

The Interpersonal Self  
in  
Early-Onset Psychosis:  
A grounded theory analysis

**Thesis submitted in part completion of the degree of  
Doctorate in Clinical Psychology at the University of Edinburgh**

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## DECLARATION

"I declare that I am the sole author of this thesis and that the work contained herein is my own. This thesis, or any part of it, has not been submitted for any other degree or professional qualification."

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## **DEDICATION**

To Graeme, thank you.

# CONTENTS

<b>TABLE OF FIGURES</b>	<b>4</b>
<b>1. ABSTRACT</b>	<b>5</b>
<b>2. RATIONALE FOR THESIS</b>	<b>6</b>
2.1. WHY THIS STUDY?	6
2.2. AIM OF THE STUDY	7
2.3. RESEARCHER'S POSITION	8
<b>3. INTRODUCTION</b>	<b>10</b>
3.1. THE PRODROME IN PSYCHOSIS	10
3.1.1. WHAT IS THE PRODROME?	10
3.1.2. HISTORICAL CONCEPTS	11
3.1.3. CURRENT CONCEPTUALISATIONS OF THE PRODROME	12
3.1.4. CLINICAL UTILITY OF THE PRODROME CONCEPT	14
3.2. CURRENT RESEARCH PARADIGMS	15
3.2.1. SYNDROME BASED RESEARCH	15
3.2.2. THE SYMPTOM APPROACH	21
3.2.3. PSYCHOTIC EXPERIENCE AS A SEARCH FOR SELF	25
3.3. INTERPERSONAL FUNCTION, DEVELOPMENT AND PSYCHOSIS	30
3.3.1. ANXIETY AS A CORE FEATURE OF PSYCHOSIS	30
3.3.2. WHAT IS THE RELATIONSHIP BETWEEN SOCIAL ANXIETY AND PSYCHOSIS?	30
3.3.3. EARLY DEVELOPMENT AND INTERPERSONAL FUNCTIONING	32

3.3.4. ADOLESCENCE	33
3.3.5. NO MAN IS AN ISLAND: THE DIALOGICAL SELF AND PSYCHOSIS	36
<b>3.4. RESEARCH IN PSYCHOSIS: POSITIVISM V. CONSTRUCTIVISM</b>	<b>37</b>
3.4.1. THE PROBLEM OF POSITIVISM	37
3.4.2. SOCIAL CONSTRUCTIVISM AS A CREDIBLE PARADIGM FOR RESEARCH	40
<b>3.5. SUMMARY</b>	<b>44</b>
<b><u>4. METHODS</u></b>	<b><u>45</u></b>
4.1. DESIGN	45
4.2. MEASURES	47
4.3. PARTICIPANTS	49
4.4. PROCEDURE	49
<b><u>5. RESULTS</u></b>	<b><u>53</u></b>
5.1. ANALYSIS OF PILOT INTERVIEWS	53
5.1.1. DESCRIPTION OF PROCESS	53
5.1.2. ANALYSIS	54
5.1.2.1. Interview 1	54
5.1.2.2. Interview 2	57
5.1.3. DISCUSSION	59
5.2. ANALYSIS OF THIRD INTERVIEW	60
5.2.1. DESCRIPTION OF PROCESS	60
5.2.2. ANALYSIS	61
5.2.3. DISCUSSION	63
5.2.4. QUESTION RE-FORMULATION	65
5.3. ANALYSIS OF INTERVIEWS 4 AND 5	66

5.3.1. DESCRIPTION OF PROCESS	66
5.3.2. ANALYSIS	66
5.3.2.1. Interview 4	67
5.3.2.2. Interview 5	76
5.3.3. DISCUSSION	82
5.3.4. QUESTION REFORMULATION	88
<b>5.4. ANALYSIS OF INTERVIEWS 6 TO 8</b>	<b>88</b>
5.4.1. DESCRIPTION OF PROCESS	88
5.4.2. ANALYSIS	89
5.4.2.1. Interview 6	89
5.4.2.2. Interview 7	98
5.4.2.3. Interview 8	107
5.4.3. DISCUSSION	115
<b>5.5. OVERALL THEMES</b>	<b>116</b>
5.5.1. A SURVIVAL PROCESS	117
5.5.1.1. A polarised past	120
5.5.1.2. Being defined by friendships	120
5.5.1.3. Developing a positive perspective	121
<b><u>6. DISCUSSION</u></b>	<b><u>123</u></b>
6.1. LIMITATIONS OF THIS STUDY	126
6.2. CLINICAL UTILITY AND FUTURE RESEARCH	128
<b><u>7. CONCLUSIONS</u></b>	<b><u>130</u></b>
<b><u>8. REFERENCES</u></b>	<b><u>131</u></b>

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9.1. APPENDIX I: INFORMATION SHEET FOR PARTICIPANTS	139
9.2. APPENDIX II: STRUCTURE OF EMERGING THEMES	141

### **Table of Figures**

Figure 1: Thematic Structure: Participant 4.....	68
Figure 2: Thematic Structure: Participant 5.....	78
Figure 3: Thematic Structure: Participant 6.....	91
Figure 4: Thematic Structure: Participant 7.....	100
Figure 5: Thematic Structure: Participant 8.....	109
Figure 6: Hypothesised thematic structure of psychotic process.....	119



## **1. Abstract**

The prodromal phase has been conceptualised as a discrete phase in the disease process relevant for its 'warning' status. Recent psychological and medical research has suggested that intervention during this period may be beneficial. However, the phase is not well understood and definitions of it are both vague, referring to non-specific changes in interpersonal and intrapersonal functioning, and symptom led. The aim of this study was to explore how young people construct this period and how this may contribute to our understanding.

Using a social constructivist approach and grounded theory methodology, eight people aged between 18 and 23 who had experienced a first episode of psychosis were interviewed sequentially.

Analysis suggested that in this sample the self was described in interpersonal terms. The experience of developing psychosis was not considered by the sample as a series of discrete phases but as a process of survival over adversity. Two strategies emerged for this survival process, defined by the relationship between psychosis and self. Self-concept appeared to be a mediating factor and individuals vacillated between these two strategies. Survival and recovery was defined as re-establishment of interpersonal relationships, mainly with peers.

The research suggests that psychosis may best be understood as a struggle for self. The interpersonal nature of self may be a feature of developmental stage and/or predisposition to psychosis.

## **2. Rationale for Thesis**

This thesis explores interpersonal processes as an aspect of the psychosis prodrome using a qualitative design and a grounded theory methodology. The author has chosen this area of study and this design for a number of reasons. This first section gives a preliminary rationale for the study area and design in recognition that it is being conducted as part of a clinical psychology qualification, a discipline that has endeavoured to uphold the positivist paradigm<sup>1</sup> in its research practice. In keeping with the qualitative tradition, a statement of personal interest and intent is included in this section.

### **2.1. Why this study?**

In my third year of training, when this thesis was written, I worked in an early intervention service for young people with psychosis. Despite the high levels of experience, training and openness of the people working in this team, it seemed that we were not providing an early (primary) intervention service but a tertiary prevention service, i.e. one in which work was focused on limiting duration of the and minimising the longer-term secondary handicaps associated with a severe and enduring mental illness. Although the prodrome was frequently discussed, it was always in retrospect, as we infrequently received referrals for anybody who wasn't already acutely psychotic. It became evident that the prodrome was discussed only as an indicator of impending psychosis and was not considered inherently meaningful in the development of a first episode of early-onset psychosis. Encouraged to work in a

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<sup>1</sup> The positivist paradigm is based on a philosophical position that knowledge can only be derived from that which is observable, and therefore argues against the search for first causes that can only be inferred. It assumes that what can be observed and measured is an objective reality.

developmental way with individual cases by my supervisor and taught to consider the underlying structures for behaviour, thought and feeling, I was surprised that none of this was taken account of when the prodrome was being discussed.

A recurring theme during the period before an individual becomes acutely psychotic is the development of social isolation and anxiety. This seemed almost universal and clinically presented as one of the most enduring problems and the main reason that we were unable to help young people on to the next stage of their lives. This theme, therefore, seemed a possible focus for my third year thesis, and was justified by the literature around this area.

## **2.2. Aim of the study**

The aim of this study is to explore the role of interpersonal processes in young people's understanding of the psychosis prodrome. This will be attempted through a qualitative analysis of interviews with young people who have experienced psychosis.

The literature relating to the prodrome in psychosis will be used to explore the clinical and theoretical utility of the prodrome concept in understanding psychosis. Alternative theories of psychosis and the prodrome (though not universally defined as such) are presented and critiqued as a means of broadening the realm of possibilities in prodrome conceptualisation.

Semi-structured interviews with individuals who have experienced a first-episode of psychosis will involve an exploration of their lives in the years before their first involvement with the early intervention service. This exploration may include the role of interpersonal relationships in creating an understanding of the experience of developing psychosis. As

themes emerge from analysis of these interviews, they will be explored through subsequent interviews and reference to literature.

A model will be proposed that makes use of the existing literature and the evidence gained from this piece of research. It will aim to be conceptually strong and to provide a framework for further research and theory.

### **2.3. Researcher's position**

I have been interested in psychosis since studying psychology at school, finding the symptoms fascinating because they seemed to represent the outer limits of imagination and creativity (psychosis being defined for me at this time by its depiction in case studies, films and art). Working in the voluntary sector for a self-help group of people with bipolar affective disorder and in the NHS as a volunteer at a day centre for people with severe and enduring illness, my enthusiasm for working in this area increased, as did my sense of injustice about society's response to these individuals. However, I also saw that the relationship between individual sufferers and their clinicians could bring comfort and reassurance and that this was valued as something quite separate from the sometimes sub-optimal treatments.

Since working within psychiatric services as part of my training I have at times found that, at a service level, our approach to understanding and helping people with their difficulties can sometimes reinforce those very difficulties. Whilst I recognise that we are constrained by the resource limitations of the service, it also seems that the way we conceptualise the difficulties of an individual with psychosis might be for our benefit rather than that of the individual.

I am keen to challenge this approach with a more holistic framework that places the individual at the centre of their own experience, and which accommodates the multitude of evidence suggesting that psychosis is not just a brain disease but like any human experience a result of a multitude of interacting influences.

### 3. Introduction

In this literature review I will consider historical and current theories about the prodrome. A brief review of the dominant paradigm in psychosis will provide a context for exploring alternative theories about psychosis and the prodrome. Developmental models, adolescence, and interpersonal processes in the context of psychosis will be reviewed. Finally, a discussion about the underlying theoretical perspectives in psychosis research will be presented, and will provide a platform on which a rationale for this study will rest.

Both psychosis and schizophrenia will be referred to in this literature review. In general, the term *psychosis* will be used, as this review will attempt to address issues relating to the whole experience of psychosis rather than adhere to diagnostic classifications or their specific criteria. Where research or theory is cited that refers specifically to *schizophrenia*, or another diagnostic term, that term will be used. In this thesis, the term *psychosis* covers any emotional disorder that might be considered to fall into the psychosis spectrum, and which, in diagnostic terms, might be described as schizophreniform or bipolar disorders. This allows for a broader exploration of the prodrome in psychosis and accommodates the population from which a sample will be drawn for this research.

#### 3.1. The Prodrome in Psychosis

##### 3.1.1. What is the prodrome?

The concept of the prodrome dates back to the early classification of psychosis by Kraepelin (Bentall, 2004). In psychosis, this concept evolved jointly from an awareness of problems or symptoms prior to the onset of an acute episode and a medical or disease perspective of

psychosis. In the past 10-15 years, there has been increasing emphasis on this period of the psychotic course as a means of establishing preventative treatment. This has been a response to a body of research highlighting the Critical Period Hypothesis (Birchwood, 1998), which suggests that intervention in the first two to five years after the initial onset of psychosis can have a long-term positive effect on outcome. In all fields of medicine, health models have been progressing towards a preventative approach in recognition of the spiralling costs of treating established and chronic disease. This has provided an economic and cultural context for mental health research also. Early intervention for psychosis is now a government target.

### **3.1.2. Historical concepts**

We should lay great stress on the prompt investigation of failing adjustment, rather than ... waiting to see what happens. (Sullivan, 1962, p.105)

Sullivan, coming from a psychodynamic perspective, criticised the contemporary psychiatrist for having a static view of “schizophrenia as a strange entity which befalls the predisposed”. He argued instead for a dynamic conceptualisation. He observed that the individual with psychosis would have a long history of adjustment problems and prior to psychosis would likely experience a “psychoneurotic” or anxiety condition. This concept was also supported by Kubie (1971) who regarded psychosis as an extreme point in neurotic illness, and believed that people could, through treatment, be returned to a neurotic state and from that point cured.

Sullivan described the prodromal stage as one in which the symptoms of psychosis develop. He gave what would now be considered a cognitive model of delusion formation (Morrison *et al.*, 2004) as an example of the process by which an individual misinterprets experience and responds in a way that provides a defence for the individual against perceived threats and

which responses increasingly appear to others as psychotic phenomena. According to Sullivan (1962), the individual in the final stages of the prodromal phase may appear to show marked psychotic features. This culminates in onset of the acute episode, which may not always be distinct from the rapidly deteriorating final stages of the prodrome, in which the individual's entire cognitive efforts are focused on the elaboration of the delusional state. He identified key features of the prodromal period: depression, perplexity and fear-states.

The belief of these early promoters in a preventative approach through accurate identification of the prodrome was debunked as the psychodynamic model fell out of favour and research into psychosis became focused on psychopharmacology for symptoms, corresponding with a drop in interest in aetiology. Psychodynamic conceptualisations of psychosis were not obviously amenable to quantitative research methods, the efficacy of psychodynamic treatment of psychosis was challenged (Mueser & Berenbaum, 1990), and the language used to describe the process became unfashionable. As a result the concept of psychosis onset as dynamic, as having its basis in earlier psychological difficulties, and as being influenced by environment or 'extrinsic reality' (Sullivan, 1962, p.107) was abandoned by the majority.

### **3.1.3. Current conceptualisations of the prodrome**

In 1990, McGorry *et al.* argued for a paradigm shift in the conceptualisation of psychosis. Attempts to draw together clinical presentation and aetiology had been unsuccessful, and the idea of a single neuropathology contributing to a range of psychotic symptoms (pleiotropism) was probably defunct. Attempts to create a limited categorical system within the spectrum of psychosis had also been unsuccessful and McGorry *et al.* remarked upon the surprising survival of the Kraepelinian dichotomy, despite an absence of supporting evidence.



They suggested an alternative paradigm that accepted an unknown origin within the brain and which focused instead on the assessment of process and outcome across the spectrum of psychosis. This, they argued, would stimulate new knowledge, allow advances in treatment and might even contribute to an understanding of aetiology, and a new paradigm.

This article makes an interesting and compelling case for abandoning the disease concept of psychosis, yet at the same time argues for its continued pursuit through abandonment of the core task of establishing aetiology. The bountiful literature considering the non-medical influences on psychosis development and maintenance such as family, social environment, economic climate, developmental stage, coping and cultural factors is re-framed as contributing to an understanding of disability and handicap resulting from the initial impairment of the psychotic disease (see McGorry *et al.*, 1990, for a review of this literature). It refers to the problematic nature of diagnosis that relies on a combination of impairments, disabilities and handicaps.

This would appear to be an attempt at parsimony; if psychosis is stripped bare of all its secondary handicaps such as depression arising from stigma and isolation, disabilities such as not being able to work, the remaining clinical picture should be one of a pure disease process. Within this context, modern medical research on the prodrome has flourished – without reference or heed to a possible aetiology, and with regard to development as a largely irrelevant notion.

This might appear to be a return to the positivist origins of the medical model by attempting to measure only that which is observable and not attempting to infer causality from those

observations. However, not all observable data is used, specific 'symptoms' being identified as more pertinent than others. In addition, the search for aetiology has not been abandoned because such a quest deviates from the positivist paradigm but because an organic aetiology cannot be found.

### **3.1.4. Clinical utility of the prodrome concept**

...non-specific changes in mood, behaviour and thought in the days, weeks or even months before the florid episode. (Cutting, 1985, p.179)

The definition above reflects both the observable truth and the fact that the prodrome to the first episode of psychosis is only ever recognised in retrospect. When clinicians take recent histories from families and other professionals, the report they often get is of non-specific changes in behaviour. This lack of specificity is a pervasive problem in conceptualisation of the prodrome and severely limits its clinical utility. The definition above could refer to most people at some time in their lives. This definition assumes that normal adults are constant in their thinking, emotions and behaviour. Defining non-specific changes further by using only observable quantifiable symptoms becomes a fruitless quest for symptoms that will not differentiate the individual from either the normal population or from others with a non-psychotic psychiatric disorder.

Nevertheless, there is a recognition that successful identification of prodromal symptoms could result in earlier treatment, predicting shorter, less severe illness and lower chronicity (Larsen *et al.*, 1996). Intervention during the prodromal period or immediately at onset has the aim of reducing the secondary handicaps associated with psychosis, i.e. stigma, affective disorders, and disruption to social and occupational functioning. This is consistent with a

dynamic concept that psychosis follows a trajectory of severity in which the earlier the intervention the more successful the outcome. Consistent with this, research into specific disorders, such as bipolar affective disorder, have revealed specific and unique symptoms that have aided intervention (see Jones et al (2005) {Jones, 2005 #202} for a review).

Therefore, the prodromal stage, whilst not appearing to have current clinical utility, is considered to have great potential for preventing or delaying onset and therefore reducing prevalence and minimising disability arising from psychosis. This provides a strong argument for researching the prodrome in order to establish its exact nature, and there is an ever-increasing body of research addressing this. This research is reviewed below.

## **3.2. Current Research Paradigms**

### **3.2.1. Syndrome Based Research**

Syndrome based research is historically and currently the dominant model for psychosis research. Following the publication of a review by Yung & McGorry (1996a) there has been a significant paradigm shift away from trying to establish aetiology and towards accurate identification of the prodrome. This focus has been taken up by a number of large research programmes across the world including PRIME (McGlashan *et al.*, 2003), EPPIC (McGorry *et al.*, 1996), TIPS (Larsen *et al.*, 1996), the CER Project (Klosterkötter *et al.*, 1997) and the Edinburgh High Risk Study (Johnstone *et al.*, 2000), and has involved the development of a multitude of different quantitative measures identifying presence of symptoms (e.g. Klosterkötter *et al.*, 2001; McGlashan *et al.*, 2001). This body of research rests on the

assumption, consistent with the medical model, that psychosis is a distinct psychiatric illness marked by discrete stages.

Yung & McGorry (1996b) have attempted to clarify the staged course of psychosis with a progressive model of the prodrome marked by increasing evidence of symptoms developing from: patient notices change in self - family/friends notice change - patient notices psychotic symptoms - others notice psychotic symptoms - first psychotic intervention. McGlashan *et al.* (2001) described this process slightly differently: early-premorbid – late premorbid – prodromal (symptom formation and disability have begun) – onset – post onset. This appears to conflict with Yung & McGorry's model as psychotic symptoms form a necessary feature of the prodrome, whereas non-specific, pre-symptomatic features are sufficient for Yung & McGorry's model.

These are purely descriptive models of psychosis onset and lack specificity. However, they were intended to provide a framework within which future prodrome research could take place (though it is not clear how they differ from previous descriptions of the course of psychosis).

Research into the nature of the prodrome has established a great number of different prodromal signs. Smith & Tarrier (1992) identified 40 possible prodromal signs to 'manic-depressive psychosis' covering a range of cognitive (e.g. worrying a lot), metacognitive (e.g. thinking my thoughts are controlled), emotional (e.g. feeling sad), physical (e.g. lots of aches and pains) and behavioural (e.g. neglecting hygiene and appearance) signs, and noted that in addition to these common symptoms, participants reported a number of idiosyncratic symptoms as well.

Yung & McGorry (1996a) explored prodromal symptoms in twenty-one participants with a wide range of psychotic disorders and found thirty-nine symptoms, again bridging cognitive, physical, behavioural and emotional domains. Three of the most common symptoms were affective: anxiety, anger and depressed mood. The PRIME group (Miller *et al.*, 1999) reduced the items down to nineteen symptoms falling into four categories complying with Liddle's (1987) three-dimension categorisation of psychotic symptoms: positive, negative and disorganisation, with a fourth category – general symptoms – to accommodate miscellaneous symptoms. The rationale for this reduction is clear; the aim of quantitative research is to reduce large amorphous phenomena down to specific, utilisable constructs. Unfortunately, their reduction minimised specificity. For example, 'decreased expression of emotion' and 'odd behaviour or appearance' do not provide any quantifiable or specific idea about what would constitute a prodromal presentation and what would differentiate this from any other stage of psychosis.

The stage models also create an apparently arbitrary split between psychotic and other symptoms or signs, and characterise the course of psychosis as one-dimensional and one-directional. This creates a non-interactive conceptualisation of prodromal signs. When these signs are all considered as equal in significance such that the more signs an individual has, the greater their chances of developing a psychosis, specificity remains very limited. However, if the signs were conceptualised as interacting with each other, such that, for example, excess worrying causes sleep disturbance which causes fatigue, amotivation and de-realisation, a worsening and increasingly complex picture of problems can be seen that is dynamic, meaningful and manageable. This approach requires an acceptance of

psychological variables as fundamental to the development of psychosis, which challenges the status of psychosis as a purely organic disease, separate from affective disorders.

