who I'd volunteered with.
	6	… it felt as if there was some sort of, like connection between us. And then, felt like they were… aware of, like, aware of it, and… purposely trying to control my emotions and… upset me.
	6	… well, it's kind of, erm…it felt like, she was trying to make me do things like, sexually. Erm, and trying to force me to do that, erm… which I didn't… want to… that's why it was so distressing.
	6	Although there was one person who I ha…, was having a similar thing with. Where it felt like she was trying to control me or put, put things into my… body, s..., energy kind of thing. Um… a feeling of something invading me.
	5	No, they tried to contact me through my family. I was scared.
	4	And they had to restrain me because I was so aggressive. And then they put me into a room and injected me in my backside with a massive needle.
	4	The voices m… you know, *made* me aggressive and *made* me possibly feel like… you know, I w…, I was invincible…
	4	so like you are hearing a voice in your head, but now it is telling you to do something or… you're going to die or they're going to kill you, or… someone's going to, you know… come into your bedroom at night and… slit your throat or, you know… if they was saying you're going to have someone come into your, you know, bedroom and… harm you, you know I… believed that… You know, the voices were so real that, you know… what's stopping anyone from doing that? You know, I actually, I was so out of my, I'd so lost my marbles that I didn't… I just didn't realise what was going on you know I, I could have believed anything.
	4	I would have been suspicious about people even if the voices hadn't said anything, you know. I would have still would have been suspicious of them, for… look at the way he's standing, does he look like he wants a fight?
	4	I would even be suspicious of my own dad…
	4	It felt like everything that I had taken was, was now coming to get me, and… it was like a massive, the biggest comedown ever, you could ever ever ever, you know, think of.
	4	I tried escaping [from detention on the inpatient unit] at night, I booted down the back… the back door, the fire exit [laughs]…

Appendix 8

		and then next thing you know you've got 5 geezers on top of you… get, getting you, you know… giving you a good little hiding… giving you, sort of… a bit of a beating because of what you've done, you know. …you're not, not realising that actually if you play by the book at that place and you keep yourself to yourself and you… if you're on good behaviour I would have been out a lot quicker.
	3	… if it isn't the webcam, then… someone's hidden a camera in the room somewhere.
	8	…anyway, he used that chlorophene stuff as well, do you know, that stuff that you use. And when he done that I felt fucked, proper fucked…
	8	And so I went to lay down and that's when he hit me round the head with the baseball bat. And then like he started like, he had a knife and he was cutting me with a knife and that…
	8	Jane is apparently the one who's meant to be able to track me down…if I move or something, they can look it up on their records and find out where I live as long as I'm in the Mental Health Team.
	8	Well they did rape me, didn't they?
	8	Well he told me that there was cameras in my room, that they'd been watching me in my house…and he was like, didn't you hear that beeping noise? And I said there was a beeping noise that I picked up in my room like…
	8	But I was trying to say that the doctor had put a chip in my head. Because when she went round to examine the back of my head, she had something in her hand. And then when she was pushing, you know she actually did push down, so I was saying like that she had put something in my head.
Self-assertion and efforts to maintain control	1	Erm, so basically… yeh I moved away, not too far from there, but I… I moved away. And things were fine until…
	1	…this time I wasn't going to let um, the bullying… sort of, make me move or push me out again. I wasn't going to let that happen. I wanted to make a stand.
	1	…so I just didn't bother. And basically, [sighs], you know, I ended the relationship with my partner. Um, I feel like I'm free to be myself now.
	1	…to listen to what people are saying outside it just doesn't make sense, because if they don't know you, why should their opinion… you know…
	1	[Work] was like an escape for me, because yeh I worked quite far away.
	1	You know what? It's not me that's got the problem, it's not me with the issues, it's them. So, when they do like, insult me, call me names and stuff, I just… ignore it, I just let it go.
	1	And… but you can't change who you are as a person, and if people can't accept you for who you are then that's just, that's just their loss, that's it.
	1	there's people out in this world that love me, why should I, take my own life because… of people that are of irrelevance? [The overdose]… was a real eye-opener.
	2	I weren't doing it, I was trying to control it, I was… I weren't going to say it, and the voices were just getting, kinda louder… in a …demanding, like a really deep, sorta like strong voice.
	2	even when I got that seven I'll be honest with you erm, it got to the point where I literally still took two, two of them a night …even though doctor didn't prescribe it, I still took two. It just worked. It stopped it for that night…
	6	Erm I left working for her because of it.