Observable symptoms might be considered the tip of the iceberg in psychosis. Contrary to the medical model of psychosis, a psychological model would hypothesise that deeply distressing thinking styles and the accompanying coping behaviours do not come from nowhere – it would be logical to think that, like any other psychiatric condition it has distant roots and a progressive increase in depth and breadth of manifestation (and this can be seen in psychological model of bipolar disorder, for example). On this basis, accurate measurement of the prodrome through measurement of observable symptoms taken over a limited time period is necessarily flawed. Despite this the prodrome as ‘first noticeable symptoms’ is the pervasive definition used in research.

Confusion exists as to whether psychosis can be separated into discrete stages and if those stages are then meaningful. For a prodrome to work as a discrete stage it must be differentiated from and provide a gate between being well and being ill. Therefore, in psychosis, it is necessary to identify a time when the person had no symptoms that might have been indicative of a future psychosis. Mental health problems prior to onset of psychosis are very common. More than 80% of McGlashan's (2001) sample had a psychiatric history, 90% had received psychotropic medication from their physician, and 60% had received psychiatric diagnoses. In Klosterkötter *et al.*'s (2001) study, the participants had been gleaned from psychiatric clinics and were all eligible for alternative diagnoses at the start of the study including personality disorders, obsessive-compulsive disorder and a range of depressive and anxiety disorders. The reason for this may have been pragmatic – thousands of people would have to be recruited from the general population to identify a

substantial number who would actually develop psychosis (though a much smaller number would be needed to identify prodromal symptoms). However, this decision is also consistent with Jaspers' (1962) distinction between schizophrenic and non-schizophrenic symptoms, the former 'trumping' the latter, so that affective disorders occurring prior to psychosis are viewed as potentially indicative of a psychotic process and those occurring once psychosis has been established as a secondary handicap, a result of schizophrenia rather than a core feature of the psychotic experience.

Adherents of the Kraepelinian model of psychiatric disorder would see the logic in this distinction, but approached from a psychological perspective it appears arbitrary. A categorical distinction is made between affective and psychotic disorders despite overlap in symptoms and early non-organic risk factors (e.g. abuse, poverty, difficulties at school). Co-occurrence of affective and psychotic diagnoses suggests that the two are not mutually exclusive.

Bentall (2004) has comprehensively argued that the Kraepelinian concept of dichotomous diagnosis - schizophrenia and manic depression - bears little relationship to the clinical presentations of individuals with psychosis. From a research perspective, this has been a problem that has not been adequately addressed. Some researchers have used strict inclusion criteria based on diagnostic interviews and have therefore run the risk of over-specifying their sample and limiting generalisability whilst basing this specification on a sub-optimal classification system. (e.g. Smith & Tarrier, 1992). Other researchers have included participants with any diagnosis of psychosis but have pursued an examination of the observable symptoms whose only use was to delineate between specific psychoses, thus risking under-specificity and atheoretical constructs (e.g. Klosterkötter *et al.*, 2001; Yung &

McGorry, 1996b). Difficulties seem to lie in both the use of a staged disease model to describe the psychotic process and in the simplistic use of observable symptoms to define those stages.

It could be argued that psychosis does not have its origins in an organic deficit. This would explain why no specific organic cause has been found but would mean that psychosis can no longer be considered as a disease or medical problem. An argument against this position is the efficacy of medication such as Olanzapine in the prodromal and acute phases of psychosis (McGlashan *et al.*, 2003). However, though there are hypotheses about how Olanzapine has a specific anti-psychotic effect, its most obvious effect is to sedate the individual. It is possible that the main effect of medications such as Olanzapine is to reduce distress and lability of mood, which in turn might have an effect on psychotic experience. If this hypothesis was correct, it would suggest either that psychosis has its origins in affect regulation or else that the relationship between neurochemistry and symptoms is mediated by mood rather than symptoms affecting mood, as has been assumed within the medical model.

Following this line of argument, the disease concept could be abandoned and symptoms could be considered only as observable manifestations of affect dysregulation (which may or may not have some physiological origin). This might contribute to an understanding of psychosis that would be more meaningful to the individual.

Morrison *et al.* (2004) argue that characterising distressing psychotic symptoms as part of an illness (with no physical manifestation) contributes nothing to the individual's understanding of what is happening to them. People rarely attend initial appointments with psychiatric services with self-reported 'delusional ideas of reference' and 'auditory hallucinations', but



may instead express strong emotions relating to significant changes in their experience. A psychological symptom based approach was designed to address the problems inherent in the diagnostic approach to psychosis (Bannister, 1968, in Morrison *et al.*, 2004).

### **3.2.2. The symptom approach**

The premise underlying this area of research and practice is that psychosis is, in essence, a biological event over which the individual ultimately has no control, and which has many psychological consequences that can, to some extent, be minimised through effective coping.

Cognitive therapy is compatible with this position, having its roots in providing treatment for medically diagnosed psychological conditions such as depression. Given that the medical model still provides the dominant treatment approach, it can be helpful for the individual with psychosis if clinicians involved in their care provide a unanimous message about the nature of psychosis, and it is a common assumption amongst clinicians that describing psychosis as a disease over which the individual has no control effectively removes blame and therefore is a comfort to the individual (Fowler, Garety & Kuipers, 1995).

However, adherence to this principle does not successfully overcome the difficulties of the medical model. Firstly, it is based on individual medically defined symptoms such as auditory hallucinations. As most patients experience more than one psychotic symptom (they would otherwise not be considered psychotic), this means that multiple models must be used to explain their symptoms and treatment may lack coherence for the patient (Morrison *et al.*, 2004).

Difficulties could be conceptualised differently in order to address a number of different symptoms consecutively and in a manner that would be meaningful to the patient. Morrison *et al.* (2004) argue that the formulation approach to psychosis addresses this problem by using a single cognitive model that can explain any symptom and which can account for the origin of those symptoms without recourse to a biological aetiology.

Cognitive models developed in the past 10 years have focused on two main areas. The first area is management of specific symptoms, such as hearing voices (Morrison *et al.*, 2004), and is aimed at reducing distress associated with them by increasing understanding of the symptom and developing cognitive coping strategies. The second area of focus is combating 'secondary handicaps' such as anxiety and depression (e.g. Birchwood, 2003) through developing explanatory models of emotional dysfunction and the adaptation of existing cognitive models of anxiety and depression for psychosis.

The focus of these cognitive models is on current difficulties and the prodrome is not referred to at all. However, in developing a formulation with the patient, early experiences contribute to the formation of beliefs and dysfunctional assumptions that predispose the individual to difficulties. A critical incident is believed to trigger these assumptions and negative automatic thoughts, which then contribute to a search for alternative explanations and external-personal attributions, or over-valued ideas/delusions. These ideas are then reinforced and maintained by cognitive strategies such as selective attention, memory changes and interpretation of ambiguous stimuli.

This conceptualisation of the development of psychosis has many advantages. It may allow an explanation that would be acceptable to the individual and as with cognitive models for

other psychological disorders implies a treatment plan and the possibility of recovery. It also brings psychosis back into the domain of psychological problems historically thought of as neuroses – depression, anxiety etc.

However, there are difficulties with this theory in terms of its management of the onset. The critical incidents referred to either do not imply such a catastrophic outcome as psychosis (e.g. doing badly in exams) or are a symptom of current psychological difficulties rather than future ones. For instance, the evidence that drug, and especially cannabis, misuse precipitates psychosis is based on the assumption that drugs cause psychosis rather than being used to cope with psychosis. Since the model does not identify a particular set of circumstances around the onset or in the background that separates psychosis from other less pervasive psychological difficulties, it could be suggested that the model assumes much more vulnerability than stress and perhaps might only apply to a sub-section of the psychosis population. However, the authors might argue that this difference is simply a matter of pre-conceptions about psychosis, a failure to accommodate the normalisation literature and an ignorance of the level of disability experienced by some individuals with non-psychotic psychological problems (Morrison *et al.*, 2004).

Problematically, Morrison et al's (2004) model assumes that one or two co-existing events will qualify as a critical incident. In practice, one tends to see a pattern of events contributing to a picture of vacillating deteriorating function. These events may be chronic or acute, minor or major, and whilst the more immediate and significant events would certainly feed into unhelpful beliefs about the world and self, many of these events appear to be the result of deteriorating function, such as falling out of college or employment, becoming socially

isolated, and experiencing cognitive difficulties such that ordinary living is becoming challenging.

Therefore, whilst this model moves away from the rigid and non-explanatory medical model of psychosis it appears to both over-simplify and under-estimate the circumstances around the onset of psychosis. Its explanation of the role of the critical incident as presumably triggering the prodromal period neither adequately demarcates the prodromal period nor offers a compelling alternative dynamic explanation. Psychosis appears to have been shoehorned into the cognitive model, in contrast to other psychological problems such as anxiety, which appear to be well defined by this model.

The cognitive approach, with its focus on symptoms, maintains a disease concept in which symptoms are pathological or maladaptive. This misconstrues human behaviour. Arguably, human behaviour is basically adaptive, as survival of the human race is the ultimate goal. From this perspective, apparently anomalous behavioural or cognitive responses, when seen in a holistic context, are meaningful and useful. The symptom approach, by contrast, perpetuates the medical practice of splitting symptoms or responses from the individual and classifying those responses by criteria external to the individual (such as a diagnostic tool or psychological model).

It might appear from this discussion that a cognitive approach is not appropriate for psychosis, but this interpretation would underestimate the value of cognitive approaches in treating psychosis. The development and maintenance of beliefs through cognitive processes is a key theme in psychosis, and this model has much to offer in respect to that. However, this model, with its deliberately current symptom focus, fails to address the subtle but

important underlying factors that must contribute to the process of psychosis. There are, however, an increasing number of cognitive models specifying processes such as metacognitions (e.g. Morrison et al, 2003{Morrison, 2003 #203}) and personal beliefs (e.g. Morrison et al, 2005{Morrison, 2005 #204}), which allow for a more dynamic and subtle explanation of the psychotic process. There is still lacking, however, a compelling developmental model that fully explains the nature of the pre-onset and onset phases.

### **3.2.3. Psychotic experience as a search for self**

Psychodynamic theories from the 1960s explored the nature of adolescence and psychosis in an integrative style, referring to developmental factors creating a predisposition to psychosis that was triggered by adolescent crisis of ego development (e.g. Erikson, 1968; Kubie, 1971; Sullivan, 1962). In these theories, development of the self was seen as pivotal to successful maturation, and failure to develop a coherent self was catastrophic.

These theories were recently revived in a thesis by Harrop & Trower (2003), in which many features of psychosis were related back to the core tasks of adolescence. This work provided an explanation for why adolescence should provide hothouse conditions for the development of psychosis.

They posit that adolescence is dominated by the development of the self. Self is conceptualised as comprising three elements: the objective self, the subjective self and the other. The subjective self and our concept of the other both contribute to the development of the objective self and must coincide for an integrated adult self to emerge. Therefore, the adult self is partly developed through interactions with others. In psychodynamic theories,

the self has a moral and developmental basis (e.g. Freud's id, ego and superego; Berne's child, adult and parent, both in Nelson-Jones, 2001).

Key themes represent the separation of the adolescent from his or her parents and the development of a new identity that accommodates the needs of the individual and others. Self-development is impaired if early experiences or personal deficits contribute to an imbalance in the cohesion of the three elements of self. The *insufficient self* lacks interpersonal skills, and fails to meet their own needs or consider the needs or wishes of others and cannot learn effectively from interpersonal experiences. An example of this might be the individual with autistic features. The *insecure self* has an over-idealised sense of self and cannot incorporate the needs and wishes of others or the environment into this, often resulting in rejecting or unwished-for responses from others. This means that the subjective self and the other do not correspond often enough for the objective self to develop a single self-concept. The *alienated* or *engulfed* self, by contrast, prioritises the needs of the other over their own. This may arise if the primary caregiver gives conditional and/or unpredictable praise or recognition. The individual is unable to develop a reference to their subjective self and has an unstable perception of the wishes and needs of the other. An objective self cannot develop in this. Where an objective self has not successfully developed, the individual cannot successfully complete the separation from their parents and integration into the adult environment.

These different types of self are understood to be reflected in the beliefs held and interpretations made by individual with psychosis. The hypothesised selves were explored through structured interviews with twenty-one people aged 17-45 years. Interviews were analysed for examples of the objective self, subjective self and other, and from this two

themes emerged: the inhibited self and the ‘anger expressers’ (who felt compelled to express their self to the exclusion of others’ needs). A small third group emerged who inhibited *and* expressed, creating conflict for the individual. Specific symptoms such as voices, for example, were understood to arise from excessive angry rumination. In general however, the analysis focused on interpersonal aspects, attributions and beliefs, rather than symptoms traditionally understood to be psychotic.

This theory may explain why interpersonal deficits are so frequently seen in young people with psychosis, the early age of onset, and why so few individuals who develop psychosis succeed in leaving the parental home without support. It considers the failure of self-development as catastrophic because the individual is forced, ultimately, to recreate reality to accommodate their fractured sense of self in the context of the outer world (and in this respect differs from earlier psychodynamic theories in which disintegration of the ego was viewed as resulting in a loss of objective reality). The theory, by its nature, rejects any conceptualisation of pre-morbid, prodromal and acute phases. It views the onset of psychosis as an adaptive reaction rooted in the earliest experiences of the individual, in which the developmental process is impaired through early experience and collapses when this impairment prevents accomplishment of the key tasks of adolescence.

This theory also represents a rejection of the symptom-based approach to understanding psychosis. Whilst their research explores the content and meaning of symptoms in the context of their model, the symptoms are regarded as a manifestation of underlying problems. These problems underpin not only ‘psychotic’ symptoms but also those symptoms typically thought of as ‘secondary handicaps’ such as depression, anxiety and low self-esteem. This sets this theory apart from other contemporary explanations of psychosis. When thinking

specifically about the prodrome, it has been seen that much of the confusion over the nature and timing of the prodrome is due to a focus on the observable symptoms rather than meaning of the experience.

This theory would arguably have more clinical utility if it could offer some specificity about the nature of onset in terms of likely precipitants and qualitative changes in the individual's experience. From this starting point, however, exploration of specific processes within the development of psychosis could be considered.

Parnas (2003) has attempted to do this, albeit from a medical perspective. He notes that the original descriptions of psychosis by individuals such as Janet and Bleuler (Bentall, 2004) referred to a disintegration of the self, but that in recent thinking this concept has fallen out of use and been replaced with symptom-focused research. Parnas gives a descriptive account of the ways in which self can be seen to disintegrate in the pre-psychotic individual, and suggests that aetiology starts at birth and may have some neuro-biological basis. However, he sees psychosis, in its broadest sense, as best conceptualised as neither affective nor organic disease, but as a self-disorder. His evidence, based on a retrospective study of the prodromal period, uses standardised measures and in-depth analysis of specific cases (Parnas, 2003; Parnas *et al.*, 1998), which illustrate how symptoms describe an existential crisis played out in themes of corporeality, consciousness, self-demarcation and solipsism.

Scharfetter (2003) reports on the development of the Ego Pathology Scale from which he has explored how symptoms evolve from disordered self-experience. He argues that 'the acute and severe experience of a loss of or disordered self-experience does not allow auto therapeutic, self-rescue strategies or defensive, adaptive, coping efforts' (p.278) and that



consequently there is a basic uniformity to symptom presentation reflecting the limited primitive responses available to the individual. This does not seem entirely accurate. Broadly speaking, there are similarities of symptoms across individuals such as auditory/visual hallucinations and delusional/over-valued ideas, but the content and meaning of these symptoms within the individual tend to be highly sophisticated, specific to that individual and very much about survival strategies described by Scharfetter - defence, adaptation and coping. His methodology is rigorous and his theory is rooted in observable signs whilst moving beyond to the underlying meaning, creating a sense that the individual with psychosis is still a whole person to those around them, even if they do not feel whole in themselves.

The potential of Scharfetter's work is restricted however by the development of a hypothesis within the positivist paradigm; such that specific interview questions have been used to confirm his hypothesis about ego pathology rather than allowing free self-report to guide his thinking in new directions. Furthermore, ego pathology is understood as a self deviating from what is generally understood to be normal. This conflicts with Parnas' philosophy of self as a highly individual experience, and Harrop & Trower's (2003) self, in which its nature is not elaborated upon, presumably because self cannot be prescribed.

Scharfetter's predicament underlines the limitations of considering the experience of psychosis within the medical positivist paradigm. Underlying themes and explanations for psychosis always return to a description of deviation from the norm.

From this exploration of the self in psychosis, two related aspects emerge that are pivotal to these theories and which offer a greater understanding about how the self can so dramatically

collapse. Interpersonal development and adolescence can be viewed as distal and proximal factors in risk for psychosis, and their relationship with psychosis are considered below.

### **3.3. Interpersonal Function, Development and Psychosis**

#### **3.3.1. Anxiety as a core feature of psychosis**

It has already been demonstrated that interpersonal problems, manifested in anxious behaviours are predictive of future psychosis, and that the basis for this may lie in early attachment experience. If attachment were the underlying cause for interpersonal problems such as social anxiety, one would expect to see continuing problems across the life span. Social anxiety has been found in the psychiatric histories of people who go on to develop a psychosis (Johnstone *et al.*, 2000; Klosterkötter *et al.*, 2001; Preda *et al.*, 2002). It is a feature of the prodrome manifested in social withdrawal, social phobia and paranoia. It may be evident during an acute episode when pharmacology is often focused on relaxing the individual through sedation (e.g. Olanzapine), and may be a residual symptom post-episode, resulting in difficulties in re-engaging with normal difficulties, distressing symptoms and increased likelihood of relapse. Myerson (1944) proposed that anxiety about others was a key ingredient in the development of schizophrenic symptoms such as paranoia, preoccupation and distorted perceptions.

#### **3.3.2. What is the relationship between social anxiety and psychosis?**

As a result of Jaspers' (1962) distinction between schizophrenic and non-schizophrenic symptoms, the former 'trumping' the latter, anxiety has subsequently been regarded as a secondary handicap, a result of schizophrenia rather than a core feature of the psychotic

experience. This has contributed to a lack of interest in the nature of anxiety in the context of the development and maintenance of psychosis. As has been discussed in the context of the medically led prodrome literature, research has veered away from exploring the meaning of symptoms and concentrated merely on their appearance.

Studies show that anxiety is not only very common and disabling in people with psychosis (Cosoff & Hafner, 1998; Dilsaver & Chen, 2003; Hirsch & Jolley, 1989) but also arguably not simply a secondary handicap, having aetiological significance. Furthermore, within the broad spectrum of anxiety disorders, interpersonal fears are most evident (social phobia, agoraphobia). Gumley *et al.* (2004) draw together these themes and suggest three possible explanations for the co-occurrence of social anxiety and psychosis: 1. Social anxiety and poor pre-morbid adjustment is an early precursor or risk factor for psychosis; 2. Social anxiety may share a common psychological process with psychosis and; 3. Social anxiety may occur as a consequence of self-stigmatising negative beliefs about the experience of psychosis and therefore becomes a marker for poor social and emotional adjustment. These hypotheses are not mutually exclusive and are perhaps describing different stages of the same process.

In the early theories of Myerson, Kubie and Sullivan, anxiety was seen as a precursor of psychosis and different from psychosis in a quantitative rather than a qualitative sense. Hence they would be part of the same process, and anxiety would predispose the individual to psychosis. If an individual has developed a view of the world, self and others strongly mediated by anxiety the person will unconsciously process all information through an anxious filter. Hence the experience of psychosis and its stigmatising (through public perception) and isolating (through symptom content and nature) effects will be easily accommodated within a perception of the self that is inadequate and the world and others as

rejecting and threatening. These three ideas encapsulate the relationship between anxiety and psychosis and remind us that the individual's psychological processes are integrated. Common themes will not only exist between difficulties apparently classified as distinct but will underpin all of the individual's psychological functioning, and will probably have their roots in early development.

### **3.3.3. Early Development and Interpersonal Functioning**

Gumley & Schwannauer (2005) provide an account of how early attachments shape future interpersonal functioning, and this is evidenced with research showing insecure attachment styles in individuals with psychosis (e.g. Dozier & Kobak, 1992; Dozier & Tyrrell, 1997; Drayton *et al.*, 1998). Bowlby (1973) posited that attachment experience dictates the development of internal working models, or core schema (Beck, 1976). Internal working models are responsible for the self and other concepts, and as a result shape the way the individual maintains that self concept through affect regulation, problem-solving and interpersonal functioning. Interpersonal functioning will have a direct effect on social learning, and the effects of a secure or insecure attachment will have an exponential effect along the developmental trajectory.

Much of this evidence is found from studying adults, but there is retrospective evidence to show poor interpersonal functioning in children who go on to develop psychosis. Hodges *et al.* (1999) found a significantly greater instance of childhood antisocial behaviour or social isolation in participants identified as high-risk for developing psychosis compared to controls. Hellgren *et al.* (1987) also identified a significantly greater incidence of anxiety-based emotional problems in children who went on to develop psychosis during adolescence. In

their experimental group, 7 out of 40 had lost a parent during late childhood (11-17 years), compared with none in the control group. Olin & Mednick (1996) in a review of the literature around risk factors for psychosis argue that separation from a primary caregiver may not in itself be a significant risk factor but a marker of likely subsequent family trauma that would serve to increase risk. Nevertheless, they report that interpersonal problems, especially shyness and withdrawn behaviour (consistent with an avoidant attachment pattern), had been reliably established through teacher reports in a number of different studies.

Cornblatt & Keilp (1994) suggested that early expressed attentional deficit might result in impaired processing of interpersonal information. This in turn would lead to difficulties in social interaction and compensatory social withdrawal. This is a dynamic and integrative approach to psychosis and interpersonal functioning but rests on the assumption that psychosis is the underlying impairment and social anxiety, though it may appear earlier, is a manifestation of that impairment. This closely adheres to the idea that psychosis is a disease and trumps affective disorder.