Appendix 8

	6	yeh, there were times when it, it wasn't there, because I was able to study and get on with my life as well.
	6	I just… have to try and calm myself down. Erm… maybe talk to my dad or… someone in my family.
	5	I knew I was [laughs] going to become a victim of some type of crime so I decided to leave… And it… it was a good opportunity to change my life I think.
	5	I got paranoid and I started informing on everyone that I found to be criminals to the police.
	5	I felt a little bit sad but I try not to stay, try not to be as sad because erm… otherwise you just feel bad for yourself the whole time and you become a victim almost, after a while if you…You have do something.
	5	I try, try not to think about [threats from the gang]. If I think about it, properly scared…
	5	I can't live in the same town again…. So I have to live in another town if I want to go back [to Sweden]. And I need to get protected, protected identity.
	5	…I was scared so I started planning what to do to feel safe.
	4	And I've been offered… I've been offered by my friends, er… to take cocaine and stuff, and I've said no, not doing it… I couldn't run the risk of having a relapse again because it could be 20 times worse and a relapse… and psychosis that I had before was pretty much bad enough.
	4	I said to my dad, I said "I need to go hospital, because I… I don't, something's not right".
	4	…every single one of the people in that hallway had to come out and restrain me 'cause I was… you know… I was fighting them off. I felt quite invincible, in a way… I felt generally quite good, quite a… very very very aggressive though.
	4	…there was one person I'll never forget called [X]… I spoke to him, it was like speaking to a mate.
	4	I, I packed my tools up and went. Said "I can't focus, I can't be here, I'm not healthy." I am not mentally stable enough to be able, even able to work…
	4	Paranoid, you're in a state of… you're very, in a very vulnerable sit… state so what you try doing is, you know you… you get aggressive… it could be to pro… protect yourself yeh, it could be. It could be just to… to see who's the bigger man, you know.
	3	…yeh, just get back to how it used to be. That's what I want to try and do."
	3	So I felt like I should… hit it on the head, and say "I'm not going to do this course, 'cause I don't want to fail it, and… build on what I've already done and… move on from here"…
	3	I'm doing alright. I'm doing alright and I don't need… your input, 'cause… I'm, I'm smart enough to… to live a normal life, if I get better. I mean, I shouldn't have to worry about mounting debts and blah blah. I should be able to just… live a steady life and, baby steps and… just get on to… doing what, doing I'm trying to do there.
	3	I've learned a few things along the way, and like a few quotes and that and… the one I really like, "Do or do not, there is no try". I like that one… Either you're going to do it or you're not going to do it.
	3	And like, I was only drinking because I was quite depressed.
	3	*How did [the experience of GBH] affect your mental health?* …maybe more aggressive…. It made me feel victimised, and… it's like that fight or flight mode. I wasn't going to run… I was thinking like, 'well, I gotta stand up to them'.
	7	I wasn't sure if it was the sunlight or not, if it was affecting me. And so I was wearing sunglasses a lot. I wouldn't go out in the sunlight. Yeah. It was really bad.
	7	I had a go with a guy at the train station because I thought he was being funny to me. He kept staring at me and I thought he

Appendix 8

		said something about me and I goes "What did you say?" and he was standing there all puzzled.
	8	And then it got to a point where I thought if I had to come here, because I thought maybe if [care co-ordinator] is involved, like she could say well she's coming here this day. So I started coming here with knives in my bag.
	8	I went through a stage at one point where I was thinking about killing them. Like, because I thought that if they're going to get me first then if not, then I'll get them first. And because I thought I know where they live. So I thought I'd just get them. But then I started thinking about it and I thought if they trace it back to me like…
	8	Like and I thought they was going to kill this guy, Jack… they [had] added him on Facebook. I said "Jack like, you need to delete them off Facebook."
	8	It left me more like to wanting to kill them because I thought well, this way I'll get heard. Because they'll be like, what was your motive and I'll tell them what my motive was…I said I'm going to go for the police officers and the doctor as well. I said because otherwise I'm not going to get heard properly.
	8	And it was just like waiting for something better to happen to take your mind off it. And nothing come and you just got to think to yourself like, just pretend it didn't happen like…No one wants to hear it…And so you just think to yourself like, what are you holding on to it for. No one cares…I'm used to blocking things out.
	8	I say it's my break from it. If I've like, if I smoke a joint, I feel chilled. I don't feel anxious. I don't feel stressed up. If people moan at me I can just be like "Whatever."
	8	Like if I go out once a month or once every couple of months and I go to a rave and I take some drugs there, I feel on top of the world. And it's not often I feel like that. So it's one of them things like, I never thought I'd turn to drugs. I've only just recently started taking it. I've always been dead against it. But it's one of them things that if it's going to make you happy ... I know it sounds stupid, it gives you something to look forward to…Like, you haven't got a worry in the world…
Master theme: The urge to explain it all		
Sub-ordinate themes	**Participant**	**Supporting quote**
A need for certainty or logic	1	I think it was the fact that I didn't know why these people were doing this to me, that's what made it even worse.
	1	…obviously someone wants to hurt me, but I don't understand the logic why.
	1	you know I did feel, it was more of a case of why, why were they doing this to me? It wasn't a case of the fact they were doing it. I mean, I knew, know that what they were doing was wrong, and it is wrong. But at the same time, I just wanted to know the reason why, if someone had come up to me and said… something to me, then, it's just the fact of not knowing, um…
	1	I think over time I've sort of built up that sort of… knowledge… the team…, …they've just kind of helped me understand certain things.
	1	And sometimes I do tend to think back…you know, about why they done this to me and stuff like that.
	1	I guess I will never know so, you know, someone said to me there's no point in trying to find out why about things when you're just gonna… you're just gonna make yourself like, just go mad because you're gonna keep wondering why, why, why?
	1	I'm the type of person like, I believe that there's a logic for everything, and… like, I always want answers… like to make sense… to know where I am as a person and... I'm, I'm always trying to make sense of life, in a way.