### **3.3.4. Adolescence**

Harrop & Trower's (2003) thesis offers an explanation for why psychosis commonly develops during the adolescent period, identifying individuation from parents and the emergence of the self as the primary tasks of this period. Research in attachment has shown that these two tasks are intrinsically linked, and some idea of the difficulty of this period for the individual can be seen. Harrop & Trower identify key themes in this period that provide a context and a process for the adolescent and which are briefly described in Table 1 below. These themes are helpful for describing normal adolescence as well as adolescence in the

context of psychosis. They conceptualise aspects of adolescence with illustrations of everyday adolescent events and behaviour that simultaneously demonstrate how difficult this period is for the young person (as well as those around them) whilst not pathologising their behaviour. It therefore creates an opportunity to see the experience of psychosis as lying at the extreme end of a normal trajectory rather than being something qualitatively different from normal experience and thus marking the individual as different or defective. By bringing psychotic experience back within the normal trajectory it can be viewed as adaptive to experience and current circumstance (both internal and external) rather than essentially maladaptive.

Table 1: Adolescent Themes and Manifestations (summarised from Harrop & Trower, 2003)

Theme	Tasks
Conflict and renegotiation	Asserting authority, changing from subordinate to self-ordinate, the need for freedom versus protection, negotiating for leaving home, entering the adult workplace, and establishing relationships with peers instead
De-idealisation	Parent falls from grace as infallible and becomes useless due to the adolescent's 'black & white thinking' style: rules must be challenged, opinions derided and advice rejected.
Depression and loss	Loss in terms of attachment and security, uncertainty, loss of parents as ideal beings, lack of felt security when parents are not accepting
Egocentrism	Adolescent believes they are so important to so many people (the imaginary audience) they come to see themselves and their feelings as very special, even unique. Some of this egocentrism is attributable to the lack of abstraction in this age group
Grandiosity & self-consciousness	This ties in with egocentrism falling away during adolescence and self-consciousness developing – I am therefore the whole world is
Significance, uniqueness & indestructibility	The personal fable of being significant, unique and immortal is similar to egocentricity and probably borne out of the same lack of understanding about others as well as fading away at the same time
Mentoring and seeking 'new gods'	The young person, having lost the parents, but still having the need for a protector, mentor or parental figure, must seek out someone new. These characters may tap into ideas of idealism, infallibility and uniqueness
Psychosis-like experiences	McGorry et al (1995) found in a population study of 657 Australian teenagers "Prodromal signs" in 10-15% using strict diagnostic criteria and in 50% using loose criteria

### **3.3.5. No Man is an Island: the dialogical self and psychosis**

The research discussed thus far suggests that a persisting theme has been the importance of the self in psychosis and a recurring finding has been of interpersonal problems in the development and maintenance of psychosis. These two aspects are brought together in an article by Lysaker & Lysaker (2001). They present a thesis rooted in Nietzsche's concept of consciousness as a "net of communication between humans" (Nietzsche, 1887/1974, p.298, cited in Lysaker & Lysaker, 2001), suggesting that self is both developed and directed by our communications with our self and others, and that our representation of self may be more or less dominated by others at different times, and is hence dynamic. They also review more recent literature focused on self-narrative and experience of negative events.

Lysaker & Lysaker (2001) argue, 'the experience of psychosis can be conceptualised as a breakdown in dialogue within the self and between the self and others' (p.27). This links in with previously discussed conceptualisations of the self and psychosis. Parnas (2003) and Scharfetter (2003) both identified self as separate from others as a difficulty for the psychotic individual, and Harrop & Trower's (2003) premise for the failure of self to develop is difficulty individuating from the parents and connecting appropriately with peers following failed communication during early development.

The concept of the dialogical self also accounts for the prevalence of interpersonal problems seen in the development of psychosis. Early difficulties establishing communication with others may contribute to poor internal dialogue resulting in a number of other difficulties such as problem solving and coping, and following the thesis of a dialogical self, a developing self-concept. Lysaker & Lysaker (2001) develop their thesis to suggest that the



breakdown of internal dialogue is perhaps both influenced by and contributes to strong emotions that cannot be resolved. Furthermore they reiterate Frosh's (1983) idea that this breakdown is brought about by anxiety. Hence anxiety, interpersonal difficulties and psychosis are brought together into a coherent inter-relating model. The problem for this model is its basis on a single-case study. It has face validity and makes a useful contribution to a discussion of the self in psychosis, but requires theoretical and empirical development.

### **3.4. Research in Psychosis: Positivism v. Constructivism**

#### **3.4.1. The problem of positivism**

“A necessary requirement for any coherent reductionism is that the entity to be reduced is properly understood” (Nagel, 1974, cited in Parnas, 2003)

Thus far the positivist paradigm has been challenged as an approach to researching psychosis. This criticism has largely been focused on the problem identified by Nagel above. Psychosis remains a disputed quantity in terms of specificity, nature and relationship to other psychopathology and normality. Therefore, attempts to reduce it to a quantifiable set of variables have been largely unsuccessful, and research in this area has been methodologically flawed because of its premise. However, the problems associated with a positivist approach are not limited to the conceptualisation of psychosis, but also the assumptions of positivism. Positivism assumes a static objective reality, and it is from this position that individuals with psychosis are pathologised as they adhere to an idiosyncratic version of reality that does not wholly match up with the one accepted by others in their environment.

There is an abundant literature on 'normalisation' demonstrating that psychotic experiences such as delusions and hallucinations are frequent in the non-psychotic population (individuals who have never been labelled with psychosis as they have not presented to a health professional with distress resulting from these experiences) (Morrison *et al.*, 2004). Whilst this literature has been used to reassure individuals with psychosis that they are not alone in their experiences, it also serves to demonstrate that reality might not be as uniform as we imagine. John Mack, a psychiatrist at Harvard Medical School, took up this challenge to positivism, with his research into alleged alien encounters. He held a position of openness to his participants' experiences, considering them to be both spiritual and real. This position provoked an investigation by Harvard into his clinical competence, which found in his favour. The investigation demonstrates how zealously our shared concept of reality is guarded and how difficult it can be to consider an alternative.

Positivism limits exploration to observable data, and in its original conceptualisation (e.g. Wittgenstein) this would have referred to science type phenomena. When applied to human experience, its application is properly limited to observable behaviour. It is questionable whether there are any consistently found objectively observable signs that are specific to psychosis. Limiting exploration to such signs (for instance organic pathology) has not thus far increased our understanding of the nature of psychosis. One of the strengths of positivism is its self-limiting definition, and adherence to that definition means that it is not applicable to researching psychosis as a holistic human experience.

The recent growth of qualitative research outside of its traditional place in sociology and anthropology into nursing and education (bolstered by the demand for service user participation in research and development) means that the positivist paradigm, though still

dominant, is no longer exclusive. Much of this research is under-pinned by a constructivist or constructionist framework. These two positions are often confused but have an important distinction (Burr, 1995). Constructionism is based on the notion that there is no objective reality, only the collective realities of individuals. On this basis, positivism is fundamentally flawed as it seeks to describe a reality that does not exist.

It has been suggested that constructionism has been created simply to challenge the autocracy of positivism rather than to provide a philosophically possible alternative. Constructivism, by contrast, acknowledges the existence of an objective reality. However, due to the subjective nature of humans, it is not possible for us to fully grasp that reality, and what we individually experience is a subjective reality. Radical constructivism argues that when more than one person agrees on a version of reality through dialogue, the objectivity of that reality is illusory, and serves only to comfort us. Hence, this position recognises our need to believe in an objective reality.

A constructivist position can be helpful when attempting to conceptualise the experience of psychosis. It recognises the threat felt by the individual and those around them (including professionals) that their version of reality no longer concurs with that of most others, but importantly it also allows that alternative perception of reality to legitimately exist. For the individual, this is empowering and reassuring, and for those researching the area, or treating the individual, it becomes possible to accept the individual's frame of reference, compare it with one's own, acknowledge the similarities and differences, and in sum, enter into a dialogue without prejudice or fear.

### 3.4.2. Social Constructivism as a credible paradigm for research

There are a small number of qualitative studies relating to meaning and development of psychosis, which have been reviewed below. They cover a number of different aspects of psychosis, but their relevance to this discussion is whether they successfully hold a position of reality as subjective, if their results accurately reflect the participants' experience and whether this position helps to develop an understanding about the experience of psychosis.

Corcoran *et al.* (2003) and Møller & Husby (2000) have published the only known qualitative pieces of research specifically exploring the prodromal period, but Georgaca (2003) and Hirschfeld *et al.* (2005) also cover this period. Møller & Husby (2000) argue for the need to understand 'naturalistic' dimensions of the prodromal period and analysed extensive clinical interviews with 20 first-episode participants. They appear to have treated their qualitative data in a quantitative manner, categorising excerpts according to diagnostic criteria such as 'disturbance of formal thought' and 'attenuated delusional ideas or perceptions'. The examples presented for these categories strongly support the notion of disintegration of the self discussed earlier, but they consider only some of the examples in this light and, again, as a means of fulfilling diagnostic criteria. It appears that by remaining faithful to a disease concept of psychosis they have failed to grasp the subjective meaning of people's experiences, although it is evident in their data.

Interestingly they also comment on the communication problems of this group. It appears from their examples that their sample was an articulate one, and their observation of poor communication might better be described as a different conceptualisation of the experience from the one the researchers use, represented in different language and explanations that the

researchers cannot fit into their own frame of reference. A truly qualitative piece of research would have reflected on this, and made use of it. Instead, Møller & Husby appear to have explored their own subjective experience of the prodrome, filtered through the words of people who have actually had the experience. Nevertheless, it still succeeds in illustrating the poverty of our current criteria for psychosis development.

Corcoran's study is based on the observation that previous qualitative findings (Møller & Husby, 2000) are not encapsulated by current research and clinical criteria for the prodrome and that the dynamic nature of the prodrome is not recognised in the measures used. However, their interest lies in gaining a more accurate picture of the prodrome as they conceptualise it, not as their participants might. Hence, they interview the parents of individuals prodromal to psychosis. This suggests that they are looking for the objective reality of the prodrome rather than the subjective reality (though they will, in fact, find the subjective reality of the parents, which will answer quite a different question from the one they believe they are asking). This piece of research, is still, therefore, constrained to the positivist paradigm. They do not ally the research to a particular methodology such as interpretive phenomenological analysis or grounded theory, although it appears from their description to be a thematic analysis. Their data is very interesting and evidently depicts a number of themes about parental attributions and coping. Unfortunately this is largely overlooked as they seek for the 'factual' information about symptomatic and behavioural changes in the prodromal individual. In sum, this piece of research has misplaced its focus, largely because there has been no consideration of whose reality is being studied.

These studies clearly demonstrate how difficult it can be to shift out of our own world view and into that of another's. It also shows that a single 'objective' version of reality cannot be

assumed. These studies are remarkable for the conflict between researchers' and participants' versions of reality and the attempts to draw them together, unsuccessful because they are drawn together into a paradigm that is not meaningful to non-medics.

Georgaca (2003) uses a single interview with a woman recently admitted to hospital to illustrate how opposing versions of reality can contribute to apparent difficulties in communication for the psychotic person. In her interviews she attempts to reach a psychological understanding with the patient about how her psychotic ideas have developed, and what they mean to the patient. Using extracts of her interview she demonstrates that the clinician assumes a clear distinction between objective (factual) and subjective (feeling) reality that the patient will conform to, but that this distinction may be meaningless to the patient and an artefact of our perception of mental illness. Her patient introduces a third kind of discourse - religious discourse - that allows her to describe her experience in a way that is meaningful to her and can be understood by the clinician. Through exploration of this discourse, Georgaca comes to the conclusion that 'the reality of [the patient's] experience is something interactionally constructed during the interview' (p.129). This position exemplifies the social constructivist positions and demonstrates how distant our understanding of psychosis using the positivist paradigm (effected through the medical model and quantitative methods) is from that of the participant. It is not only the language we use that does not match up, but also the way we use language and the assumptions we bring to discourse about psychosis.

Hirschfeld *et al.* (2005) explored the meaning of psychotic experience for young men using a grounded theory methodology. There are some methodological problems with the research. They report using a social constructionist approach, but assume an objective reality. The

interviews are not analysed reflexively so the authors appear unaware of their own position in the research (although it is evident to the reader). A semi-structured interview is used and the emerging themes reflect this, for example “experience of psychosis” is one of the interview sections and a theme. These problems limit the findings and there is a tension between a wish to communicate the subjective experience of psychosis and the constraints of thinking within existing symptom-based models and the limitations of the interview style. Nevertheless, this piece of research attempts to be a genuinely qualitative piece of research and not simply a quantitative piece of research using interviews.

In exploring the experience of psychosis, Hirschfeld et al found that ‘personal explanations’ emerged as a theme. The participants identified themselves at a time before psychosis during which interpersonal relationships were important. Changes in relationships were seen as part of the slide into psychosis. However, Hirschfeld’s description of this experience latches onto ‘factual’ changes that are commonly associated with the prodrome, rather than focusing on the meaning of participants’ personal accounts of this time.

Despite the methodological flaws of these studies, some common findings emerge. All these studies refer to the inseparable relationship between sense of self and psychosis; the struggle to survive, conceptualised as coping (Hirschfeld *et al.*, 2005), plans of actions and expectations for the future (Corcoran et al, 2003) and across dimensions but not articulated in Møller & Husby’s (2000) study; and the dynamic nature of the experience.

Only sense of self has been researched quantitatively (Scharfetter, 2003) and this has been considered within a disease concept. These themes suggest a more adaptive quality to the experience of developing and understanding psychosis that is consistent with non-

pathological theories of human behaviour (e.g. evolutionary models). It appears that, if researchers can challenge their own preconceptions about psychosis, qualitative approaches can contribute to a new understanding that is meaningful to both researcher and participant, and would therefore have clinical utility.

### **3.5. Summary**

The key points of this literature review are presented below:

- The dominant paradigm in psychosis research and practice is the medical model. This model describes psychosis as a disease comprising discrete stages including the prodrome
- Attempts to conceptualise the prodrome in terms of duration, nature and meaning have been largely unsuccessful
- Psychological models have attempted to branch away from the medical model but are constrained by prioritising psychotic symptoms as defined by the medical model, and by conducting research within the positivist paradigm
- Recent research has explored the relationships between psychosis and self, providing both theory and evidence suggesting that psychosis might be better conceptualised as a collapse of the self rather than an organic disease
- There is a small body of qualitative research into psychosis and the prodromal period specifically. This research is encumbered by methodological problems, mostly attributable to the influence of positivism, but supports the influence of self-concept in psychosis
- There is an argument for purely qualitative research into the nature of developing psychosis, using a social constructivist paradigm, that accepts the psychotic individual's perception of reality over and above medical or psychological definitions



## 4. Methods

### 4.1. Design

A qualitative design using a constructivist grounded theory methodology has been chosen for this research. As discussed above, there are a number of problems associated with the use of a positivist paradigm in psychosis research. In summary, these are:

- The concept of psychosis is not well-conceptualised and it is therefore not possible to confidently assert a theory from which a hypothesis might arise
- The nature of reality is assumed by positivism to have an objectively observable nature. However, features of psychosis such as delusions and hallucinations, which are also seen in the non-psychotic population, suggest that reality does not fulfil this assumption.
- Quantitative research in psychosis has become atheoretical, focusing on controlling variables rather than extracting meaning.
- Research conducted in psychosis based on the positivist paradigm has not yielded explanations of psychosis that are meaningful to individuals with psychosis or increased the clinician's understanding of psychosis beyond the early Kraepelinian model of a cluster of symptoms.

A social constructivist approach to psychosis research may be more appropriate, as discussed earlier. In summary, the strengths of this approach are:

- Reality may be objective, but is not objectively observable by humans, due to the social learning that informs our perception of the world. By accepting this definition of reality, it becomes possible to accept the perspective of the individual with psychosis and therefore to engage in a mutual understanding of their experience.

- Through this mutual understanding, psychosis may be researched within a framework that reflects the individual's experience and enhances the clinician's and the researcher's understanding.

The chosen methodology for the current study is grounded theory. The background to this methodology is described in this section, and its practical application in the procedures section below.

Grounded theory is a qualitative methodology and was devised by Glaser & Strauss (1967) to answer criticisms about the lack of rigour in qualitative research design. The original method, although considered a qualitative method, had positivist leanings. The researcher was considered as an objective observer, independent of the data being collected, and capable of arriving at generalisable conclusions through *saturation* of data, whereby repeated sampling would generate the same emergent themes. The procedures were highly prescriptive and systematised. Later adaptations of grounded theory saw a move away from pure positivism by Strauss & Corbin (1998) and they described analysis as 'the interplay between researchers and data' (p.13).

Charmaz (2003) has argued that grounded theory still allies itself too closely to the positivist tradition by considering reality as objectively observable, and presents constructivist grounded theory as an alternative. She argues that data does not have and could not have objective status, being instead a 'narrative construction' (p.258) between researcher and participant of a prior experience. Therefore, the researcher cannot position themselves as external to the data but must recognise their role within this construction. In addition, the data can be recognised as existing within a context, for example the immediate context of the

interview situation, the broader personal contexts of the researcher's and the participant's prior experiences and learning and also the cultural and societal context within which ethnicity, class, gender, socio-economics and education would be considered.

In clinical psychology practice the psychologist attempts to be inclusive of contextual factors. In working with the individual there is a recognition of the interplay between therapist and client. Finally, the role of the psychologist/therapist (especially in psychosis) is to reduce distress and enhance emotional, cognitive and social functioning for that individual within the context of the client's belief system or concept of reality. Therefore, psychology-led research that has the ultimate aim to improve treatment approaches should adhere to the same ideals, and the methodology described above fulfils those requirements.

## **4.2. Measures**

An open-ended interview was used. Interview questions evolved across the sampling, and as emerging themes became more specific. The initial question was about interpersonal processes in the months and years prior to the onset of the first episode of psychosis. The researcher wanted to create an unconstrained discussion around this area in the first interviews, and rather than using specific questions, encouraged the participant to lead the conversation by explicitly asking them to do so before the start of the interview. To avoid subconsciously steering the interviews the researcher retained an awareness of her own pre-existing knowledge and ideas about topics and possible themes, which are presented in Table 2 below. These were employed or discarded in the interview depending on the participant's engagement with the topics and themes. It was acknowledged that the interviewer's pre-conceptions and response to the individual would inevitably have some influence on the

interview. However, the use of a social constructivist approach rather than traditional grounded theory accommodated for this, allowing the interviewer to hold pre-existing biases as long as an awareness of them was explicit.

Table 2: Potential topics and themes at the start of the interview process

Topics	Themes
School	Change
Family	Relationships
Peers	Emotional language
Hobbies/Interests	Enthusiasm/avoidance of topic
Neighbourhood	Statements about self/others
Religion	

Following the first round of interviews, the analysis and subsequent reading contributed to a re-formulated question. This process is described in the procedure section below.

Throughout the research process, a reflexive diary was kept by the researcher. This provided an opportunity to draw together emerging ideas from clinical and research practice and charted a growth in understanding and a change in attitudes about psychosis. Its primary function was to increase awareness about possible influences on the data analysis and to encourage honesty. The reflexive diary was heavily drawn upon in the analysis of the pilot studies, and in the subsequent interviews a section is given over to personal reflections drawn from the diary.

### **4.3. Participants**

The participants were all aged between 18 and 23 and were currently receiving services from the Early Psychosis Support Service (EPSS) at the Young People's Unit, Royal Edinburgh Hospital. They had all experienced at least one episode of psychosis, were no longer acutely psychotic and were able to give informed consent (see Appendix I for information sheet).

Participants were approached by their keyworker initially and invited to participate. Two participants who had previously had repeated contact with the researcher agreed to provide pilot interviews. Following this, three people did not accept an invitation to participate and six people did agree to participate.

Ethical approval for the study was acquired from Lothian Research Ethics committee.

### **4.4. Procedure**

The researcher gave a presentation to the staff of EPSS about the project and asked the team to consider possible participants. If the potential participant met the inclusion criteria, the keyworker would provide the individual with a leaflet and ask them if they would be interested in participating. If the individual were agreeable, they would then meet with the researcher for an explanation about the interview process and an opportunity to ask any questions. If they were still agreeable, a consent form was signed, and a date was set for the interview to take place, allowing at least 24 hours for the individual to change their mind. If a participant became unavailable for an interview (through failing to attend the arranged interview appointment), the keyworker would make contact with them and check they were still interested in participating (it was recognised that individuals found it easier to tell

someone they already knew and trusted that they had changed their mind). Interviews took place at a location of the individual's choosing, usually at home or a public location.

Two pilot interviews were conducted and a preliminary analysis of practicalities, interview style, and response to the questions informed the actual interview process. A review of the pilot process is included in the results section. Following this analysis, a new question was formulated and another interview was conducted. This was analysed for emerging themes, and the researcher was guided to further reading of the literature as a result. This contributed to further reformulation of the question and two more people were then interviewed. This interview-analysis-reading-question reformulation pattern was repeated until eight participants had been interviewed.

A description of a grounded theory analysis is given here as it contributes to an understanding of the procedure of the research. In qualitative research, the analysis is considered as integral to the methodology as it informs subsequent interviews. This analysis follows a number of stages. Firstly, a faithful transcript of the interview is made. This transcript is then coded. Coding is conducted simultaneously in two ways: The researcher re-reads the interview and makes memos of possible themes, points of interest and questions arising from the interview; and the transcript is coded using a qualitative analysis computer package (NVivo). Coding may be done line-by-line and paragraph-by-paragraph. Charmaz (2003) provides an example from her own research (p.259) in which each line of text is given one code. Her codes are quite highly specified to themes that have emerged from previous interviews and completed studies.