Appendix 8

	1	…sometimes I can't… understand, you know I just want to live my life and be happy.
	2	[The groups is] something I would recommend to anyone going through what I'm going through. Just to get that understanding of what's going through your head and how you, how… you could help yourself with it.
	6	…it might have been nice to… got a bit of feedback from her, just to get her perspective on things. 'Cause it might have helped to sort of clarify the actual situation, po… possibly… I have doubts now about whether that is the ac… whether that was the truth. Erm… because she did once say to me when I had the opportunity to speak to her that she didn't know… about it.
	6	…but at the time it was hard to kind of, understand why. well, looking back on it now, I don't think… it was necessarily what I thought it was,
	6	[Psychologist] has given good suggestions about erm… what might be a possible expl… explanation for, for the… for the voices. Which, so that kind of gives me a reason for… why it might be happening.
	5	I am not sure how er… how psychosis works, but… yeh.
	4	…we try understanding things. And…try understanding why I feel like this…
	4	…you are freaking out, you are like, you're shaking your head going "what's going on? You know".
	4	You don't understand what's going on, you know. And it's very, it's very, it's very… scary, 'cause you don't know what you can do as well, you know.
	3	I went to the doctor, I mean, I said to him "this is, this is… what my mind's telling me. But… I know it's not true, because… the last 20 years that hasn't been the case, it's only been recently."
	3	And… that idea came to me, the way my Maths comes to me. So it's very difficult to say "no" to it, when… my instinct is telling me that that is what it's saying… if I'm doing a Maths question and I… I know 2 plus 2 is 4. I mean, if you're going to tell me otherwise, I'm going to say "no, I know 2 plus 2 is 4"… So when it comes to you naturally like that, then I'll say "no, this is how… this is how it is". But… it… it's how I felt. It wasn't necessarily the truth. It's just how I felt. Er… I didn't know if it was true or not. But I believed it was true, it's very hard.
	3	I'd just be like, well what can I do? I mean, I'm here to do Maths… but… everything my Maths is telling me is… is, is not right. Because I'm trying to do the Maths, I'm trying to work it out, and… I'm getting the answer… Joe Bloggs down the road is sit… sitting behind his TV watching me on the screen sort of thing. [Laughs]. So… yeah, it's very much trying to rationalise. I mean, if someone comes up with um… some sort of theory, they have to… to prove it. You have to say "because". You can't just say "this is this"… So… they're the sort of questions that I pose to myself as well…
	7	…a lot of things that I heard through my mind, I acted out on them in reality and a lot of them things weren't right. Some things were though funnily enough. So then I stopped acting on the voices, so now I choose to ignore them.
	7	I didn't know what was happening. Didn't know if I was human or not…I thought "Why's my head like this? Why am I like that?" and I done so much research…
Identifying a suitable framework of understanding	1	You know it is a crime, it is, what they... what they… what they did to me was wrong.
	1	Erm... even though it still shouldn't be happening, but it does happen.
	1	…they want me to feel scared, they want me to feel intimidated. And… because I'm not giving them that response, it's