In this study, the interviews represented the beginning of a process of understanding and there were no pre-existing themes around which to shape coding. Therefore, several codes were generated for single sections of text. A single interview might generate between 300 and 500 codes. Based on the memos and the codes, a process of reduction then takes place in which the codes are merged into broader descriptive codes and categorised according to potential themes, e.g. loss of friendships. At this stage, emerging themes may be evident. The researcher may want to re-visit the literature to find a context for these themes, and from this develop a new question for the next stage of interviews. The final thematic structure was drawn from consensus between the researcher and both supervisors.

There were three stages of interviews in this piece of research (not including the pilot interviews). In order to illustrate the developmental nature of this research and the process by which conclusions were drawn, the results are presented chronologically and stage-by-stage.

#### *Validity: Saturation and Crystallization*

As with quantitative research, qualitative research aims to produce valid findings. Two means of achieving this are saturation and triangulation. Saturation is a process by which increasing numbers of participants are included until no new themes emerge. Depending on the nature of the question, the number of necessary participants will vary, and it is difficult to say in advance how many would be required. A second method is triangulation or crystallisation (Janesick, 2003). Triangulation is a means of avoiding an over-narrow and invalid interpretation of the data emerging too soon and influencing further data analysis. It can take the form of multiple data sources, investigators, theories or methods.

In this study there were two data sources (reflexive diary and interviews), three investigators (the researcher and two supervisors), a consideration of dominant and peripheral theories about psychosis, although all were medical or psychological, and one method (grounded theory). Therefore the methodology would be better described as a crystallization process, in which several influences simultaneously steered the analysis.



## **5. Results**

Throughout this section, I have referred to myself in the first person, as the interviews are recognised as being a construction of the experience in question created jointly between researcher and participant, and it is therefore relevant to the findings to reflect the experience of both myself and the participants.

The results section is divided into four sub-sections based on stages of interviews. At each stage I have provided an exploration of the emerging themes in each interview, followed by a discussion that informed a re-formulation of the question for the next stage of interviews. I have provided excerpts from the interviews to illustrate themes.

Following the final stage of interviews a presentation is made of an overall thematic structure that describes the interviews and informs future research.

### **5.1. Analysis of Pilot Interviews**

#### **5.1.1. Description of Process**

The first two interviews were intended as a means of practising the style and content of interviews. Therefore, two young people who were already known to the researcher were invited to participate. I understood that the interview style should be more relaxed than that of a structured interview or a clinical interview; that I should listen carefully to the participant in order to follow their narrative and to be careful not to ask leading questions or make observations that would encourage the participant to conform to my pre-conceptions. In practice, this experience was very challenging, and a brief description is given about my

experience of each interview. Observations about these interviews focus on the patterns of communication between researcher and participant so that this process can be enhanced in future interviews.

## **5.1.2. Analysis**

### *5.1.2.1. Interview 1*

I interviewed this young man, who I had known through the EPSS group programme, at the YPU. He is quite willing to participate in anything helpful to staff. I wasn't confident about how well the interview would go, feeling both uncertain about my interview style and about his willingness to share information, as my previous experience of him had been that he was very guarded about any self-reflection.

I was feeling self-conscious about interviewing on tape and didn't feel confident to challenge the participant about his guardedness. In addition, I could not understand a lot of what he was saying because his speech was rapid and incoherent. Nevertheless, the transcript revealed a lot of information and I felt a little more confident after this. Despite asking the participant about the time before he came into EPSS, he was keen to speak about the actual onset and experiences of being sectioned. I resolved to explicitly allow a discussion of this in the next interview, and then to work backwards from that point.

### *Observations about Interview*

Whilst the participant appeared keen to share his experience with me, he seemed less enthusiastic about describing his life directly before this. When I asked him about how his

current friendships compared with those from before the onset of psychosis he was able to tell me a lot about who his friends were and what they did but related few stories about them spending time together. I got the impression of being told about hearsay rather than about reciprocal active friendships.

Throughout the interview I felt confused about the information he was giving me. There appeared to be a lack of coherent narrative. During the interview I had attributed it to not being able to understand what he was saying to me. An example of the confusion is illustrated here:

I: Right so what did you, you said that you first noticed the voices and it felt like it was aliens that were trying to make contact with you?

P1: The first night it was aliens but the next time my head was screwed up and (inaudible) it was them, but on the night ah heard them (inaudible) me with probes

I: Okay so the voices were separate from the aliens?

P1: Yeah

I: Okay sorry I didn't get that. And were the voices people you knew?

P1: The night I heard my auntie and my pal Becky saying "ehey ehey" cos eh ken the level of your mind the voice level I made mine go really loud and I (inaudible) so I turned up the volume, ken, so I could hear them going "name, name, hiya, hiya" but they widnae say that it'd be aw shut up so I say it again but it wasn't (inaudible) ...

In this extract, the participant appeared keen that I should understand what had happened to him, and yet I still struggled to understand the sequence of events. Where it says '(inaudible)', I had been unable to transcribe his words after digitally slowing his speech down. In the live interview, I understood even less.

There seemed to be a number of possible reasons for this confusion. I had moved the participant backwards and forwards in his narrative which meant that his narrative was not chronological. Although the participant appeared forthcoming, I felt awkward about pushing him for more information or taking control of the interview and getting the information I needed. An example of this is given below:

- I: So what was it about you that they liked?
- P1: Personality
- I: Personality? Okay what kind of personality was that?
- P1: Well you know me
- I: Well, how would you describe yourself?
- P1: Dunno
- I: How do you think people at school would have described you?
- P1: How? How would you describe me?

In this extract he expressed interest in my perception of him and also appeared to be steering me away from further discussion about the group of friends and how he perceived himself or what his friends thought of him. In the context of the rest of the interview I had a sense of him deflecting attention away from himself, but he also appeared to be trying to make a connection with me. This might have been to increase his own comfort in the interview or to gain control. At no point in the interview did he give an explicitly emotional account of his experiences. As this was the first interview, I had nothing to compare it against, but it seemed possible that it related to his deflection of attention away from himself and his relationships.

Following analysis of this interview, I was struck by how significant the researcher-participant relationship was in the interview. The participant had a reciprocal interest in me, and in my opinion of him. He appeared keen to impress me, and this may have contributed to the limited amount of negative information he gave about himself. There was a sense of confusion in his report that may have reflected a feeling of uncertainty or lack of coherence in his life narrative, perhaps through lack of articulation or suppression of emotionally potent memories. Overall it was the lack of information about his recollections, feelings and opinions that stood out.

#### *5.1.2.2. Interview 2*

I interviewed this young man at the YPU. I knew him well as he had been one of my own clients, and whilst this meant that we had good rapport, it also made it difficult for either of us to stay in the role of research interviewer and participant rather than clinical psychologist and client.

#### *Observations about Interview*

Participant 2's interview was stylistically different from the first interview. He spoke at length and with a lot of emotional content. He could speak articulately and without prompting for several minutes at a time. Like the first interview, he was focused on his first episode, and I was not sufficiently active in directing him to the time before that. Nevertheless, where the first participant had been guarded about speaking about difficulties, this participant was open about challenges in his relationships. Following this first interview, I was interested to see how our relationship in the interview was reflected in the content.

The participant appeared to have developed a coherent narrative of his experiences and had an understanding of what happened to him. He spoke about himself as an active agent in the process (“I would even start to ... abuse substances”) but also referred to himself as a recipient of abuse and bullying. His language was evocative and expressed the emotional strength of experience (e.g. “my relationships with people were *absolutely* null and void”) drawing the listener into his narrative.

He might have been more able to engage in the interview because of his apparently positive self-concept. He appeared to identify strongly with the person he became during this episode, which may have been a way of taking control over an uncontrolled experience. His graphic and full account of his experience also minimised my role in the interview, which gave him control. This sense of his control was increased by his frequent use of my name:

- P2: ... first time I experienced depression and it was honestly, you can probably guess, this was quite obvious Emily, this was one of the worst periods of my life...
- P2: ... that's about all I'm willing to say, so, yeah, that's as far as I can remember Emily.
- P2: That was only about 20% of it Emily
- P2: These are things that I talk about since to someone, no offence, to anyone up here, especially yourself Emily, these are things I'd have to feel comfortable with someone for a long time before I'll talk about...
- P2: That's, that's the main stuff Emily, that's the stuff I'm willing to talk about

All but one of these instances were in reference to what he was willing to speak about in the interview. So, although he appeared to be speaking openly about his experiences, these comments suggested that he felt he was holding back some information and was almost warning me away from asking about it, whilst at the same time making me aware of its existence. The first extract referred to a period of depression. Throughout the interview his

focus was on times when he was 'high' (to use his language) and though he referred to depression, he never elaborated except to report how bad it was.

### **5.1.3. Discussion**

In both interviews there appeared to be a struggle for control in the interview, and this had an impact on the content of the information given about the participants' experiences. Both participants appeared to be trying to protect themselves from something negative, the first participant by avoiding any emotive topic and the second by cancelling out negative with positive interpretation. Despite the intended mutuality of a research experience, it was likely that these two individuals, having prior knowledge of me as a member of clinical staff, felt aware of a power differential, and therefore felt vulnerable. My lack of confidence in my interview technique at this early stage meant that I might not have been containing enough in my approach and therefore did not provide reassurance. It wasn't clear if the dynamic of these interviews originated in the context of the interview (our prior relationship, a service context, gender and age differences) or the experience (emotional impact too strong and needs to be guarded).

From these first two interviews a number of issues were evident:

- I had not established an interview style with which I was confident and competent

*Solution:* Practise interviews with supervisor and colleagues to develop a non-clinical but inquisitive style

- Situational factors were important in eliciting a non-intervention, pre-psychotic recollection from the participant

*Solution:* Conduct future interviews away from the YPU if possible

- My pre-existing relationship with the participant would influence the interview content

*Solution:* Ensure minimal or no previous contact with participant, and remain aware of the influence of the researcher-participant relationship when analysing interviews

- My temporal starting point was over-focusing the participant on the psychotic phase rather than the period before, and causing confusion for me when moving backwards from it

*Solution:* Start by asking the participant about starting secondary school (as a major transition that all would have experienced and have a recollection of but which would not cue participants to speak about acute psychosis) and move forward in time from there

## **5.2. Analysis of Third Interview**

### **5.2.1. Description of Process**

Following the pilot process, the first 'real' interview was conducted. For ease of communication this is referred to as interview 3. This interview was conducted at the YPU as the participant was not willing to be interviewed elsewhere (he was very socially anxious). Although he had agreed to the interview and attended for it, he was not forthcoming and appeared quite uncomfortable throughout. He was mostly monosyllabic, only engaging in a lengthier description when explaining about his wish to own a fast car. Nevertheless, the focus on an earlier period in his history appeared effective as he gave a guarded description of school and friendships prior to the onset of difficulties.



## 5.2.2. Analysis

### My Reflections

This interview left me feeling despondent at his lack of conversation and a bit desperate. Although I had emphasised to staff that I wanted a cross-section of the young people, and not just those who were eloquent, I struggled to imagine how I was going to draw anything useful from this transcript. As the volunteers for interviews were not pouring in at this stage, I realised I would have to use every interview, no matter how bad it was. I also felt that my interview style must still be quite poor and that I was partly responsible for this interview not going well.

### Emerging Themes

I asked him about family, friends, school, hobbies and interests, changes before he developed psychosis and the circumstances of his first episode. Overall, he gave little information. Therefore, one dominant theme emerged of reluctance to speak.

#### *Reluctance to speak*

I: And tell me a bit about your sisters, you say you've got two younger sisters.

P3: Aye.

I: Okay, tell me a bit about them.

P3: I don't know.

His response of "I don't know" was effective in ending the topic of conversation as it was neutral (if he had refused, I could have asked him why) but also informed me that he had no information to give me (if I had asked him what he meant by his answer he probably would have answered "I don't know"). The question may have been too non-specific for him, but

had been preceded by closer questioning about his parents and his relationships with them, from which I had learnt about their jobs and that his relationship with them was 'fine', but nothing else. His response to questions asking him to interpret his experience met with a similar response:

I: How did you feel about not hanging about with anybody?

P3: It didn't really bother me.

I: Was it something you'd chosen?

P3: No, it just didn't bother me.

Prior to this extract I had found out that his friendships had broken down in the months prior to his first episode and I was interested to find out more about this. Again, his response to my curiosity and the topic of conversation was one of neutral disinterest. The repetition of his opinion seemed to make it clear that he had nothing to add, and that re-framing my question would be pointless.

On a couple of occasions he elaborated on a topic, but if I asked him to repeat his words he then retracted or minimised his comments:

I: What were the things about school that you liked?

P3: Just everybody and the classes and that.

I: Sorry?

P3: I don't know.

I: Did you say it was the classes?

P3: Aye, just some of the classes.

### 5.2.3. Discussion

This interview was defined by its limitations. The participant appeared very unwilling to impart information and this can be interpreted in a limited number of ways. He may simply not have understood the questions being asked of him, although the questions were not especially complex. He may have been worried about how information would be used, and therefore withheld it where possible. When I asked him to repeat comments I had not heard, he might have interpreted this as a potential challenge to his comment and so he retracted it, and then when encouraged, only gave part of his original answer, missing out the mention of other people. This perhaps reflected a lack of certainty or confidence in his own report, even when speaking about apparently 'safe' topics, and might suggest that he felt threatened in the conversation. It might also reflect a basic lack of interest in the conversation. This is possible, as he briefly became more enthused when speaking about his interest in fast cars, and elaborated on this topic in order to clarify to me exactly where his interest lay. Following this, he returned to his customary monosyllabic style.

Although the first two interviews were pilots and therefore should be treated separately from this interview, there seemed to be a common theme emerging of guardedness, though the approach taken by each participant was different. The first participant appeared keen to engage in the conversation but wanted to avoid difficult or emotive topics or ones that might reflect badly on him. The second participant used an assertive positive interpretation of his experience to compensate for negative experiences and interpretations. The third participant failed to engage in the interview by withholding information and giving neutral responses that could not be elaborated upon.

In all three interviews the style of participation influenced the entire conversation and potentially concealed other significant themes. Drayton *et al.* (1998) view the strategy of avoiding complex interpersonal communication as having the objective of achieving equilibrium in a fluctuating disorder. Jackson & Iqbal (2000) suggest that refusing to talk about the experience of psychosis can in the short-term help an individual to avoid adverse emotional states and maintain psychological equilibrium during the early recovery phase. This description seems especially applicable to Participant 3, who refused to talk and denied any distress.

This response has been related to trauma, both as a response to the symptoms of psychosis (Meyer *et al.*, 1999) and to the measures used to manage psychosis such as sections and hospitalisations. Individuals with psychosis may show similar strategies to those with post-traumatic stress disorder such as avoiding talking about the trigger event in an effort to manage distressing emotions evoked by the memory and engaging in emotional suppression in order to maintain a sense of control (Mueser *et al.*, 2001). In the first two interviews, the participants spoke about difficult topics such as being sectioned (participant 1) and being bullied and rejected by peers (participant 2) but showed little emotion and did not elaborate on their own thoughts and feelings at this time, giving descriptive accounts instead.

A number of defence mechanisms described by the psychoanalytic literature may provide an explanation for the dynamic seen between interviewer and participant in the first three interviews. Some of the participants' responses in the interviews, such as denying difficult emotions, avoiding answering the question, deflecting attention and focusing on positive events could be defined in psychodynamic terms such as sublimation, repression, denial, rationalisation and regression.

McGlashan *et al.* (1975) described resistance to exploring the experience of psychosis as 'sealing over' and compared it with 'integration'. In the former the individual experiences psychosis as alienating and incompatible with life goals so encapsulates it as isolated experience, are resistant to any exploration of the experience or investigation of symptoms, maintaining an awareness only of negative symptoms, and are consequently at greater risk of relapse. Integrated individuals, by comparison, attempt to understand the experience of psychosis in the context of their own history and future, take responsibility for the experience and are active in coming to terms with what has happened. Participants 1 and 3 fit the description of 'sealing over' well, both being reluctant to explore the experience of developing a psychosis in terms of their own life, appearing to view it as an event unconnected with themselves, and engaging in safety behaviours to avoid difficult emotions. Participant 2 does not clearly fit into one or the other category. In keeping with a 'sealer' he had not integrated the negative symptoms (depression) into his life experience, instead focusing on the positive symptoms (mania). However, he was keen to explore his symptoms and to find a way of integrating the experience in a meaningful way.

#### **5.2.4. Question re-formulation**

Following the first three interviews, I was interested in the context of these defensive manoeuvres; whether they reflected a part of the coping or adjustment period for these individuals, a more stable underlying mechanism that appeared in other aspects of their lives, or were an artefact of the interview context. The relationship between the researcher and participant seemed potentially relevant for understanding interpersonal processes of these participants. I therefore decided to be more vigilant to the interaction between researcher and participant in the following interviews.

## 5.3. Analysis of Interviews 4 and 5

### 5.3.1. Description of Process

The next two interviews were conducted at locations other than the YPU, and which the participants chose. Interview 4 was conducted at the participant's parents' home (not his own), and Interview 5 was conducted in a park near the participant's home. Both participants were keen to participate in the interviews. The experience of conducting the interviews is described below.

### 5.3.2. Analysis

#### My Reflections

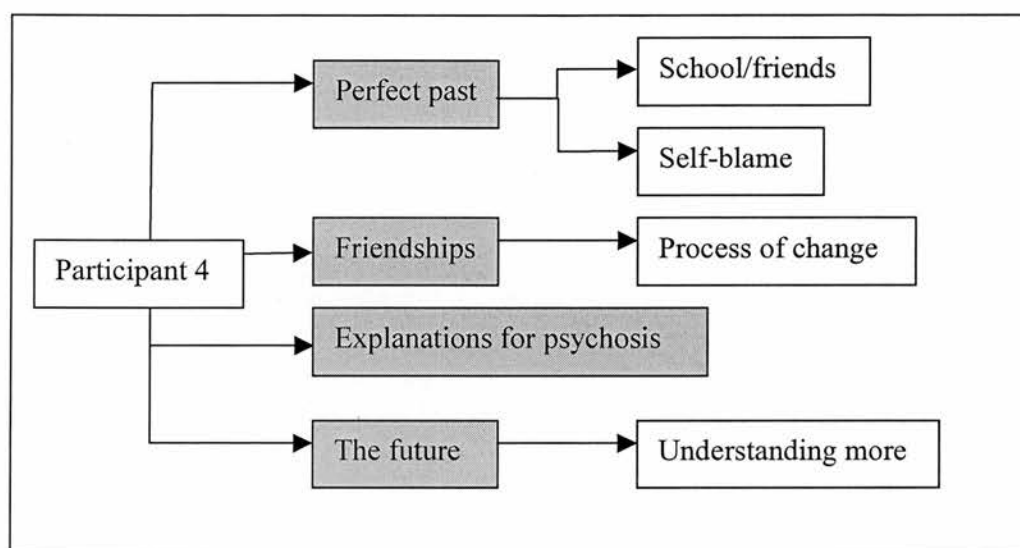
I had never met this young person before, but had heard him spoken about in team meetings. When I went out to see him he seemed enthusiastic about doing the interview and was very chatty. He spoke for nearly an hour and appeared thoughtful about the questions I asked him, asserting that he had not been asked much about 'these things' before (referring to relationships and feelings in the months and years prior to onset). He expressed a lot of distress about this period and appealed to me for help in understanding what had happened. Starting to find my role as a researcher I was aware of resisting helping him formulate his difficulties within a psychological framework as in a clinical interview, and came away from the interview feeling both good about the material he had given me and bad that he might not have found the experience a helpful one. If time had permitted I would have wanted to go back and interview him again, and share some of my ideas from the analysis. I was interested in his description of a dramatic decline from high functioning as a result of a few key interpersonal events, and I had this in mind when I conducted the next interview.

### 5.3.2.1. Interview 4

#### Emerging Themes

Four main themes emerged from this interview: a perfect past (school and friends; self-blame), friendships (a process of change), explanations for psychosis, and the future (understanding more).

Figure 1: Thematic Structure: Participant 4



#### *A perfect past: School and friends*

Participant 4 described his past in positive terms. He described himself as a popular boy who enjoyed school:

**P4:** ... I had a willingness to learn. The school was fun you know, there was never any trouble, mind you it was a big team that everyone... loads of people used to hang about, there was like 30 or 40 of us.

He mentioned enjoying school several times and referred to himself as a bright student. In this extract he described himself in positive terms. He also volunteered that there wasn't any

trouble and placed himself in the midst of a large peer group, using the word 'team'. This description created an image of a teenager in the midst of a normal happy life, with no problems.

*A perfect past: Self-blame*

This participant, viewing his past as positive, appeared self-critical about the way he had behaved:

P4: I had an attitude problem, the attitude is the problem. I wanted to stick in, I wanted to do well but I had the wrong attitude with... with slacking off, if you know what that is. Not trying as hard as I should be.

I: Right, okay.

P4: Not trying as hard as I should be and being distracted and some of the people I was hanging about with they weren't any good for me.

I: Right, okay.

P4: But I still did well at school. It was fine.