Appendix 8

		frustrating them and they're just doing it until, you know… maybe they push me out of the area again…
	1	…maybe it makes them feel better about themselves. I mean, that's what bullies… they, they do things for attention and… to make themselves feel better don't they?
	1	And… I'd stopped taking my medication, which didn't help.
	1	I guess I've just learned that people do things to hurt people in this world and… not everyone's going to like you as well.
	1	I know why they've done what they've done. It was to do with my, my ex and… a girl that he was seeing previously before I think. It was her and… her friends that got involved.
	2	But, it was just… really stressful, and it was more stressing me out as well… And… it just triggered everything off I think.
	2	I'd think 'do you know what, I'm not hearing voices anymore'. And I think that's down to the medication.
	2	That [CBT] group was a big impact to my recovery. I think it was having the understand… um, having the understanding of… what your problems are and sort of like, how you can sort of work your problems out… It was literally balancing it out…
	2	it got to the point where I see the voices as my own, as my own… mind… those voices was me thinking out loud sort of thing… I think that just from then, me thinking that my voices, my own voices were my own, um… just made things better as well.
	2	I was living in quite a rough area…Um, it was really rough and there were stabbings, shootings and God knows what, literally, outside the doorstep…That just made my, my, my condition worse…there was lots of gangs and as I said the police were constantly living there, and… I think that was a whole big change as well.
	6	I was kind of practising some like meditation, sort of, spiritual practices at the time. So I don't know whether that was anything to do with it. Um… and then I did the mindfulness as well, um… so there was that…
	6	*[The voices] have lessened?* … maybe because my relationship with that lady was quite a long time ago, so… and I, I don't see her anymore, so… perhaps that's, that's the reason.
	6	*Sounds like you've become more anxious than you used to be?* I don't know why that is. I think, I'm not sure… whether perhaps it's the medication that I'm taking or whether it is just me, sort of, feeling anxious. Um…I don't know whether I've just got into a bit of a habit of… feeling that way.
	5	I had been doing drugs before that… and er…the psychosis… it was… er… it started when I tried the er… ADHD medicine?
	5	So I always think that I was so scared and er… stressed out and the pressure and everything so… that's why I became psychotic again I saw someone being stabbed and I had to give him first aid and it was in the head and it was coming down a lot, the blood, and I was calling the police and I was stopping the blood. And another time, maybe two months after that, no before that, I was… I stopped a murder. one guy was going at er… yeh, with a knife and he's standing here and it's… the heart and the blood vessels and everything are there so, and he was going to go on him again so I took him and I started [laughs] pulling him back. .... I do have post-traumatic stress. from the experiences and also things that happened before, they was… was scary.
	5	Ritalin… Yes it was prescribed to me by a specialist doctor also, but it still happened, and it's one of the side effects you can get psychotic from.
	5	I think [the weed] was what pushed me over to the psychosis, otherwise I probably be able to manage the stress.
	5	So, and… I think it's… in your body for 4 weeks or something, and the long-term effects are… because it's different from other kinds of drugs because it's, it… the THC er…

Appendix 8

	5	I'm less scared, and I feel better. I think it's because I don't use drugs anymore… I feel more positive without drugs…
	5	Yeah, it was so… such a long time ago and afterwards they gave me some strong medicine so I forgot everything.
	5	I came over from a good upbringing, but I moved out when I was 17…to a bad neighbourhood and… yeh, I think it was the neighbourhood, not the… my family that shaped me.
	4	I had erm… psychosis in August and that could… drugs are the main erm… thing that could erm, er… spark a relapse.
	4	I guess that is just what marijuana does really, I mean… you, it… it can, it can turn a nice subtle conversation on its head because a little bit of paranoia, paranoia sets in… it doesn't matter who you are or how much you smoke, it will still trigger paranoia in… even in sociable situations…
	4	…paranoid thoughts can sometimes spark off voices, because you're thinking… talking to someone, and you get paranoid thoughts about them… that can sometimes spark aggressive thoughts, aggressive feelings and aggressive voices…Paranoid, you're in a state of… you're very, in a very vulnerable sit… state so what you try doing is, you know you… you get aggressive… it could be to pro… protect yourself yeh, it could be. It could be just to… to see who's the bigger man, you know.
	4	I was taking a lot of marijuana, sh…sh… bucket loads of marijuana, bucket loads of alcohol and a lot of cocaine and a lot of MDMA, so… you know, if you're taking that… Sooner or later your brain is going to go f… f… collapse, and mine did.
	4	You know, so you actually don't really realise that the drugs that you're taking is… are triggering this, you know, triggering all these paranoid depression, voices um… threatening behaviour, you know.
	4	… it's a lot better… And it's because I've dropped the drugs, you know. There's only one way about it, and that is because the drugs have gone out of my life.
	3	It may have been triggered by drugs, it may have been triggered by stress. I think it was a mixture of both.
	3	I think [the pain in my head]'s more to do with when my mind wanders on to something that it shouldn't. I think it, I th… I think it's linked to being wrong. I think it's… whatever I was thinking, what I'm thinking about, forget it. Just… that, it, it, it shouldn't even be there in the first place, you got to…
	3	I keep, erm… thinking about… er, my jaw, because erm… I was the victim of er, an assault, GBH? … like my jaw was broken and they re-wired it and stuff like that, and then… I had a court case, and they got convicted, the 3 of them got convicted… And that's, that's still playing on my mind, I've seen, I'm seeing the psychologist um, we're going through it at the minute.
	7	I think what was happening is, that I'm really fast at analysing body language and things like that and I think what I'm doing is I'm adding it up all really fast in my head and it was coming out as a voice…and the thing with the sunlight I actually looked that up about getting the sunlight in the head and it can affect your mind.
	7	I read parts about unleashing the reptile, reptilian side of your brain. Things like that… It's about opening your third eye. And you use the sunlight to do that.
	8	…then [John] dropped me off, after we'd been drinking we went to the train station and I went this way and he went that way and I got on the escalators. But as I'm going down the escalator I turned round and as I turned round, I thought to myself, "I swear he just took his wig off like, and then I thought, "No. Just keep going like." And then anyway, got on the bus … he got back on the bus with me as [David], like as himself and took a picture of me on the bus. Like on his Facebook there's pictures of me on the bus with him.
	8	And I started thinking that's what they're going to do. That's what they're going to do to me like. Because I called the police and that and I was raped and that and it all made sense to fit in with that programme.