In this extract he referred to an attitude problem and differentiated between his wish to succeed and his actual behaviour. He reflected on what he *should* have done. He then appeared to attribute this, in part, to a group of peers who exerted a bad influence. He followed this more negative turn in the conversation with a reassuring summary that it was all 'fine' in the end. This was a recurring feature in the interview. The negative self-judgement was seen throughout the interview and grew in strength. Later on in the interview he said:

P4: I was a total star when I was at school too. I screwed it up.



In this statement he described himself at school in an exceptionally positive way and took ownership for things going wrong. Although he earlier attributed failure to his choice of peers, he otherwise took the blame for his difficulties as seen in the extract below:

**P4:** It is my fault, I was the one taking drugs, I was the one being so stupid, I was the one doing the wrong thing my whole life and not realising what I was like. If I'd just stayed away from it in the first place everything would be perfect, would have been... right on track.

In both these accounts he drew a sharp distinction between how good his life was before and how much he was to blame for what happened. In the earlier extract he appeared to apportion blame to his friends, but in these later extracts and elsewhere in the interview he assumed all the responsibility for himself. When I asked about other people in his family, he was swift to absolve them of any responsibility for his mistakes (although I had not asked about or implied their responsibility):

**P4:** I used to hang about with Steven [older brother] a lot sometimes when I was younger but it's got nothing to do with him.

### *Friendships: a process of change*

It can be seen from the extracts above that this participant used friendships to exemplify his positive past. He also gave an account of friendships falling apart. By virtue of being a bit younger than his classmates, he was held back for half a year at school, whilst his friends moved on to college:

**P4:** But at school it was pretty lonely and everyone knew I never really wanted to be there. I never paid attention I just sat and listened and never really did anything else. All the teachers knew it so they weren't really bothered, you know. But everyone left. I enjoyed school, I never had any big problems at school. It was only the time I actually left school that things started to go wrong, mind you that's my fault.

He described being lonely and unhappy at school during this time, and as our conversation continued it became evident that he lost touch with his school friends permanently. As observed earlier it can be seen that he compensated his account of school not working out with a statement that everything was fine, and assertion that any problems were his own fault, even though he has also said that teachers colluded with his sense of being at school unnecessarily.

He also used his friendships to describe his increasing difficulties with paranoia:

P4 ... I mean thinking your best friends are playing mind games with you and freaking you out and doing things that you never knew about it and if you never knew about it you were no worth a fuck basically and you'd just go and dump them, know what I mean. It was sort of like that, it was sort of like that. I mean that might have been what was going on at the time with people and I'm just being in it the way it was, just thinking it was something else. It affects the way you think ...

In this extract he described how his anxiety centred on what his friends were saying about him, about having a sense of being worthless and ending friendships because of this. Looking back, he still seemed uncertain about what was really happening; whether his friends really were speaking about him, or if it was his mind playing tricks. He commented that the psychosis affects the way that one thinks, suggesting that he didn't know if he could trust his own mind. He used strong language - this was an emotionally charged point in the interview. This account also seemed to lack the self-assurance that appeared in the accounts of his time at school and with friends. He gave a sense of how difficult this time was, which was elaborated further in the extract below:

P4: Friendships after school, I never really seen anyone and after me being sick as I say, I didn't know that I was, I was heavily depressed as well so that was obviously affecting everyone because they were like, ken is he alright and stuff like that but I wouldn't be (inaudible) so because I'm feeling so bad I'm taking more drugs to make me feel better. Mind you that did help for a while but it damaged... it was too much. Can you imagine being totally freaked out all the

time... paranoia and being depressed at the same time plus having a total mind screw as well, that's what it was like having psychosis. I felt really bad. I mean I felt like I was going to die a few times and stuff like that, panic attacks. I don't know. And that went on for about six months before someone realised that you're not well and you'd better go and see someone about it because I was looking really bad.

Here he described mounting problems and unsuccessful attempts to cope whilst being isolated from school friends. He gave the impression of feeling that he hadn't done justice to the experience in his explanation when he asked me if I could imagine what it was like. He emphasised how bad it was and how long it lasted. He noted the effect on others – concern but also lack of understanding – and also that it was others who suggested he get help and that he did not know what was happening. This extract gives a vivid depiction of the crisis of this time, and it is interesting to note that he was speaking about events from 6 years previously, yet they appear fresh in his mind.

After providing a description of the horror of the experience, he could then provide a story of recovery, centred on relationships:

**P4:** I'm back to my usual self. I'm feeling myself again. But it takes a long time to pick up the pieces and stuff like that, especially being away from home so long and not seeing my friends and that. I used to be out every night you know what I mean, after school, every night. Seeing people all the time and my life was a hell of a lot better for it. I miss that. Especially with your best friend being taken away because she moved away. They moved away to Spain.

For this participant, recovery was defined by being able to re-establish and maintain valued friendships. In this extract the participant expressed a sense of loss at how his social life used to be, and at the impossibility of the past being re-created. He was an active agent in this statement: “I used to be out”, “my life”.

### *Explanations for psychosis*

The participant attempted to identify the onset of his problems. He identified a journey to the interview for an apprenticeship as a turning point:

**P4:** Yeah, I was afraid. I remember getting this anxious, really bad feeling on the bus up there and I actually had to get off the bus and I went home. I don't know what happened there... But everyone else did. I was doing really well as well, I picked it up no problem. I was really bright at school, I was bright with it.

In this statement he talked about his first (as he recalled) experience of a panic attack, but struggled to explain what happened. Curiously, he said that everyone else knew what had happened, but it was not clear what he meant by this. He referred back to his school performance to show that there was no precedent for this turn of events, highlighting his own uncertainty about the cause of this event. He described this event as a turning point in his life. Prior to this event he was doing well but afterwards he failed to get a job and started using drugs.

**P4:** I guess it was... I don't know, maybe I just said oh screw it, I'll do whatever the hell I want. I was hanging about with some really bad people that I shouldn't really have been there with being so young, it was just stupidity basically. I hung about with them for a little while.

**I:** And was that after you'd not got into college?

**P4:** Yeah, that was after that for some reason but there was no reason to be but I did. I think I was angry at myself.

**P4:** Yeah I was I was fine, I never had any problems until after I left college and then everything just went bad you know and I was a really bad person for like two years or something, no about a year and a half.

**I:** What were you doing?

**P4:** Hanging about with bad people, doing bad stuff, doing drugs and all kinds of stuff and it just went on and on and on and that's how I got psychosis basically.

- P4: No, not really, I just remember feeling a certain way and it's the most horrible feeling I've ever had. It's more inside, you know. It was the chemicals in my brain what did it to me, probably that much ecstasy I was taking on top of the other stuff that probably did it. They think that's what it was. I mean I don't know what it was.

In these extracts there was a developing idea about the cause of the psychosis. In the first extract he attributed his problem to active life decisions made when angry. In the second, he attributed his problems to hanging around with the wrong people and behaving badly. In the final extract he attributed the psychosis to the chemical effects of ecstasy, though he did not seem completely convinced by this explanation.

### *The future: understanding more*

Participant 4 spoke a lot about the future, as explained above in the context of friendships, but also in terms of how he had changed his understanding of life:

- P4: I didn't really understand about anything, really, to be truthful, but I was happy because I was in my own wee way and I was quite comfortable. But after doing a lot of drugs and that it seemed to, not make any sense really. Understand?
- P4: Yeah. It's really hard to describe you know. If you come back in a little while I'm sure I will have it figured out, you know I'll be able to tell you properly. You know this is what happened, this is what I think it was like, but it's very confusing right now. As I say, I wasn't really bothered what was happening in my life at the time, I was more concerned about myself and the way I was and trying to get better after what I found out what it was. Than spending my whole life, well right up until about a year ago getting yourself right you know. Getting your life back and stuff like that and then after that you've got to sort of get over all that stuff...

In the first extract he reflected in a nostalgic manner to when he was young and did not understand much, but also didn't need to. He compared this with developing psychosis, which he has blamed on drug use as a lifestyle choice he made. In the latter extract he compared his perspective when he was developing psychosis with the one he has now. He

acknowledged feeling confused about what had happened, but seemed to want me to understand, suggesting that if he could have some time to think, it would become clearer to him. He referred again to the struggle of 'getting your life back', suggesting that this had occupied all his recent life.

### *Interaction in Interview*

Although this participant appeared to easily disclose, it could be seen in the transcript that he often compensated bad news with good. This appeared to have a reassuring function that may have been for both our benefits. In this one-off research interview with someone he had not met before there may have been conflicting motivations in his conversation. On the one hand he had nothing to lose by disclosing personal detail because he would not meet me again and I would not breach confidentiality. On the other hand the material was sensitive, evoking strong emotions in him, and he had no guarantees about how well I would contain that distress for him. In addition, he may have wanted to maintain some self-dignity in his disclosure.

I was aware of a strong opposite-sex dynamic within the interview: he as a strong angry man, evidenced in his use of strong language, his repeated "you understand?" questions at the end of statements which seemed to function almost as a warning to listen carefully. By taking on a masculine role, this pitched me into a feminine role, associated with being caring, listening and submissive. It was effective in taking control of the interview, and engaging me in his story and in taking his perspective.

## Discussion

Across the interviews he was self-reflective, within which there was a recurring theme of self-recrimination and loss. His descriptions of life before and after psychosis were quite different, and it was almost as if the pre-psychosis person was looked back upon with nostalgia and fondness for the good old days when there were no problems, and with anger that he could have been so careless as to lose everything. His self-recrimination may have had a protective purpose as well. It would have been difficult to be more judgmental about him than he was about himself and his self-critical stance may have served to protect him from criticism from others, and to elicit reassurance and sympathy. This self-criticism also seemed to place him in charge of his own actions rather than depicting him as a victim, which again enhanced his image as a strong individual. This perhaps gave him empowerment over a traumatic loss event.

He referred to relationships during all parts of his narrative. He placed himself at the centre of his relationships with others and maintained a non-judgemental view of others whilst being very critical of his own actions. It was not clear if this claim for responsibility rested on a belief in his self-efficacy or in a lack of faith in others. At various points he compared himself with others and with himself in the past. He used the re-establishment of relationships as a marker for recovery.

He expressed a lot of distress about this period and appealed to me for help in understanding what had happened. Starting to find my role as a researcher I was aware of resisting helping him formulate his difficulties within a psychological framework as in a clinical interview, and came away from the interview feeling both good about the material he had given me and bad that he might not have found the experience a helpful one. If time had permitted I would

have wanted to go back and interview him again, and share some of my ideas from the analysis.

### Summary

In summary, this participant gave an account of a socially and academically competent young man whose life quite catastrophically collapsed, with anxiety contributing to failed career plans, drugs being used to cope with depression and then becoming the problem and friends being asked for help but becoming a focus for anxious thoughts. In this story, he presented a strong sense of self, although it was not clear how positive that sense of self was. He described a traumatic experience and the struggle to assert himself over psychosis, claiming sole responsibility for this task. His determination to assert his prior positive self was evident throughout the interview and perhaps reflected a determination to survive, grief for a lost self, a positive self-concept, and/or a need to engage me in the conversation and prevent criticism from others, including me. I was interested in his description of a dramatic decline from high functioning as a result of a few key interpersonal events, and I had this in mind when I conducted the next interview.

#### 5.3.2.2. Interview 5

##### My Reflections

I had met this young man on a couple of occasions previously in a group setting but did not know him well at all. He was known in the team for being preoccupied by his past in conversation with others, so I knew I would have no difficulty getting him to speak, but might have some problems directing him towards a specific period of his life. In fact, he responded very well to my being open with him about the period of his life I was interested

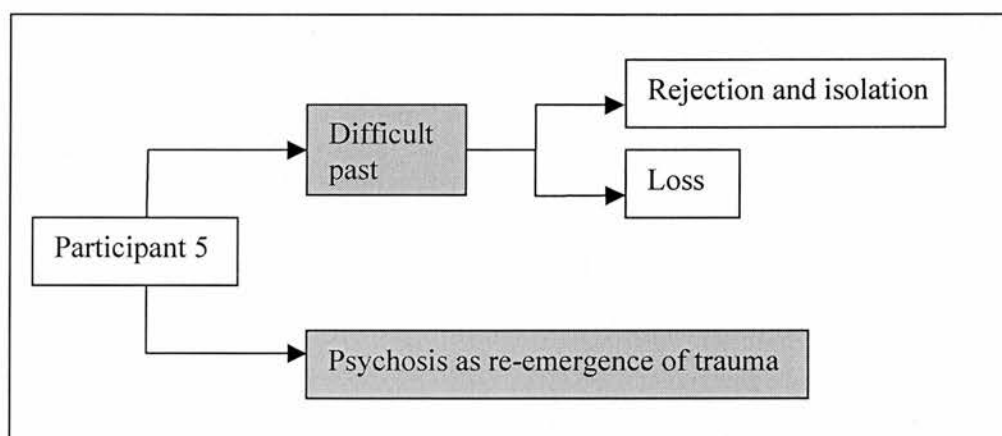


in, and gave a thorough account that initially seemed to contrast with Interview 4 as he described a lifetime of rejection and isolation. However, towards the end of the interview, he gave a narrative that suggested an interpersonal crisis and a revival of previous trauma. I was interested to see if this would be captured in the analysis.

### Emerging Themes

Participant 5 presented a coherent and full narrative about interpersonal difficulties and repeated trauma. The main themes were of a difficult past (rejection and isolation, loss), and psychosis as a re-emergence of trauma.

Figure 2: Thematic Structure: Participant 5



#### *A difficult past: Rejection and isolation*

Participant 5 described a long history of being considered odd by others, including peers and teachers, and of trying to find acceptance from others by doing whatever they wanted. This seemed to backfire for him:

I: And it was just to please other people that you would do these things?

P5: Yes. But nobody seemed to understand this so I was labelled a problem child and a retard and a freak. And... this was in primary school. And basically I wandered about the street and I had no friends. And then there were times when I'd get kicked on the way home, times when I get punches, times when I get things thrown at me. There was one time I went to the swing park and a girl, this

big hard nut girl ordered me off the swing and when I didn't get off she lobbed a can at my head and I was bleeding. And I was crying all the way home but when I got home I told my mum that I'd fallen because I didn't want her to know that anything bad happened. There's all sorts of little incidents like this, I can't remember most of them, it was a long time ago.

In this extract he gave an evocative portrayal of an isolated and tormented young boy. He described wanting to conceal bullying from his mother. His comments about his parents suggested that he felt unable to get the support he was looking for:

**P5:** I don't know, I don't know how to describe it. My parents think that they know me inside and out because they see how I behave and what I do, you know. But they don't know what, that my behaviour was only sort of... it's like, you know how a computer has interface, you know where you get the little pictures?

**P5:** Also my mum tried to encourage me by pressurising me, she didn't seem to, she understood me well enough but she didn't believe that coaxing and mollycoddling would do anything for me and one day she went into school when I was about 6 and tried to find out if I was being bullied and the teachers told her lots of crap had been spread around by the kids and, and she came home and started shouting at me.

These statements conflicted because he suggested that his parents both did and did not understand him. However, both statements implied criticism. He was critical of his parents for not understanding him or comforting him at difficult times, but it also appeared that he felt criticised by them. He used an analogy to describe how he might have appeared to his parents as compared to how he really was. The second extract was an emotional account and one which did not evoke sympathy for his mother. However, he appeared to present her rationale for not comforting him in a non-judgemental way.

### *A difficult past: loss*

A key event in this participant's life, and one which he returned to many times in the interview, was his brother's death and the emotional impact it had on him:

- I: You said when you went to secondary school that nobody knew you. Was it like a new start?
- P5: Yes, it was like a new start but for most people it's interesting and a little scary, but for somebody whose brother's just died and is still suffering very raw grief it's too much for them to take and my mind was very mental. At that point I was very mentally controlled but my behaviour was very erratic in school. I'd jump on tables, I'd do things like talk in stupid voices in the middle of a class and I'd frighten people, you know. And this was almost a reflection of what I was like in primary school when I was being bullied.

In this extract he acknowledged the twin challenges of losing a brother and starting secondary school. He compared himself to other people in terms of how the experience of starting school should have been and how it turned out. He drew a distinction between his mental and physical being, seeing his erratic behaviour as separate from his mental control. He noted his effect on other people, and also related his behaviour back to being bullied when he was younger. Along with the earlier extracts, this statement was very explicit in describing how hard his life had been and how he had struggled to cope. Whilst he used emotional language ("raw grief", "stupid voices") his narrative style seemed descriptive like a diary.

### *Psychosis as a re-emergence of trauma*

Despite his story of early rejection by peers, bullying and being misunderstood by his parents, he described persevering with searching for friends and found eventual acceptance at primary school, and then at secondary school. This was shattered by the arrival of some bullies:

- I: You kind of started becoming the person you wanted to be?
- P5: Yes. But unfortunately, unfortunately this group of friends moved, were transferred from Winchburgh High to my school and they saw me sort of strange, strange as anything. Everybody else had grown to accept me as being clever and smart and nice and sound, there's nothing wrong with him, he's just a bit, a bit silly. But they saw me as everybody saw me at the start, they saw me as a freak, but they were exactly the same people, they hadn't seem to have grown up since primary school. They were the same kind of bullies that bullied me in primary school and they made my life a living hell.

In this extract the participant seemed to acknowledge that he would always be considered as a bit odd but that it was possible to be accepted this way and that if people knew him for long enough they would realise he was harmless. He described the bullies as immature and exactly like his bullies at primary school. The context of this account suggested an element of defeat, as if after all this time and effort he would never escape from bullies. He defined this event as a catalyst to an emotional breakdown:

**P4:** I was really upset and miserable and the stress of secondary school got too much. So basically I just, I just started to go mental. But then I remember one day I kicked one of the guys in the stomach and he doubled over and then the bullying stopped but by then it was too late, the damage had been done and... from then on I was really upset, I didn't see anybody. In 2002 it was like one of the loneliest years I'd had. I had lost touch with all my old friends. I was miserable, stressed out, hearing a lot of voices, unhappy and felt worst. And anyway this comes back to the party I went to, you know which, which...

In this extract he described himself as damaged by the experience, despite managing to stop the bullying. He mentioned the voices, which throughout the interview had been described as, after initially being comforting and likened to a spiritual experience and contact with his brother, bullying him:

**P4:** But... slowly the illness got worse and worse and worse and I was hearing voices who would pretend to be these people and they would start abusing me, telling me horrible things, shouting at me, telling me I was an arsehole ... by this time the voices caused me to believe I was going to go to hell. It was really upsetting and I was really scared and I tried to kill myself several times.

As with earlier extracts, this account appeared emotional and painful, but shocking facts such as suicide attempts were described in a quite matter-of-fact way. The experience of hearing voices appeared to be something he could not escape from, and in this extract represented a spiralling crisis.

### Interaction in Interview

Whereas Participant 4 was keen that I appreciate how hard his experience had been, this participant seemed to relate his story as if the facts spoke for themselves, and he could trust me to understand how awful his life has been. It was as if he was talking at me rather than with me about his experience. It was evident throughout the interview that he had a style of relating his story as a rehearsed complete narrative. When I showed an interest in a particular aspect he would respond to the question but then explicitly return to his narrative:

P5: ...and then, the next story is basically where I started drinking...

P5: Anyway, to go back to the story I was telling."

P5: But, on to the story. The story is now again up to the illness..."

I wondered if this method of story-telling protected him from hearing feedback from others that might challenge his narrative or his depiction of himself, and that he could maintain a sense of constancy in himself by sticking to his scripted narrative, even if that constant self was a somewhat negatively conceived one. In the first extract above, each sentence started with an "And...". This might have functioned as a marker for his listener that he had not finished speaking, and perhaps reflected his sense of not being listened to in the past.

### Summary

Throughout the interview, this participant appeared as a victim of peers and teachers who did not understand him and therefore bullied him, and of his parents' perceived inability to nurture him as he wished. He nevertheless described a determination to overcome these difficulties, to be understood and to be accepted. In the interview, he seemed to give an open

account of his experiences, trusting me to agree with his perspective. However, he also spoke in a constant fashion, making it difficult for me to take an active part. I wondered if this was a way of avoiding negative feedback. It wasn't clear to me if he felt understood by me in the way that participant 4 appeared to have done. Participant 5 seemed to have found an identity in not being understood and it was not perhaps important to him to be understood so much as witnessed in his recounting.

### **5.3.3. Discussion**

The emerging themes following the first 5 interviews seemed to be describing a process of experiencing and overcoming trauma within the context of a specified history (positive or negative). Neither participant showed any recognition of a 'prodromal' period either explicitly or implicitly. Instead, friendships were used to exemplify aspects of themselves and their lives. The researcher-participant interaction continued to be evident but its role in the latter two interviews was not clear.

Both participants related a story about having a definite identity prior to the perceived development of psychosis that was described through the eyes of others (mainly peers). Both participants described themselves as bright, which was based on their school achievements. Their self-descriptions, therefore, all appeared externally ascribed. Both participants countered these self-descriptions with a story of how the social structures that supported their identities then failed them. The participants focused on their interpersonal world changing, and it seems that it was only following this that changes in their selves occurred.

A re-consideration of the relevance of defence mechanisms and an exploration of psychosis as a trauma process were necessary.

### Defence Mechanisms

During the interviews there did not appear to be a particularly defensive strategy emerging. In fact, these interviews were so markedly different from earlier interviews that I could not fully explore my original question and overlook my latter question. However, during analysis, I became aware that there were processes that might be described as defensive strategies at play, but that these were subtler. Embedded in the narrative of Participant 4 was anger, recrimination and grief at losing his pre-psychotic self. I wondered if he had idealised his earlier self to protect himself from the shame of his current worthless self. Reflecting back on earlier interviews, Participants 1 and 3 had both depicted their earlier life as one with no difficulties, and had been at pains to show how 'normal' they had been.

Participant 5's style of reportage was a well-rehearsed and fully constructed narrative, and one in which I barely participated. Whilst Participant 4 had considered my questions and attempted to answer them, I had a sense during the interview with Participant 5 that he was waiting for me to stop speaking so he could continue. I wondered if this was a means of preventing unwanted feedback from the listener. It appeared that the defensive processes in both interviews were largely independent of interview style.

The use of defence mechanisms as a conceptualisation provided a useful tool for identifying over-arching influences on the interview that might not be identified from close exploration of the text, and provided a structure for thinking about the way in which people describe themselves and their experiences. However, psychodynamic theory suggests that everyone

employs defence mechanisms and thus the appearance of them in these interviews is to be expected. It is not clear how a conceptualisation of these processes as defence mechanisms contributes to an understanding of the interpersonal processes at play during the pre-psychotic period, so much as the person's reaction after the event. The interaction between interviewer and participant is important in the process of re-constructing the experience of the participant, but cannot necessarily be generalised beyond the present context. However, through an awareness of possible 'defensive processes' I have become aware of how much the individual feels the need to protect himself. By asking how and why an individual is protective in their self-narrative, a connection might be seen with the nature of the story being told.

### *The Trauma Process*

In Interview 5 the participant described the experience that brings about his psychotic breakdown as a repeat of previous experiences. Steel (2004), reviewing models of trauma and psychosis, noted that psychosis might be induced by trauma (Kingdon & Turkington, 1998) and that PTSD and psychosis might share a phenomenology in terms of causation and symptomatology. In particular, the participant gave a strong emotional description of this experience, consistent with a trauma response. The transcripts for all the interviews read like trauma accounts in some key ways. Firstly, the experience of acute psychosis was an important story for the participant to communicate to me, and was described in emotionally potent terms. The accounts, though some years old, sounded fresh in the participant's telling, and at times there appeared to be strategies being used to keep the emotional aspects of the narratives at a distance.



Secondly, an understanding of this experience in terms of causation and effect on the individual was primitive, suggesting that it had not been meaningfully processed. This was evident in the number of times participants reported not knowing and not understanding what was happening or why. Thirdly, the black-and-white position about pre- and post-psychotic selves as observed above is common in unprocessed trauma stories. The individual cannot reconcile the trauma experience with their previous sense of self and loses continuity in self-perception. This can create a sense of 'jarring' in the self-narrative that is evident across these interviews. Fourthly, the process of recovery from trauma may be similar to the grief process, and the sense of loss is pervasive in these interviews. If a trauma or grief process can be used to describe the narratives of the participants, what was previously considered as defence mechanisms can be considered as core features of this process. Participants' accounts were marked by shock and denial, anger and a lack of coherence with self. If the process of assimilating a traumatic loss event (e.g. psychosis) into a coherent sense of self has not been accomplished, one would expect this to have an effect on the individual's capacity to develop a mature sense of self. Thus, it would be reasonable to find young adults referring to their self in adolescent terms.

Steel (2004) queries whether the concept of trauma in psychosis might relate to normal adaptation processes, citing a number of theories not relating to psychosis to assist in developing this idea, namely emotional processing (Rachman, 1980); Horowitz's (1986) two-factor model of assimilation and integration of information, and Janoff-Bulman's (1992) "Shattered Assumptions Theory". Similar to bereavement models, Rachman speaks of a block that may occur during the 'working through' of an experience influenced by poor engagement with services, avoidance of emotionally provocative stimuli and lack of perceived control. Horowitz describes an information processing system in which an

inhibitory mechanism prevents continued processing that leads to emotional distress. In some people this inhibitory mechanism may become over-active leading to overt and covert avoidance. Janoff-Bulman views avoidance as a by-product of the rebuilding process following the shattering of pre-trauma appraisals of the world, self and others as safe and good. Using these theories, Steel suggests that avoidance or suppression of the recollection of developing a psychosis is seen as a core problem in processing the experience, preventing the individual, even temporarily, from being able to integrate the experience into their sense of self, and to accept and manage their emotions about this process.

A common thread emerging from these last two interviews has been the perseverance with which they have approached their lives. Participant 4 depicted an experience that seemed to shatter his life and yet constantly refers to things being better now and in the future. He held onto his sense of agency in his experience by taking responsibility for what had happened and expressed determination about re-establishing his life. Participant 5, although focused on his past almost to the exclusion of the future, detailed a life in which he has never felt fully accepted or understood by others, even his parents, and yet continued to tell his story, attempt to make friends, and try to understand his experience. This striving for survival seemed like a potentially significant theme and a more positive way of understanding defence mechanisms.

The hypothesised relationship between PTSD and psychosis, and the theoretical similarities between grief and PTSD allow psychosis to be considered as a process in which the individual is an active agent. In exploring the experience of psychosis with these participants, it is helpful to have an awareness that they are describing a process of which they are still a part, rather than a discrete historical episode separate from them. The five participants whose transcripts have been analysed may be describing different stages of a

similar process, and may be approaching that process in different ways according to particular idiosyncrasies such as previous experience, attributional style, or coping and competence, for example. In the context of this the observation about perseverance may be significant as well as a motivating factor for these individuals.

### *Self as Externally Constructed*

In both interviews the description of self as externally constructed seems to be relevant to the process of developing psychosis. Referring back to earlier reading, in particular Harrop & Trower (2003), this self-description seemed consistent with the adolescent period when the individual has not yet developed a sense of self that is consistent with but independent of external determinants (such as parents' perception of their child). Harrop & Trower suggest that for some individuals, who have an insecure or engulfed self, the influence of others on the self exceeds the individual's own influence.

Without interviewing a number of people who had not developed psychosis, it was impossible to know if this expression of self was consistent with any person of that age or whether it was particular to individuals who had developed psychosis. However, it was of relevance that none of the participants were under 18, and yet their expression of an externally defined self is understood to be consistent with the understanding of a younger adolescent. In this respect, there appeared to have been a failure to mature. This is a common theme in psychosis and is considered as a 'secondary handicap' associated with the cognitive and emotional assault of psychosis. Within this study, this apparent failure to mature should not be accepted as a given, but questioned for its nature and reason.

### **5.3.4. Question Reformulation**

At this stage in the research process, my question had become more clarified. My earlier questions about the role of interpersonal processes in the development of psychosis and about the function of defence mechanisms had been merged into a question about the nature of self-concept in the context of the psychotic process. Although this might not appear related to the process of developing psychosis, the interviews and literature reviews had convinced me that the development of a first episode of psychosis was inherently linked to the development of the individual, and the later conceptualisation of that period, as explored in the interviews, revealed the current state of self-development. Thus, I became interested in the individual's perception of their current and future self in comparison to the pre-psychotic and psychotic self. I was also interested to see if the individual continued to define themselves in interpersonal terms if I did not use this as a focus for discussion around current and future self. I was also interested in the survival story or perseverance that had appeared in the previous interviews. Less attention was given to the researcher-participant relationship in these interviews.

## **5.4. Analysis of Interviews 6 to 8**

### **5.4.1. Description of process**

The final three interviews all took place at the individual's homes. Participant 6 and 8 both lived with their parents; participant 7 lived with a flatmate. All three participants were male; meaning that my entire sample was male, an unintended but unsurprising outcome, as the majority of young people who develop psychosis are male, and the number of male users of EPSS outnumbered females.

## **5.4.2. Analysis**

Interviews 6 to 8 were analysed individually and collectively, and then collated with the previous interviews to provide an overall analysis.

### *5.4.2.1. Interview 6*

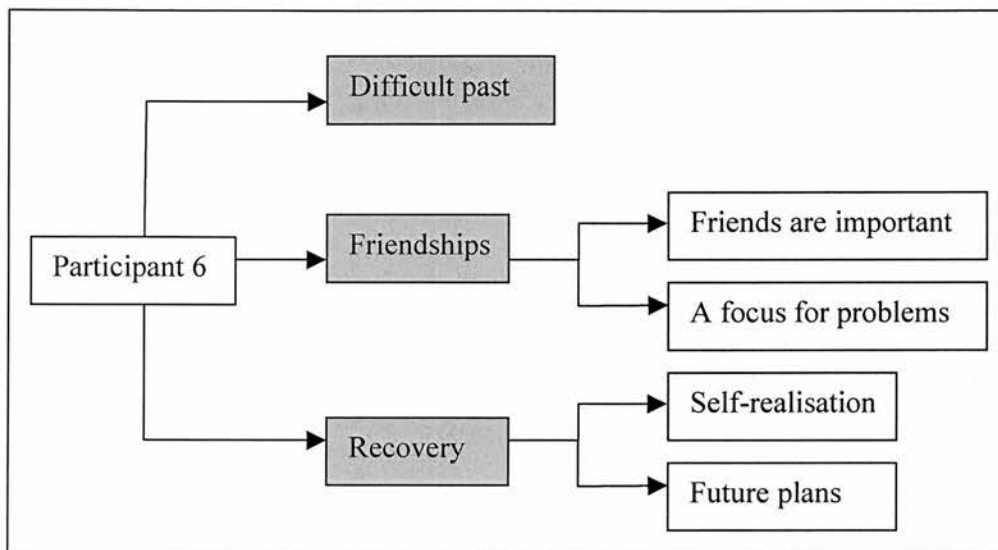
#### *My Reflections*

I had not met this participant previously and had been advised that he would make it clear if he did not want to pursue the interview or if I was using ‘psycho-babble’. I therefore approached this interview with some trepidation but after finding some common ground in cars, he engaged well in the interview. I was taken aback by his self-reflection and also the spirit he showed in wanting to take control of his life by understanding what had happened to him. He made some very direct comparisons between himself and me and a particular clash of cultures (explored later) made me aware of the great difference between us, but also of a connection that had been made between us. He told me after the interview that he felt as if a great weight had been lifted from his shoulders. A few weeks later he attended a psychology session with my supervisor and I (unrelated to the research) and he referred again to how helpful the interview had been. His determination to use the interview for his benefit was similar to participant 4’s, and these two interviews stood out for me as being particularly illuminating and positive experiences in the research process.

### Emerging Themes

Similar to earlier interviews, the past emerged as a significant theme, depicted as a difficult one. Friendships were used to exemplify the process of psychosis and future plans were important, encapsulated in social functioning and managing psychosis.

Figure 3: Thematic Structure: Participant 6



#### *A difficult past*

Participant 6 described a difficult early life featuring a violent father who had died the previous year:

**P6:** So I just really don't want it to happen to me, eh. I've seen my mum and that being stabbed before, dad and that when I was younger as well.

**I:** Really.

**P6:** Things like that. I've had a bad past when I was young as well. I've seen my mum getting battered and hit with hammers and things like that. I've seen all that when I was younger.

In this extract he was describing the treatment his mother used to receive at the hands of his father. He explained that many of the things he witnessed he should not have because he was supposed to be in bed, and as a result he could not share his memories with his mother. He appeared matter of fact in his description of the past but clearly identified a past a child should not have. His relationship with his father appeared to be a conflicted one:

**P6:** I just remember things that happened to my mum and that, like for instance if I've been arguing with my mum and then when I go up to my room I say, fuck it my dad used to do that to her as well. And like there's a few times my mum says ah, you're just like your dad. I hate when she says, like if we've been arguing or that, had a really bad argument, she says ah you're just like your dad. I hate when she says things like that.

**I:** Did you still see your dad before he died?

**P6:** I seen him up to his past, his last 6 months.

**I:** Had he been ill or?

**P6:** I used to steal off my dad and that, things like that. I used to take all my pals into his house, like my dad's house used to be like a café. He was an alcoholic, eh. So... So I just tried to get my dad back for what he did to my mum, eh. So I took all my pals in and things like that. Stole off him.

**I:** So you felt pretty angry at him then?

**P6:** But I didnae hit him or anything like that, I just got him back in silly ways, like bringing all my pals in, I smoked hash in front of him and things like that.

**I:** Did it help?

**P6:** Nut, I loved him eh. I did love him.

In this extract he explained his fears about becoming like his father in the way he treated his mother, and gave evidence for this with his mother's comments. He spoke about trying to avenge his mother and punish his father but that his methods were 'silly'. Finally he admitted that he loved his father. In this statement he appeared very open about his feelings.

### *Friendships: Friends are important*

He described the importance of friendships:

**P6:** Well my friends are everything aren't they, really, eh. Your mum's something and your friends are something as well, your friends make you sociable, eh. If you've no got friends you're no sociable.

**I:** How do you mean sociable?

**P6:** Well you dinnae go out, you know. You cannae do anything if you've no got a friend to go with, eh. I mean you can go to the pictures but you look daft. You can go up the town but you look stupid as well. You've nobody to speak to so you're on your own really. So if you've got a girlfriend you've got a friend.

In this extract he was explicit about the importance of friends in shaping the kind of person one is. He described solitude as an unnatural state that would attract criticism from others. He also drew a comparison between the relationship with friends and with mother. Whilst acknowledging the importance of the parental relationship his focus was on peer relationships. He then went on to explain the role of his girlfriend, who in the aftermath of the psychosis provided him with the 'sociability' that he wouldn't have had otherwise. It appeared very important to him that he was not alone.

He drew a comparison between his relationships with friends and girls before and after psychosis:

**P6:** Friends aren't friends if they dinnae come up to see you all the time really, eh. They should be coming up to see me, they should be here and where they should be, encouraging me to come out but they're no, they're just in their own wee world's doing their own wee things. As I say, I'm no exactly wanting everybody to run and jump on my back eh, but they can at least come and see me. As I say now I just sit in with my girlfriend or go to the pictures or we just... I'm actually better away from my friends because I never used to have time for lassies, I used to just do the thing what you do and tell them where to go, but now I've settled down and we're going to get a house and that together and maybe try for a baby. We lost a baby as well, that's what I've had a loss as well.



Here he was describing a lifestyle of one-night stands and being one of the boys before psychosis but told how his life has changed now and he wanted to settle down with his girlfriend, about whom he said:

P6: ... But my girlfriend is really supportive like, I love her to death.

From the extract above it can be seen that friendships were important to this participant. He expressed disappointment that friends have not kept up with him, but later asserted that he was better without them. He distinguished between what he would like his friends to do and what he could realistically expect them to do, and then observed that they weren't meeting either of these criteria. In this context he appeared to use his girlfriend as compensation for the rejection of his friends, and in the following extract expressed how strong their connection was.

#### *Friendships: A focus for problems*

The importance of friendships provided a context for the start of his problems, identified by him as paranoia:

P6: That's all our life, eh, you get caught you get caught but if it was me I was the one like the headless chicken, like the one that was really scared. The one who wasn't scared, the one out of all of us like, everybody else wouldnae be here, oh I'm easy if I get caught, if you know what I mean. And I was like that, oh I'm no, eh, if you know what I mean. Like I was scared, maybe it was because I was scared of my mum finding out or things like that as well, but I just knew I was getting paranoid over the slightest things. I was always with my mates and that and then it started getting to the stage when I was actually thinking my mates were actually speaking about me, saying things under their breath and that about me and that's when I knew, wow, there's something definitely wrong here.

Participant 6 became convinced that he would be caught by the police whilst out stealing. He described letting his friends down, eliciting criticism from them and increasing the chance of

them being caught. He attempted to rationalise his fear by suggesting it was related to his mum finding out, but he did not express a strong commitment to that notion. He seemed certain that the fear was not rational, and used the illustration of its spread to ideas about his friends.

Although he had described himself as needing other people around he seemed to speak about the battle to overcome mental illness as one that he alone was responsible for. He did not refer to his girlfriend, other family members or clinicians as having a role in his recovery. The mention of his own attitude towards people with mental illness suggested that he may have felt shame or stigma about his own situation, and was therefore unable to seek support. There was some evidence for this in the extract below:

**I:** And was it something you talked about with your friends at all?

**P6:** I told my friends and that when I first started going to the Young Persons Unit and that, about what was wrong with me and that, eh, but then the more I told people the more I was actually thinking maybe they are saying it now, now that I've told them, if you know what I mean.

**I:** So it was making it worse?

**P6:** Aye, I would say it was making it worse. See I was quite an open person, if I've got something wrong or something or something to say to somebody I'll just tell them, eh.

**I:** Uh huh.

**P6:** Straight to the point. Like friends-wise and that, no if I dinnae really know somebody I dinnae really like speaking about things, eh.

He described attempting to share his experience with friends, consistent with his character as an open person, but found that he then started worrying about how people might be using this information. He described learning that it might be better to keep such things to himself, and said that he would be wary with people he didn't know well.

### *Recovery: Self-realisation*

He mentioned that his brother had recognised his paranoia, having experienced the same himself:

- I: So when did you start getting closer then [with brother]?
- P6: Eh, I would say two year ago maybe, about two year ago. I would say just before the hospitals because I think he was starting to realise that I was smoking a bit too much cannabis and that. You see this kind of happened to him a wee bit, he was getting paranoid.
- I: Really.
- P6: But he was never taken to hospitals or things like that, he just stopped smoking hash, eh.

He seemed to compare himself to his brother and found himself wanting. Whilst his brother had been fine once he stopped smoking, and had not need any intervention, the participant's problem had been a lot worse and could not be so easily resolved. It is possible that these comparisons with others provided a means of understanding himself. He expressed a motivation to find out what happened:

- P6: But then, as I say, I still went up to hospital and I was still denying but deep down I knew and it was just admitting something, eh, like admitting to yourself that I am, like you hear about it, oh he's mentally ill, you laugh about people like that, eh, but when it happens to yourself it's a completely different story. You dinnae want to agree with it until deep down you know you have to agree with it, eh.
- P6: I've actually just agreed myself deep down that I have got problems, eh and that's me just agreed with it now so I'm no running away from them, I'm actually trying to fight it now, eh, if you know what I mean. If you just run away from things they just keep getting worse and that's what I done for about a year.
- I: Right.
- P6: And that's me just started to, well I have got a problem here and I'm trying to fix it.

In these two extracts he described not wanting to admit he had a problem, despite attending hospital, and that recognising his problem had not really been a choice. He also referred to what his response would have been to someone with mental illness before, and how he had to re-assess that position. He spoke about his approach to dealing with his problems as a 'fight' and reflected that his previous strategy of "running away" had made things worse. In these statements he appeared to see himself as pivotal to solving his problems, and that his attitude was important. His language was assertive, suggesting a clear and certain opinion. As with earlier extracts it could be seen that he was concerned by others' perceptions of him.

He was explicit about the difference between us at different points in the interview:

**P6:** Mm. Well like our families are not like families like what you are, all sit down at a table and things like that you know. My old man would probably be out having a drink, my ma would probably be getting battered if the tea wisnae ready, things like that you know.

**P6:** It still is. I dinnae really like going with my mates any more, eh. I'll go with my big brother's pals and that, eh, like my big brother will stay with me like, but see all his friends and that they're all proper people, like people you could have... like people you'd probably speak to for instance like. Normal, no people like neds like who I muck about with. People like you, nice people in other words, people you can have conversations with.

In these two extracts he appeared to have a clear idea about the kind of person I am and drew a comparison with himself. He seemed to have an image of my home life and friends, and this seemed to be associated with ideas about his brother's life. His brother had been moved to his grandparents' home amidst fears for his safety at the hands of the participant's father (they all had different fathers). He spoke about his brother's life with envy, as if he recognised how his life might have been. In the latter extract he described the friends who he

had valued so highly as ‘neds’<sup>2</sup> who couldn’t hold a proper conversation. It was almost as if he was acknowledging that he was not like me, but that he would like to be, and I wondered if I represented his brother in this respect.

*Recovery: Future plans with others*

In thinking about the future, this participant said there was no point in holding ambitions, reporting that his childhood dreams had been stupid:

- I: What kind of plans for the future do you have, or do you have any plans for the future?
- P6: I don’t want to look forward, I need to look about the now and see what’s wrong with me. No point holding ambitions.
- I: Is that something you’ve always thought or did you used to have ambitions?
- P6: I used to want to be a formula 1 driver, stupid things when I was a wee laddie but now.... I just want to get better.

Here he described wanting to focus on getting better to the exclusion of future plans. His comment about ‘stupid’ plans may reflect a feeling of loss – as a child he had dreams for the future but as an adult he could see that his life would not be that good. This linked with comparisons he had made between himself and others and his reflections that his early life was filled with and experiences. Despite his denial of future plans, he had previously described plans to get a house and start a family with his girlfriend. He also expressed fears about re-establishing relations with old friends as they had moved into dangerous crime, and noted the concern his mother felt for him.

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<sup>2</sup> “Ned”: Scottish colloquialism for an individual from a working or unemployed socio-economic demographic, typically lives on a council housing estate, wears sports clothes and is a member of a gang.

There was conflict in his story between a somewhat bleak portrayal of his life and the hopes he used to have, and his determination to overcome his difficulties and build a life for his future family. It was almost as if he acknowledged that he had not been lucky in life thus far but that he could take control of his own destiny. The assertiveness in his language reflected his strong motivation for the future.

### Summary

In summary, this participant described a strong sense of self described through comparison with others and with himself at different stages in his life. He was open about the struggle to accept his experience of psychosis, losing his friends, his feelings for others and his determination to overcome difficulties. He appeared to use the interview to try out ideas about his experience, and to use me as a way of describing himself and his life.

This interview suggested that an awareness of self and a search for an acceptable self-concept that was independent of friendships had become a more explicit task for participant 6. Coming to an understanding of psychosis was a means of mastering it and would be necessary for a good future.