Appendix 8

Educating others	2	hence why I want to do the, do these, um videos, to upload on Youtube about mental health, about my own experience, um… and the help I've received…. Hoping that someone out there can read it, and a lot of people don't have an experience that might understand a bit better what people, people are going through.
	4	If someone was to come to me now and say "look, you know I'm hearing voices," I would be like, "look, the best thing you can do is to ignore the voices and… stop drinking, stop using marijuana and stop doing whatever else you're doing because that's what's triggering it."
	4	you have to open up about it and say, you have to open up and tell them, the right person, that you're hearing voices. And they have to give the right advice, the right advice like, "alright, alright (name), alright patient, right what we need to do is you need to ignore these voices". That is so important to say that. Because they're there 24/7. If you got them, if you got like, if you… try and describe them and get rid of them, you know…. you gotta say look, you're using drugs you know. You, you know, you know, you need to quit the drugs… When you're going through so many emotions, you need someone there to be there, and to tell… give you the right advice.
	4	Er, hopefully every, every bit of information that I've given you, you know, you know it can help doctors, you know. It can help… it can help people that hear voices, you know.
	4	I really hope it does go forward and it helps people. You know, psychologists and nurses can listen to this you know, and it can really you know, it could really um… help them.
Master theme: FEP as a finite experience?		
Sub-ordinate themes	**Participant**	**Supporting quote**
Making a stand or managing better	1	…to be honest… it's happened, because it's happened before, it doesn't affect me that much anymore. Like, it doesn't have that psychological effect in me. Erm, I don't know, maybe it's because I've learned to deal with it.
	1	I guess, if they wanted to hurt me physically they'd have done it by now and… and they haven't. So I know that's not going to happen. So that fear's sort of gone.
	1	I don't let the words affect me or hurt me as they… as they have done in the past. Because I know that, firstly it's not true what they're saying about me, and secondly, why… why should I care about what they think?
	1	I think over time I've sort of built up that sort of… knowledge.
	2	Um, it almost feels like I'm… I'm cured.
	2	I think they just lessened. They, I mean, the content was very very strong and then it got to the point where I see the voices as my own, as my own… mind. And it, th, those voices was me thinking out loud sort of thing. Um… and I think that just from then, me thinking that my voices, my own voices were my own, um… just made things better as well. It just, they lessened, it was pretty much the same with the thoughts as well.
	2	I don't feel sick anymore. I don't even worry no more, I can go anywhere, and… and I'm having fun as well.
	6	…well, I have different ways of managing it. Um… I find that talking to people helps… about anything, just having a chat. That helps. Watching TV sometimes…. Er, reading. That helps a lot. And sort of, participating in sport as well helps a lot…. just, using my brain to do something tends to kind of… block it out, yeh.
	5	I have a plan now, so it's go back to school, and then move from Sweden again… so I am going back to Sweden and then

Appendix 8

		moving away from Sweden… the plan was the best… I think that's what helps me the most. that's why I'm not so scared… I now I try to eliminate all the dangers, all the dangers and how to live er… life, yeh…
	5	I'm less scared, and I feel better.
	4	I've completely changed my perspective, especially about drugs, it's… you know, they're… you know they're bad things… through my personal experiences now, through me having a bit of a smarter head on… on my shoulders, I decided not to do it… it's not about taking drugs and thinking it's smart and clever and getting into groups and taking… drugs with them. It's not about that anymore. When you hit 24 it's about, you know it's about other things… You grow out of them and where, as soon as I realised I wanted, I had to or I needed to stop drugs I just knocked them on the head, just totally gave them up.
	4	I just didn't know how to handle it, if I was to have a relapse now, I would be able to be a lot stronger…
	4	…it's me genuinely now, my brain thinking in… in a sensible, like civilised way now. And it's, it's a lot better… I can actually think like a normal person now.
	4	I won't put up with stress from other people anymore though… If you're going to come up to me and try and stress me out, I'll throw it right back at ya.
	3	…it's better that er… if you have a problem, to s… to do what you can now, because… To treat it, that's the early intervention team, so… It's best that, try and nip it in the bud now…. Before things gets worse because I don't want to go the next 20 years going through what I've been through. And then try and get treatment after because it's… it's a lot harder to, to recover, after… the longer it is.
	3	I've started to… shake out the cobwebs and think 'look, just get on with it'. [Laughs slightly].
	3	And… I think the medication helps. Er… I think getting back to… to your roots is a good thing. Getting back to… what you enjoy, who you, who you wanna… who you wanna do these things with… it's important to get out and exercise, and keep your brain stimulated as well.
	3	I'm definitely thinking and feeling and concentrating better than I have done for… many years.
	3	So I'm having to undo that in ment… mentally I'm having to un… undo it and say "no, that isn't the case, they wrote that because that is what they were doing".
	3	I'm not saying that my mental health isn't… is perfect, but it's a lot better to where it… It's improved. So I can see it from a better angle.
	3	It doesn't really make too… too much of a difference what I think. Because people cannot read your mind.
	3	…now I'm more, I'm like "I'm going to enjoy this". Try living life a bit, bit more to the fullest.
	3	Once I can get my teeth into something and start focusing on that, then that'll become my life. That's what I wanna do.
	3	… I don't want a stressful life, I just wanna wake up, do a nice job, get home, have a missus, get a few friends, do a few things I like... Before I was a bit more "it's gotta happen today!" [Laughs]. Yeah, the future's not going to wait! [Laughs].
	3	*It sounds like it's been quite gradual, that you've come to see things that way?* It's more layered. Definite like layer and a… maybe a knockback and… sort of like, s… s… more steady… some days I feel, some days I feel right, some days recently I've felt right as rain but… like, there's still a little bit in me that says "no, you've still got a long way to go"…perseverance is probably a good thing, like. Knowing, knowing that you c… probably can't get any worse.
	7	Now I do things. I really occupy myself so I don't really think about things a lot.
	7	Now I'm starting to get my old self back and I look back then and I feel like well, I'll never go back there. I'll never want to go

Appendix 8

		back to that again.
	7	And that's when I started calming down because I was hearing things that wasn't horrible all the time. Whereas when I was really ill, everything was negative…
	7	when I make music on my computer, I'm constantly thinking about the beat and the repetitiveness of the sound… my mind's thinking about what to do to the music rather than thinking about everything that's going on.
	7	My kids. I see them more. I help out with them because I'm not ill any more.
	7	Yeah [change] was gradual. With that heavy voice it was.
	7	Just a bit more outgoing. I give people a chance now, whereas before I just didn't want to know.
	7	I think it's something that I've built up inside. I don't know that. That's my coping strategy. You can't see it, but it's there. Something that I've built up inside and it's something that obviously I didn't have before when I fell really ill. Because obviously it was all new to me, hearing voices and it was scaring me, but now I'm used to it.
	7	If I'm out in public I'll ignore [the voice] and will not think about it. Especially if I'm working.
	7	My feelings are a lot more positive I suppose. Yeah. I feel quite special actually. I feel quite unique. And it's something that only I can really fully understand sort of thing, so yeah. I don't really have that much bad feelings about things any more. [I] live with it, yeah… I've actually been going to a few clubs and I would never do that when I was really ill. Like that many people and stuff. Now I don't care.
	8	[To dad]. "Like if it had happened to you and we was like, you'd understand how I'm feeling right now, but it hasn't so you just need to back off a bit and to leave me to it. I'm dealing with it. It's happened to me. It didn't happen to you. Let me deal with it."
	8	Writing stuff down does help a lot…I'd write down what I still believed in was true. And I'd shut the book and that'd be it and I could just think right, it's there. It's done. If anyone wants to know about it they can read it…but I've always done that. I've always put things down and when things get too much and you can't stop thinking about it, if you just write down, like and then sometimes you read back and you think to yourself, "Am I really worrying about this?" And then you just close it and if you want to pick it back up then you can pick it back up. But it's not there anymore. It's out your head. It's there.
	8	And it was just one of those things that I thought to myself, you've got to go out in the night time, so you go for a half hour walk in the night. Even though you're scared, but you're doing it. You come home and you think to yourself I made it. And then you wake up the next day and you think "But I've made it," and you go and do it again. You have to face your fears don't you otherwise …
Environmental and contextual modification	1	And then erm… that's when like, they decided, the early intervention team decided that um… I should like, move away from that place. So, it did take a bit of time, but eventually I did get my own place… And things did get a lot better.
	1	… I've got a good support network now…I've got friends that…know the situation now and understand, and it's good to have people round you that are supportive…. I know that, when, when, when… they do what they do and… at least I can go to somebody and say, look this is what's happened, and they can… I can talk through things with them, knowing that they're not going to be like, judgemental about it or, you know and give me that advice and that support sort of thing.
	2	I'm now, I'm living in [town name], now, which is a lovely area compared to where I was living before.
	2	And I was starting to get into regular sleep patterns, more sleep, and it was becoming… a natural eight hours sleep.
	2	I think the medication that I'm on now had a, had an impact altogether, not just on the sleep but on the voices as well.