### 5.4.2.2. Interview 7

#### My Reflections

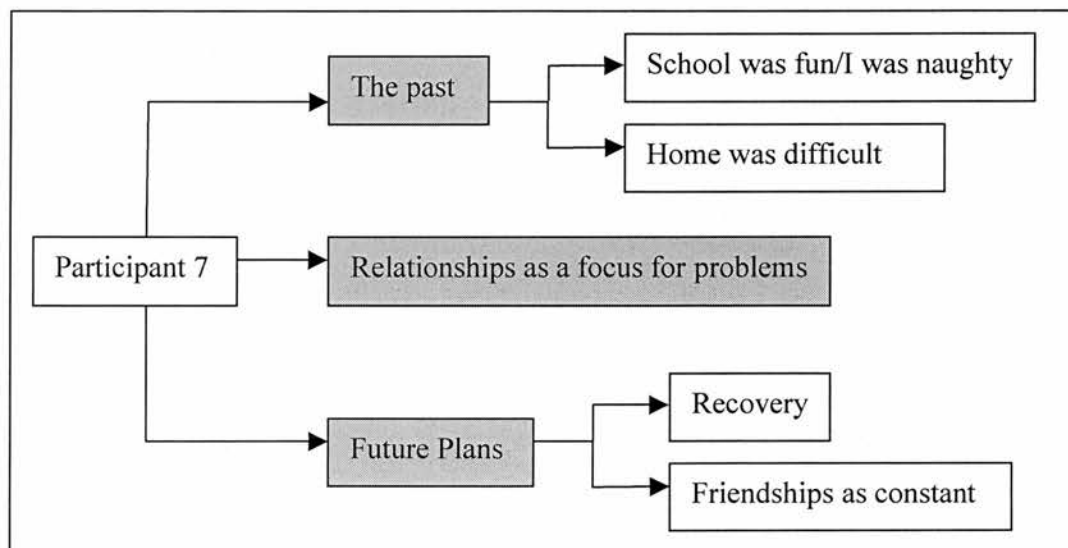
This interview took place on a hot and sunny afternoon and we sat outside, as there was no private space inside. Sitting on the grass, the interview felt more relaxed than other interviews to me. However, this participant reported after the interview that he had been speaking rubbish, then retracted this, and said that he had felt very awkward about being

taped. Nevertheless, he expressed an interest in getting feedback about the interview and participating in a verification process. During the interview I was concerned that his voice would not be picked up on tape as we were close to a train line and he was speaking softly. Though he answered all my questions readily I struggled to get a feel for his narrative, as if there were something closed off about him. I wondered afterwards if this was due to his reluctance to speak on tape or reflected a deeper difficulty in reflecting on his experience.

Emerging Themes

Participant 7's conversation focused on three main themes: The past (school was fun, home was difficult), friendships as a constant but also a source of problems and future plans.

Figure 4: Thematic Structure: Participant 7



*The past: School was fun/I was naughty*

This participant described a happy time at school taking the time to explain about the Rudolph Steiner School he had attended and about the fun he had breaking the rules:

- I: Did you enjoy it?
- P7: Yeah I enjoyed it. I met some good people there.

- I: It must have been quite different from East Craigs.
- P7: Yeah, it was. It was like you didn't have a uniform or anything, you just go in your own clothes but you weren't allowed to wear slogans and you weren't allowed to play football and there was boundaries in the school where you couldn't go. Some stupid rules that they had.
- I: And did people stick to the rules or not?
- P7: We just broke them for fun like, you weren't allowed in this part of the playground so we just ran into the playground and the teacher would try and chase us and stuff and they'd try and give us detention but we'd be off. And kicking footballs. We used to play basketball, you weren't allowed to play football but you were allowed to play basketball so we used to kick the basketballs and play football with the basketballs.

This extract described reminiscences about school days and time with friends, and he told me that he still saw many of the friends he had had at school. He described doing quite well at school (though not in the very positive terms used by participant 4).

### *The past: Home was difficult*

He reported remembering his father leaving at an early age, and then expressed surprise at bringing this up:

- I: Do you remember him?
- P7: Na, I've got pictures of him. I can't remember him at all. I have one memory that I can remember but that was him leaving, so that's the only thing I remember about him and the pictures that I've got.
- I: So you can remember him leaving, was there particular things, I mean was there something particular about that or?
- P7: I just thought about it just now, I don't like to think about it that much.

In this extract he appeared to elaborate on the story of his father, mentioning the photos, but then followed this by advising that this was not a comfortable topic of conversation for him. He emphasised that he did not remember much about his Dad and later explained that he and



his siblings all had different fathers. His younger sister's father was present throughout most of his childhood and did fatherly things with him, but never treated him as his own:

I: How do you feel about, I mean would you say there was any of them that you had a particularly good relationship with?

P7: When I was younger it was my sister's dad, I used to have a really good relationship with him. He used to see us at the weekends and stuff. I can remember a lot of stuff about him but the other dads were never there. My brother's dad, he's never been there.

I: So like your sister's dad is like the only one like who's been a proper kind of dad then?

P7: Yeah.

I: And does he treat you like one of his own sons?

P7: Na.

I: No.

P7: He treats my sister like his own daughter but.

In contrast to the previous participant this recollection of a father did not seem to have much emotional content. He emphasised the positive, "really good relationship" but appeared to overlook the negative side. When asked about seeing his own father he said that he had the option but "couldn't be bothered".

Nowhere in his narrative is there an account of others effectively caring for him, his father being absent and his mother an annoyance to him much of the time:

I: What about your mum, does she speak about it?

P7: Na, she talks sometimes about, oh, I hope you're not going to go back in hospital and stuff. She thinks she can know when I've been taking stuff and stuff like that. She's always saying that, even when I'm not taking stuff she's like have you been taking something, I don't want you going back into the ways you were. I'm like calm down.

I: So you don't have very constructive conversations about it then?

P7: No.

I: Is she, it sounds like she tries to be helpful but she's not that good at it.

P7: That's my mum!

This extract suggested that his mum was not an appropriate source of support or help for him, and it appeared that he did not like conversations in which the possibility of him developing another acute episode was mooted. His description of his mother thinking she knows suggested that he might not have felt well understood by her. He reported not speaking to her fiancé, and his sister having her own life.

### *Relationships as a focus for problems*

The participant gave a positive description of spending time with friends, getting high on cannabis:

I: What were the things about it that you enjoyed?

P7: The lift, it made things interesting and if you were bored and you got high it would just be more fun.

I: Did you do stuff when you were high?

P7: Yeah, we did some crazy stuff that I've done on drugs but most of the time it was just watching TV and eating out or getting drunk and having fun at the park.

In this extract he depicted his cannabis habit as a sociable pastime with friends, always fun, a means of alleviating boredom and a normal thing to do. He reported that he never felt that his cannabis use was out of control, and whilst other participants had made a link between their cannabis use and developing a psychosis, this participant did not offer this as an explanation immediately.

Instead, he referred to work as a trigger:

- I: What kind of job did you do?
- P7: I worked in XXX the bakers.
- I: Oh right. And how long did you do that for?
- P7: Until I went into hospital, a couple of years or a year, I think it was a year.
- I: Were you working on the counter?
- P7: Yeah, that's what made me go mad.
- I: What happened?
- P7: Just doing the same job every day and every person was just coming in, it just messed me up.
- I: How come?
- P7: I don't know it was just the kind of job. I don't think I was the right kind of person to do it.

This extract provided a fairly unequivocal statement blaming work for the development of psychosis. However, when I asked him to elaborate on his explanation that he was the wrong person for the job he explained that the other employees were fat old women. Thus it emerged that his explanation was about not finding a peer group at work. Nevertheless, in this statement he spoke about aspects of the job, the repetition and the amount of contact with the public as being stressors for him.

He described developing psychotic symptoms:

- P7: Yeah just talking to myself and getting paranoid around my friends and stuff.
- I: What kind of things were you getting paranoid about?
- P7: Just them talking about me, the usual stuff.

As with previous participants, friends provided a focus for paranoid ideas. He described his paranoia as being about “the usual stuff”. Later, however, he explained more about the experience:

P7: Yeah I thought it was all true so I just didn't think about it not being real and stuff.

I: So you never thought the voices were real?

P7: I did think they were real.

I: You did think they were real.

P7: I did think they were real, that's where the problem was.

I: So did it concern you at all that you were hearing them?

P7: Yeah it did a wee bit.

Here he identified a problem, his own lack of insight, and in doing so acknowledged that the experience of symptoms was something that caused concern. Nevertheless, he described a lack of curiosity about the experience – he thought they were true so that was the end of the matter – and appeared to minimise the level of concern he felt, “a wee bit”.

### *Future plans: Recovery*

Comments about the future suggested a certain amount of optimism:

I: Do you worry about it happening again?

P7: Yeah sometimes but I don't think it ever will, hopefully.

I: Are there like things you've done to stop it happening again or?

P7: I've just calmed down a wee bit, I haven't calmed down, well I have calmed down on the smoking. When I think about something I've got to think it through.

I: So like calming down the smoking, like calming down in other ways as well or?

P7: I haven't really calmed down the way I'm living myself.

- I: How do you mean?
- P7: Like the way I act and stuff, it's not that calm.
- I: Can you explain that?
- P7: Em... just the way I think, I just try and think ahead, the future and stuff. If I thought that, again like if I thought oh what happens in a couple of years if I'm still thinking this but what if you're not then if you're not then it's just stupid so why are you doing it now and stuff.

In this extract he expressed hope about the future and the likelihood of further psychosis. He described two active strategies for managing the future: reducing cannabis consumption and trying to take a different perspective on worrying thoughts by looking to the future and trying to imagine what he would think about the things that preoccupy him at the moment. This suggested an awareness of himself as perhaps being different in the future and holding a critical evaluation of himself in retrospect, and also of self-evaluation (“it’s just stupid”). In this statement he also expressed uncertainty about whether he had managed to calm himself down. There seemed to be an idea about how this might be accomplished, but an awareness that he still got wound up by particular thoughts. His statement about this appeared a little confused, as if he hadn’t fully thought it out. As he described coping through stopping thoughts that were ‘stupid’, he might have been avoiding self-reflection in general, hence its appearance in conversation as unclear.

*Future plans: Friendships as a constant*

His perspective on psychosis appeared to be of something that he could take control of, and which would not hold him back in life, reflecting an optimistic mindset. This was reflected in his thoughts about friendships as well:

- I: Do you still see that group of friends now?
- P7: Yeah, they're like the friends that I have.

- I: And over the time that you were in hospital and stuff did you lose your friends or were they still around?
- P7: I sort of lost my friends but there were some friends that I've stayed close to, like that came up and saw me and stuff. They were like my true friends and then I've made other mates since I've come out of hospital.
- I: I mean it sounds like I suppose going into a sort of demarcated, like your friends who were proper friends and...
- P7: Well I sort of segregated from my friends before I went into hospital, then when I was in hospital I sort of got my head together and started, when I came out I started seeing them again and stuff.
- I: So you say you segregated your friends before you went into hospital?
- P7: Yeah.
- I: Why was that?
- P7: Just because I didn't like what they were doing, like going to the pub with some people I didn't like and stuff. I just didn't like what they were talking about in the pub and that. I went a few times and it was just boring. So I just sort of stayed away from them.

Here he described successfully maintaining old friendships following his time in hospital, and also managing to make new friends. However, he also described segregating himself from some people, though the explanation for this was unclear, with some 'incurious' terms being used – "just", "boring". This extract also showed that he divided his life story by admission to hospital, time in hospital, and after hospital.

He made a clear evaluation of friends who stuck by him as "true" friends and expressed no grief for those he lost. He said that he started seeing people after he got himself together again, suggesting that he was active in re-establishing friendships, supporting the notion of someone with a positive attitude who felt entitled to friendships. As with earlier extracts there was a lack of reflection on any emotions around separating from friends, and it was difficult to get an impression of his feelings.

### Summary

In summary, Participant 7 gave a narrative about developing psychosis in the context of and contributing to interpersonal problems. He identified long-term friendships that had survived his experience of psychosis, but as with other participants, his friendships had suffered during the time he was developing psychosis. His past was described as both good and bad, and he expressed a hopeful attitude about himself and the future. When speaking about potentially distressing topics, his language was often neutral and conveyed a lack of interest, whilst the positive aspects of otherwise neutral or bad events were emphasised.

#### *5.4.2.3. Interview 8*

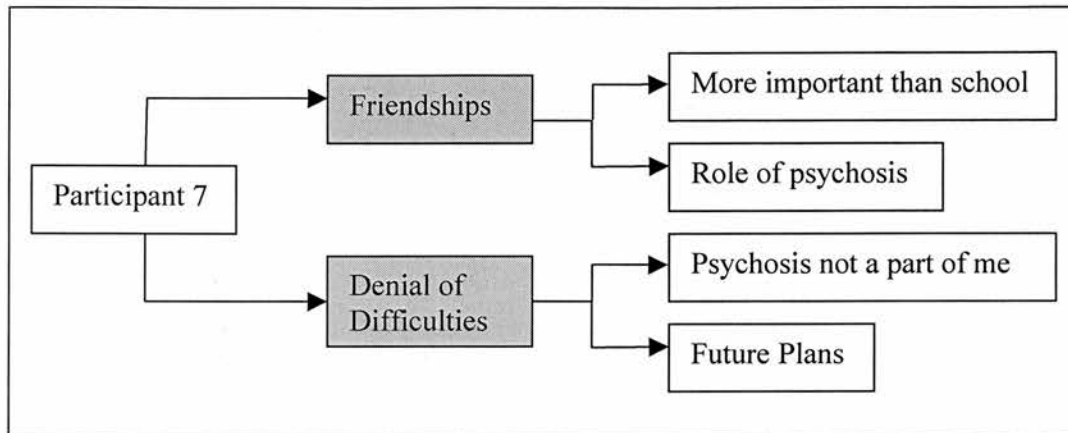
##### My Reflections

This final interview provided a contrast to the previous few interviews and reminded me of the earlier interviews where I had struggled to get any sense of the participant's experience. This participant was willing to cooperate with the interview but very unwilling or unable to offer much insight into his experience. Some of his comments were surprising, for example, his opinion about being sectioned and hospitalised in an adult psychiatric ward was "hospital was good". His exceptionally positive attitude towards the past, present and future did not appear to match up with the 'facts' of his story, such as being sectioned, losing his friends or being threatened by a gang, but his attitude seemed impenetrable. On analysis, his interview stuck out as quite different from everyone else's and I was interested to see if he was presenting a different version of similar themes or if his narrative really did contradict those of the other participants.

### Emerging Themes

Two main themes emerged from this interview: friendships (more important than school, role of psychosis) and denial of difficulties (psychosis not a part of me, future plans).

Figure 5: Thematic Structure: Participant 8



#### *Friendships: more important than school*

Participant 8 described his school days as being mostly spent out of school:

**P8:** I didnae really go to school that much, I wasn't that good at attending it, I used to skive quite a bit.

He described himself as not being “that good” at attending, which might have meant that he tried to attend school but struggled, or might be a euphemism for not having an interest in attending school. I explored this with him further and he reported that:

**P8:** It probably would have been better just staying at school.



However, he did not express regret, and pointed out that any qualifications he had missed out on as a result of non-attendance could be gained in the future. The statement above might have been a concession to my questioning about his missing out on school rather than a true reflection of his feelings. It may not have been something he had thought much about.

He described friends from primary and secondary school, amongst whom were a number of older friends:

**P8:** Aye, I used to drink a lot when I was about 13, 14, about 12, 13, 14 I used to drink quite a lot, but just through my friends. I used to muck about with people who were older than me and they used to all drink so I used to drink too, that was it. I dinnae really drink that much now, I dinnae smoke hash at all.

**I:** Did you always have friends who were older than you?

**P8:** Eh, sometimes, aye. Eh, I, in primary school I had a couple that were older and then in high school I used to muck about with quite a few folk that were older than me. Most of them were my age though, but quite a lot of folk were older.

**I:** And how did that come about, mucking about with people that were older?

**P8:** I sort of bumped into them in places, just started speaking. Well one of them, Jamie, he was one of my pal's big brother but I never see them any more. He was one of my pal's big brother's and I started mucking about with him and em, I dinnae ken, that was just pretty much it.

In this extract, he described following the actions of an older group of friends, although they did not constitute his whole circle of friends. He seemed unsure as to how he came by his friends, suggesting as before that this was something that he hadn't reflected on before. He did not depict himself as a leader of his group but a follower; he drank and smoked because others did, and he came by friends through default rather than through any active attempt by him. This was seen again in an extract relating to other pastimes:

**P8:** ... I was always in quite a lot of trouble and that. I used to get into quite a lot of trouble with the police when I was out drinking as well.

- I: What were you doing?
- P8: Eh, like fighting and that sometimes, just the people I grew up with were usually always fighting so I used to always join in.
- I: So it was the crowd that you were with rather than you?
- P8: Aye, pretty much.

In this extract he described getting into trouble but described himself as joining in rather than instigating the trouble. The motivation in this story is unclear. As with the earlier extract it depicted him as following the crowd rather than as a ringleader, and of actions by him or around him happening by default.

### *Friendships: role of psychosis*

He mentioned that he did not see these friends any more, and throughout the interview he described a series of changes in groups of friends. He had moved house and still saw some friends from primary school, but had lost touch with other more recent friends. An explanation for losing the group of friends mentioned above was given here:

- P8: Well there was folk after me and I was always carrying a baseball bat about with me in my pocket.
- I: Really.
- P8: Aye, for a wee while, but it's all fine now.
- I: What was happening?
- P8: Eh, just people I used to muck about with were always wanting to batter me and Jack [best friend] but we never really, it never really came to anything so I was always sort of carrying a wee bat about with me, so that was maybe a wee bit paranoid, but that's what probably made me a bit paranoid. I was always sort of looking over my shoulder and that.
- I: It sounds like it would be quite reasonable to feel a bit paranoid though.
- P8: Eh, I don't know. Well I never really bumped into them when I had it on me. He wisnae so much after me, I think he was kind of more after Jack. Jack had been really cheeky to him and that. But it's all sorted out now anyway. The guy lives in Wales now, he got his jaw broken before he moved out, one of my pal's hit him and he broke his jaw.

In this extract he described feeling threatened by a group of older boys who had been friends, and blamed his best friend for being cheeky to the older friends and causing their annoyance. He carried a baseball bat for defence during this period. He appeared unable to decide whether the need to carry a baseball bat was a response to paranoid ideas or whether this situation might have precipitated a paranoid state of mind. He appeared to believe that carrying a baseball bat was successful as a protective strategy when he said “Well I never really bumped into them when I had it on me.”

He went on to explain that the situation has been resolved and there was no cause for concern anymore. He also played down the danger that he was personally in, suggesting that it was his best friend who was actually both the cause and the one at risk. This did not seem to match up with his decision to arm himself.

Of note was his description of the effects of his first episode on himself and his friendships:

**I:** Do you think if you hadn't become ill, how would your life have been different or would it have been different?

**P8:** Eh, I don't know. I've never really thought about it.

**I:** Do you ever think about the time you know when you were coming into YPU, when you first started and you know when you said like you were cut off from all your friends and stuff, I mean it sounds like quite a dramatic change in your life.

**P8:** Uh huh, it was just because they were always smoking hash and that that I wanted to kind of stay away from it.

**I:** Right. How did you feel at that time, you know if you'd been hanging out with lots of people and then you didn't hang out with anybody.

**P8:** Eh... not really too bad because I was wanting to get into my body building, I didn't really think about it that much. I was always just reading books and magazines about body building and always training and that.

In this extract, he suggested that he had never reflected on his own life and the impact of psychosis. In relation to losing friends (he identified a two year period in which he saw nobody) he described it as a pragmatic decision as he needed to avoid cannabis. His statement suggested that the body-building functioned as a distraction from his loneliness, but he describes it as almost coincidental – as he was into body-building he didn't really notice not having friends. Again, he did not depict himself as an active agent in his own life so much as an individual to whom life happens.

*Denial of difficulties: Psychosis not a part of me*

He identified cannabis (and alcohol) as the cause of his problems:

I: And what was the first thing that you noticed?

P8: Eh, I don't know. I couldnae get to sleep. I just couldnae sleep sometimes.

I: And why was that?

P8: Eh, it must have been because I was ill. I just couldnae get to sleep at all. I think it's because I'd been smoking far too much hash and drinking too much and then I just started getting ill. I was used to having a joint every night before my bed and then when I didnae have any I couldnae get to sleep and I started getting ill.

I: So did you feel like you were a bit dependent on it then?

P8: Eh, maybe, I don't know. I wasn't really dependent on it, I didnae smoke that much.

I: Right. How much did you smoke?

P8: It depends if I had any or not or if I used to get it off people, but, eh, I mean we used to smoke quite a lot, me and my friend Jack. That's all we pretty much done, we went up to training and then we smoked hash.

In this extract he described a relationship between his cannabis use and the start of problems, which he identified as difficulty sleeping prior to a manic episode. However, there appeared to be some confusion in his description as to what caused what between not being able to

sleep, becoming ill and smoking and drinking too much. He also seemed uncertain about how much cannabis he was smoking. Whilst I was confused by this account, he was able to explain it for himself quite easily:

**P8:** I don't know, just I've got a vulnerability to it probably and he's not [best friend].

**I:** Right. So he could probably smoke dope all his life and never really suffer for it?

**P8:** Aye, probably.

**I:** And when you think of a vulnerability, how do you mean?

**P8:** Well my dad he was a schizophrenic so I've probably got a vulnerability to it.

In this extract, he differentiated between his best friend and himself, using his dad's mental health problems as an explanation.