Appendix 8

	2	I was doing more and more things in my life, and I started doing this Youtube for a hobby and um… I was really keeping myself busy to the point where I'd think 'do you know what, I'm not hearing voices anymore'. And I think that's down to the medication.
	2	And I don't think I've got any stresses to start that all up again.
	2	[I've] been doing a sort of like a CBT workshop. Fantastic. That was a great help, and it gave an excellent understanding of everything really, that was going on. It was also good to meet other people who were in exactly the same situation as you. You, you would listen to them, and you would think, yeah do you know what, that was me as well, and… It was, it was like a relief really, it was. I just, I could almost feel it really, releasing out of me. Sort of like being able to talk, it was like… going 'phew', sort of thing. It's just… it was like a pressure, it was like everything that was building up inside me was coming out, it was.
	2	so we're allowed to decorate now, and I've got lots to look forward to… it's just very very quiet there, and there's just no trouble. I live in a brand new building… I kind of got, to say hello to everyone and… we're a new, sort of like community there… I definitely think it's less… prejudiced.
	2	I was saying "look, can you come to this place or that place with me". And it got to the point where I could go on my own, because erm, I've already been with my family.
	2	I do feel safe now… I don't feel that anyone's watching me or… anyone's going to look at me and judge me and think 'do you know what, he's, he's a poof or anything like that… I definitely think it's less, less prejudiced.
	2	I'm at my mum's every day. I'm at, I'm there every day, I'm just, now I'm back here, I don't miss a day. It's just great um… I'm there every day. I take my mum to the hospital, to her hospital appointments, and… um, it's just good, I take her out and stuff.
	6	[The EI team have been helpful] …just to have someone to talk to about it, and be able to speak freely about what I'm experiencing, because it's not, it's not… sort of the usual sort of things that people experience, so… [laughs slightly]. [Psychologist] has given good suggestions about erm… what might be a possible expl… explanation for… why it might be happening. And also… she's helping me to… to, erm use methods to deal with the voices when they happen.
	5	…the financial situation was also bad… It is better now and I hope it will get even better soon.
	5	I think time itself… has made me forgot a lot about that but, and the medicine… I think that helps too… Er… Abilify.
	5	I have been clean for, from cocaine… for three years now… I didn't smoke weed that much, but I have been clean since… the psychosis… I think a year, I would say, yeh. [I have] a lot less [threatening thoughts].
	5	*What about meeting with the early intervention team?* Yes, that helps. To see that I don't get worse, that is doesn't get worse and… that for someone else to see me and make sure. Yeh, for someone else to see that er… I don't, I'm not sick and I don't fall back into the same pattern.
	4	…once a week I get a visit from the early intervention team. And er, it's good. It's good talk, it's allowed me to… the psychologist is very good… she asks questions, brings leaflets around, makes me fill questionnaires in and we try understanding things… Someone that… I could talk freely about stuff to… And keep me on the right path really, that was important you know, it was important to have weekly updates about me not taking… taking drugs or doing alcohol or doing anything that I shouldn't be doing.
	4	…people I really have that I can talk to is the psychologist and the nurse. And they're, you know, they're good people to talk to.
	4	I've gone 9 months without alcohol or drugs.

Appendix 8

	4	…sometimes I get down about it, and I try to go to my mum and… give her a hug and that…
	3	he put me in touch with the early intervention team. Then they started to see me from last June, so I've been working with them from last June.
	3	… I don't want a stressful life, I just wanna wake up, do a nice job, get home, have a missus, get a few friends, do a few things I like... Before I was a bit more "it's gotta happen today!" [Laughs]. Yeah, the future's not going to wait! [Laughs].
	7	[Coming to EI team has helped] a lot, I can't tell anyone about what's going on in my head, so at least I've got someone that I can, which has helped a lot…Just a lot of help, financially as well. Benefits. Moral support. Quite a lot of help actually.
	7	I found I was on quite a high dosage and I was drowsy most of the day and really sleepy… and then I lowered my dosage and ever since then I've been a lot better.
	8	Like even, a couple of people believed me, like when I explained to them and I was telling them about it, a couple believed me and that give me a bit more like, extra strength like, the ones that could think I'll have him like…
	8	Having a few people believe me, it kind of gave me like the break through the ice like, I feel like I was otherwise just trapped underneath it…and everyone was pushing me down. And then when people were saying like, "Oh I believe you like, that's terrible" like you felt like you could come up a bit and you felt like you had someone to support you…to lean on like. That you had someone to talk to, to confide in about it and they wouldn't backchat you and try telling you that you're wrong. And you were just easy like … it was like de-stressing…
Lasting remnants	1	I think the paranoid thoughts are always going to be there, they're not going to go, but they've lessened a lot. I still feel like sometimes I'm being watched.
	1	I still have trust issues, but it's getting better.
	1	The events are always, what happened, it's always going to be with me you know, I can't really erase it? And sometimes I do tend to think back…you know…
	1	Sometimes like, thoughts pop into my head. Um… now and again I get thoughts or feelings about the situation, about what's happened in the past.
	2	I think, me being a little bit down, is still there and… sort of like, there is a little bit of fear of, you know… it's almost starting on my life again.
	6	Although, some I… sometimes do still get the kind of feelings and… thoughts and… images toward, regarding that lady… and that evokes certain kinds of feelings in me sometimes.
	5	Er, I used to think about [threat from the gang] but now it's been…er six, more than six months so… I think about it sometimes…
	4	Like "keep tidy", and them voices… I do get them voices in my head, but normally it's the ones like "don't shout at my sister", [laughs]. You know, and them sort of voices which are very good, you know um.
	4	you know… someone looks at you, someone irritates you by… like I was saying earlier, erm… twitching or doing something, erm… giving off a sort of body language that erm you don't like… You might think 'oh, what an idiot' [laughs]. You know? But it ain't, they're not voices…
	4	I still get now that I think I do suffer from slight depression… I think depression's something that's um, got hold of me…
	4	I, still… still the banging of cutlery drives me flipping insane… it totally um, mucks up my thinking… it is so intruding…
	3	You might feel a little bit of jealousy… but it sort of like accumulates, d'you know what I mean? You've… got these rational, normal feelings that you'd usually have, and you'd usually dismiss them. But because of your problem, they're a lot more…

Appendix 8

		like in your face, sort of... I don't really wanna feel like that but… truth is yeh I do'.
	3	…there's still a little bit in me that says "no, you've still got a long way to go".
	7	And the voices, they're still there, but I don't really think about them too much.
	7	I think the rest … that the mind's just made it a bit better. And whereas before everything was negative what I was hearing and now it's positive.
	7	But if I come home and I replay things, that's when I think about things.
	8	You'll never forget it. It doesn't go away like. I'd say you probably think about it most days. But it's not like before, it used to be quite distressing like and whereas now you just sit and you think to yourself, it's more like, you know what's going on there and other people don't … you just, in a way you kind of feel like quite lucky that you know what's going on out there because you know to be more aware.

Appendix 9

This has been removed from the electronic copy.

Appendix 10

Summary of findings

Threatening thoughts in first episode psychosis: An interpretative phenomenological analysis of experiential perceptions of content, emotional distress, change over time and context

Background

Threatening thoughts, or *paranoia* and *persecutory delusions*, are among the most prevalent of psychosis characteristics. Key contemporary theories of their mechanism are cognitive, while one account takes a more social focus. Empirical research findings are rapidly improving current objective understanding of the cognitive, affective and contextual components of threatening thoughts; a minority of studies have investigated change over time. Some of this work has been extended to samples with a first episode of psychosis (FEP). However, the subjective experience of threatening thoughts has been largely overlooked in research to date, especially regarding FEP.

Study Aims and Objectives

The present study aimed to explore subjective experience of threatening thoughts in first episode psychosis, complementing quantifiable findings by adding details of the meaning and process of phenomena on each participant's experiential level. Three over-arching research questions addressed: thought content and emotional distress; the role of life events and context; change in experience over time.

Methodology

Eight participants were recruited from Early Intervention in Psychosis teams within [Trust name removed]. Each had current or recent experience of threatening thoughts as part of FEP. Semi-structured one-to-one interviews were conducted, audio recorded and transcribed. Data was analysed using Interpretative Phenomenological Analysis, which acknowledges the role of the researcher in the formation of themes.

Appendix 10

Results

5 master themes were identified that reflected recurring characteristics of all participants' experiences. These were: *Exposure of vulnerable self; At the limits of endurance; Elusive sense of agency; The urge to explain it all* and *FEP as a finite experience?* 16 sub-themes indicated specific elements of master themes that varied among individual narratives.

Discussion

Findings indicated the highly interpersonal nature of threatening thoughts and their role as a key organising factors in people's lives. Multiple kinds of physically and/or psychologically threatening thoughts were reported. Emotional distress was prevalent, and often appeared viewed as consequential to threatening thought content, overwhelming pressure of thoughts and linked hallucinations, an inability to stop them and the expectation of negative judgement. Finding meaning in their experiences seemed important for all. Life events and social environment identified as contributing to threatening thought manifestation included difficult relationships, substance use, online social interaction, contextual violence and discrimination. A sense of powerlessness amid these factors seemed frequently implied. Experience of change was often gradual and tentative. Reduction in distress and return of some sense of agency was commonly seen as linked to a perceived lessening of salience of thought content, and adaptation to experiences through familiarity. The latter factor highlighted the role of novelty in distress in FEP. Several participants expressed an awareness of regarding this most terrible of experiences as now over, rather than as the beginning of long-term psychosis.

Implications

Clinically, a focus on the interpersonal nature of threatening thoughts could be advantageous, as well as addressing distress directly through emotion regulation strategies. Theoretically, elements of both cognitive and social/relational accounts were supported. Potential future research includes further focus on agency and vulnerability in terms of social identity and positioning, and exploration of links between contemporary social networking and paranoia.

Appendix 11

This has been removed from the electronic copy.