#### *Denial of difficulties: Future plans*

He managed to maintain an optimistic view of his own future (his father spent most of his adult life in a secure psychiatric unit):

**I:** And do you think if it happened again you would be able to handle it differently or do you think you handled it okay?

**P8:** Aye, well I'd adjust the medication that I needed, speak to a doctor.

**I:** So it sounds like the medication's been quite effective for you.

**P8:** Aye it has a wee bit.

**I:** And do you think like having bi-polar and having to take medication, how much do you think it's going to affect your future?

**P8:** Well they're not planning on me being on the medication for ever, it's no addictive stuff that I'm on so I'll probably be on it... if I'm well for about another two years I should be coming off it again.

In this extract, he described a strategy for staying well, by using medication and consulting his doctor. He did not seem to see the experience of psychosis having an effect on his future, arguing that his medication would stop in a couple of years. Unlike the other participants, he did not see his own actions as being significant in managing psychosis. As with previous extracts, this one seemed to show a lack of self-reflection.

He had many plans for the future, including:

**P8:** Eh, well I'm qualified to be a lifeguard, I've got my first-aid, eh, I wanted to be a personal trainer though but I didn't get the full qualifications. I could go back and get them but there's a course that I've got an interview tomorrow at Stevenson, so I'll need to go part-time and do, eh, like ken like spray painting for car and that.

He described many other plans for the future, none of which he saw being affected by his ongoing problems with psychosis. He saw himself as an active agent in his career plans, in contrast to his approach to friendships and mental health.

### Summary

In summary, Participant 8 raised many questions with his apparently passive approach to life and his lack of self-reflection. He described a factually troubling recent past but appeared to have little emotional response to this. He had lost most of his friends during the onset of psychosis and had succeeded in re-establishing only a few of these relationships. However, he did not appear troubled by this, and expressed great optimism about the future, whilst not perceiving himself as an active agent in that future.

### 5.4.3. Discussion

These last three interviews had similarities and differences and it was possible to see commonly occurring themes manifested individually. All three participants, when asked about the future expressed hopes and plans. Participants 7 and 8 focused future plans around career and education whilst participant 6 was interested in recovery and relationships. They all expressed optimism about the future, although this was sometimes tempered with fears. Participants 6 and 7 saw themselves as active agents in their futures, dependent upon developing an understanding about their experiences of psychosis so that they could prevent a future recurrence. Participant 8 had placed his faith in doctors and medication and did not identify a personal strategy for preventing future episodes, but expressed the greatest optimism.

All the participants reported how real their experience of developing psychosis had been. In each case, the content of symptoms was based on experience with friends, and due to familiarity with cannabis use and the consequent plausibility of the symptoms, the participants had not been certain what was real and what was 'paranoia'. This supports Harrop & Trower's (2003) suggestion that psychosis-like experiences are common and normal in adolescents, and like other adolescents, these individuals seemed to be actively pursuing alternative experiences through the use of drugs and alcohol.

As friendships fed into psychotic experience they also suffered. All the participants describe losing friends. Participant 6 had been unable to overcome his paranoia and continued to be isolated, seeking solace in his girlfriend. Participant 7 described actively pursuing relations

with friends who had proved their worth after leaving hospital. Participant 8, more passive than the others, spent two years without friends but denied this causing him any distress.

Although all participants made a link between cannabis use and psychosis, there was general uncertainty about what had caused their problems, and where problems had actually started. Participant 6 identified several early life events that he felt to be significant, though he was unsure how. Participant 7 could not offer an explanation, but said that at the time he had attributed the experience to the immediate effects of cannabis use. Participant 8 blamed his father's genes.

There seemed to be a relationship between the individuals' sense of self-efficacy, attributions about life experiences and focus on future relationships. Those who described themselves as active agents in their life course also accepted the possibility of more diffuse and subtle influences on the development of psychosis. Those who showed greater agency also wished for or had actively pursued re-establishing relationships, whilst more passive individuals appeared to have abandoned hope of future friendships. However, this relationship did not appear clear-cut. This understanding contributed to the development of a thematic structure to explain all the interviews and is presented below.

## **5.5. Overall themes**

Following analysis, all interviews were analysed together to identify overall themes. Three main themes and a specific process emerged. These are labelled: a polarised past, being defined by friendships, developing a positive perspective. These themes reflect a process of change from before through trauma and loss (developing psychosis) to the search for a future,



and might be encompassed within an over-arching theme of survival. The process of survival is explored first in order to provide a context for the other themes. The coding structure for the process and themes is shown in Appendix II.

### **5.5.1. A Survival Process**

Participants' stories followed a consistent trajectory despite my focus on a particular period (the time shortly before psychosis). All the participants referred to life before psychosis as normal, although the majority also identified difficult early events including breakdown in the parental relationship.

They depicted the development of problems as starting with 'bad behaviour', followed by specific events that interfere with a stable interpersonal sense of self such as a romantic relationship ending, a friend leaving, or being bullied.

I: So were you in trouble quite a bit?

P7: Yeah. Not in the younger ?? but when I turned like 13, 12 or 13 I started being a bit bad.

I: What kind of things?

P7: Just smoking and, em, going out of class, skiving school and stuff.

P4: She was a model, she was gorgeous you know and she actually finished with me because I was taking drugs.

I: Right.

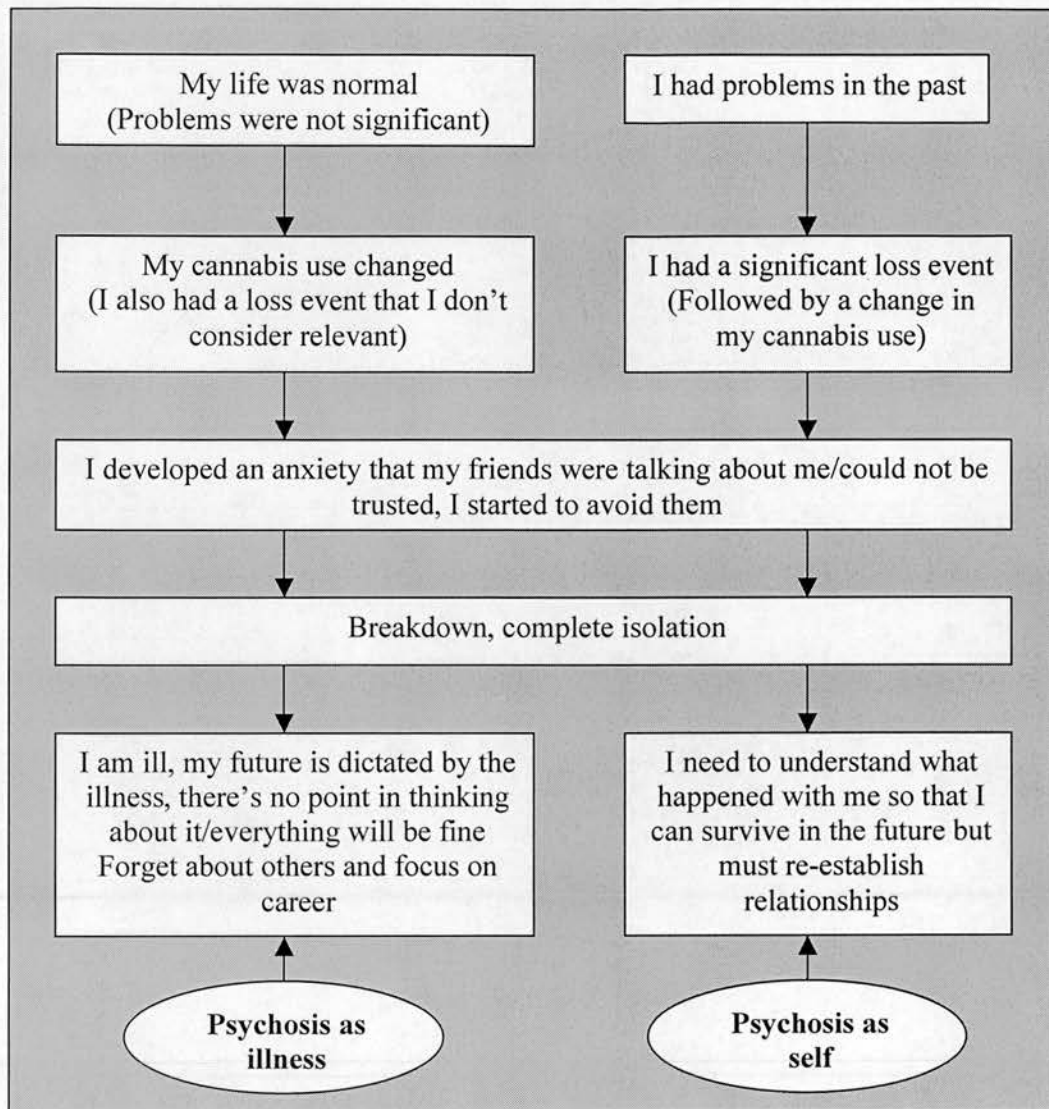
P4: Simple. Na, she was beautiful, she was the best girlfriend I ever had basically and she's at university now, she's a lawyer and stuff like that. And then again I screwed it up again, you know. But she done the wrong thing because she betrayed me when she went on holiday and didnae want to be with someone like that so I told her where to go and that's how it basically ended. Mind you I had loads of other girlfriends. I had people crying over me and stuff like that, so that was a lot of fun actually by the way (laughing)...

- I: ... But your other friends had already left school so you were... was that right? Those last three months or so that you were at school, your other friends had already left?
- P4: Uh huh, most people had left. They were... I don't know what they were doing, I never seen them really.

Experiences that were retrospectively understood by the participant to be psychotic such as voices, paranoid or over-valued ideas and extreme anxiety/panic followed this event. An association was made with cannabis consumption in all cases, and the experience was intrinsically connected to a breakdown in all relationships.

In most cases an emotionally charged account of the 'acute' phase was depicted. Finally, the present and future were described with hope, optimism and fear, and accounts could be divided between those participants who wished to forget what had happened and re-start their previous life, and those who wished to understand what has happened in order to protect themselves from the future. Those who wished to forget tended to adhere to an illness model of psychosis, whilst the latter group regarded psychosis as an experience that was fundamental to their self. Broadly speaking, this process defined two groups in terms of the attributions made at each stage. This process is described in Figure 6. In this diagram, two routes through a single process are described, the different routes being based on external/internal attributional styles, ability to hold a multi-faceted perspective on causation and belief in self-efficacy. These routes are not mutually exclusive.

Figure 6: Hypothesised thematic structure of psychotic process



Some participants vacillated between positions (e.g. Participant 7) or described making a permanent and explicit shift from one to the other (e.g. Participants 4 and 6). The themes in this process are described below.

### *5.5.1.1. A polarised past*

Participants offered polarised descriptions of the past, either explicitly defining themselves and their lives as very normal with negative events not considered relevant, or as marked by negative events that have shaped them. In the former group (psychosis as illness), some connections were made between negative events and self but typically in a way that lacked emotional resonance, as though the individual had distanced himself from the experience.

**P:** No I dinnae really remember him [Dad] leaving because there was so much before all this, before him leaving, eh, so. I've forgot quite a lot of things as well. I cannae really remember when I was 8, 9, 10, but I can always remember the bad things. It's like there's no been any joy in my life really, like anything I can really remember what was good, apart from going on holiday with my mum and that. I can remember a lot of bad things, a lot of bad things.

**P8:** Yeah, it was only like recently I started seeing him a bit more.

**I:** Right.

**P8:** When I was younger he was a paranoid schizophrenic so it was like kind of dangerous for me being around him and that. So I didn't really see him much and then, eh, I started seeing him again pretty recently. Within the last couple of years I've seen him a wee bit more.

### *5.5.1.2. Being defined by friendships*

All participants elected to focus on friendships in the interviews, and references to self were made through descriptions of friends, activities with friends, or others' perceptions of the participant. This occurred in stories about life before psychosis but also in descriptions of psychotic experience, in which paranoid ideas centred on friends, voices were those of friends, and anxiety was based on the possible actions of friends.

**P8:** Aye, I used to drink a lot when I was about 13, 14, about 12, 13, 14 I used to drink quite a lot, but just through my friends. I used to muck about with people who were older than me and they used to all drink so I used to drink too, that was it. I dinnae really drink that much now, I dinnae smoke hash at all.

**P6:** I was always with my mates and that and then it started getting to the stage when I was actually thinking my mates were actually speaking about me, saying things under their breath and that about me and that's when I knew, wow, there's something definitely wrong here...

**P6:** I told my friends and that when I first started going to the Young Persons Unit and that, about what was wrong with me and that, eh, but then the more I telt people the more I was actually thinking maybe they are saying it now, now that I've told them, if you know what I mean... Because my life was getting worse, I wisnae going out, I wisnae socialising, I wisnae just doing normal things. I was sitting in my room playing my computer watching TV. I never even had a girlfriend at the time or that, it just wisnae for me at all like...

Descriptions about the psychotic phase were marked by isolation from friends, and the post-psychotic (current) period was depicted as a struggle to re-establish friendships or the wish for friendships.

**P7:** Well I sort of segregated from my friends before I went into hospital, then when I was in hospital I sort of got my head together and started, when I came out I started seeing them again and stuff.

Those who had a wish to understand the experience also expressed a wish to re-establish friendships in the future. The rest showed little interest in future friendships, instead focusing on career plans.

### *5.5.1.3. Developing a positive perspective*

This theme was only explored in later interviews (6-8) having spontaneously emerged in interview 4.

Those participants who wished to understand their experience spoke of continuing difficulties and overcoming adversity with determination. Participant 8, by contrast did not appear to be

trying to use the past to inform his future as the others were, but hoped that his illness would simply go away. Though his perspective was markedly different from the others' it demonstrated that across the whole sample there was a strong hope for the future, however that hope might be conceptualised.

## 6. Discussion

Throughout this interview process it has been seen that finding a survival strategy is a key theme. The sample could be divided (though not exactly) by two survival strategies. The first survival strategy ('psychosis as illness') involved an acceptance of psychosis as an illness that had happened through chemical means (drug use) and genetics (in one case). This acceptance predicated a plan for the present and future that involved minimal self-reflection and an acquiescence to the illness as a deciding factor in the individual's future. The second survival strategy ('psychosis as self') involved a theory of psychosis that was multi-faceted. Though none of the participants employing this strategy asserted a certain cause for the psychosis, they acknowledged the presence of negative early events, difficulties in their life shortly before the development of psychosis, cannabis use, and their own lack of understanding as likely causes. They saw their future success as a struggle that they must personally invest in and identified an understanding of what had happened and their re-engagement with others as pivotal to that struggle. Across all interviews, friendships were used to define self and psychosis, past self was viewed as very normal or very bad, and hopes for the future were important.

It is important to note that the distinction between the two survival groups is not as sharp as might appear. Whilst some participants fell clearly to one side (Participant 8 epitomised the psychosis as illness model, whilst Participant 6 defined psychosis as self), some participants vacillated between the two positions. For example, Participant 7 was uncomfortable reflecting on his past and focused on his career rather than interpersonal relationships in the future, but also expressed a wish to understand what had happened and a determination to manage his own symptoms. All the participants described themselves as ill, an inevitable

consequence of being treated within a psychiatric service, but those who fell into the 'psychosis as self' bracket did not appear to hold a concept of psychosis as illness as something meaningful to them and expressed conflict between accepting it as an illness over which they have control and regarding it as something created by a combination of their actions (cannabis use, choice of friendships and pastimes) and events that had happened to them (early and recent loss events such as parental separation, witness to violence, being dumped by a girlfriend), and therefore something over which they might have control.

Choice of survival strategy appeared to be based on whether the participant understood psychosis to be an illness separate from his self or an intrinsic part of his self. Another way of conceptualising this, however, is to see self as the deciding factor in an understanding of psychosis and survival strategy. The 'psychosis as self' group expressed a need to assert their self over psychosis, showed awareness of a self and perhaps evidenced this through a wish to re-establish relations with others, by which means they could re-establish that self. The 'psychosis as illness' group, by comparison, may not have had a sense of self that could be asserted over the psychosis, and therefore accepted the psychosis as a ruling factor in their future and gave up hope of finding their self through relationships with others. If this is the case, it might be that a sense of self has been lost.

This division in adjustment to psychosis has been noted before, most obviously in McGlashan *et al.*'s (1975) definition of coping as 'sealing over' versus 'integration'. However, this study develops the idea beyond a coping style to something that might be fundamental to the individual and their experiences. A core problem with the sealing over/integration concept has been its clinical basis and implications. The individual is understood to have accepted and integrated or blocked out the fact of mental illness. In the present analysis, the individual



is understood to have had an experience that both represents and threatens their developing sense of self. Their survival (coping) strategy is defined not by their acceptance of an illness model but by their ability to assert their self over the illness model and find personal meaning.

Harrop & Trower's (2003) thesis is heavily drawn upon in this study as a basis for understanding the developing self and the role of psychosis within this. In the earlier stages of the research process, the self as defined by others was seen as a feature of the pre-psychotic individual, and understood as a possibly maladaptive influence in development. However, at the end of this study, that understanding seems simplistic. All the participants described a self defined by interpersonal relationships, yet not all those selves seemed to survive psychosis. As this study took place at one point in time, it seems possible that if these participants were interviewed at different times, they might express different intentions about the future and a different awareness of self. Participant 6 offered some evidence for this possibility, stating that for a long time he had refused to accept there was anything wrong, but now that he had a girlfriend and a wish to pursue a future with her, he had accepted his difficulties and was ready to face the challenge of overcoming them. In his case, it was the appearance of a meaningful interpersonal relationship that seemed to have triggered an emergence of his self. This suggests that the interplay between the self and other is a complex one, and the nature of the relationship in the context of psychosis is not explained by this research. However, this study does demonstrate that the developing self is critical to the psychosis process, and that understanding psychosis within the context of self, rather than as an illness is desired, meaningful and helpful to the young adult.

## 6.1. Limitations of this study

There are a number of limitations in this study, mainly due to the limited resources available. Some of the limitations therefore represent how this study would have been ideally conducted.

Saturation is accomplished when no new themes emerge from the data, no matter how many participants are used. A thematic structure was arrived at in this study, but it could not be said that saturation was reached. One key reason for this was the research question. As the researcher's work role and participants' inclusion in this study was defined by the dominant paradigm in psychosis – the medical model – this provided a frame for a question about the prodrome. However, it emerged early on that the participants held no concept of the prodrome, and that there was a tension between the information people had received about their experiences as a medical condition and their desire to take control and integrate their experiences in a meaningful way.

Therefore the question diffused into a number of questions about interpersonal relationships, self and the process of psychosis. Were this study to be extended, it would be worthwhile revisiting the question in the light of the current findings and developing a number of new questions that held more personal relevance for the participants. This outcome, however, serves to show that providing a medical explanation for psychosis is not necessarily meaningful or helpful for the young person experiencing psychosis.

A verification process can be used to establish whether the researcher's analysis of the interview corresponds with the participant's, usually through a second interview in which the

analysis can be explored and developed upon. In this case, time did not permit a verification process. However, there is the opportunity for this with some of the participants and would be conducted prior to submission for publication in a research journal. Instead, two supervisors and a group of peers conducting qualitative research provided comments and suggestions about the analysis, and there was a high degree of agreement about the emerging themes.

In qualitative research, transferability is considered as more relevant than generalisability. In this study, the sample was originally intended to comprise males and females. However, the majority of service users were male and only males were willing to participate. Therefore, the outcomes of this study cannot be assumed to apply to females, and this would provide a focus for future research. This research was conducted at one point in time, yet a dynamic process emerged. Therefore, it would increase the utility of these findings if a similar process emerged amongst people at different stages of the psychotic process and at different ages. The thematic structure drawn from this study is theoretically consistent with the literature on self, trauma and coping but it cannot be assumed that it could be transferred to other psychotic populations, and especially not to people who have not come into contact with psychiatric services. The thematic structure provides a starting point for further exploration rather than a comprehensive theory. One approach to addressing this would be through interviews with comparison populations such as those who have received psychiatric attention, individuals who have experienced trauma but no psychosis and a wider section of the treated psychosis population.

This was my first attempt at qualitative research and through the use of a reflexive diary I was able to chart my progress and the difficulties I encountered. Some of these difficulties

will have affected the outcome of this study and are briefly considered here. A practical problem was my role as clinician within the population I was sampling. This inevitably created a slant on the interview that was not overcome by holding interviews at venues other than the YPU. Equally, all the participants had received input from a psychiatric service and their attitudes towards their own experience were influenced by this.

My clinical and training role provided a challenge for me in terms of the interview and analysis. I struggled to think beyond a psychological framework. Having criticised previous research for adhering to imperfect and limited conceptualisations of psychosis, I was disappointed at times by my own lack of creativity and was made aware of how conditioned my thinking has been by my training. In the future, it would be interesting to include people from other disciplines in the analysis process such as anthropologists, philosophers and social scientists.

## **6.2. Clinical Utility and Future Research**

This study has clinical utility for the following reasons:

- It challenges our use of the disease conceptualisation of psychosis in communicating with patients. Hayward *et al.* (2005) recommend training in alternative (psychological) conceptualisations of psychosis across psychiatric services, and including individuals who have experienced psychosis is in this training
- Our means of dividing the phases of psychosis into pre-morbid, prodromal and acute are not meaningful to the individual, who will use events such as being hospitalised and changes in friendships to demarcate their lives. These markers are more salient to the individual and represent actual events rather than arbitrary medical distinctions

- Psychosis is perceived by people as one of many life events. A priority is to be able to integrate the event into their life narrative in a coherent manner, and in a way that empowers the individual to take on personal responsibility for their future
- The development of psychosis is inherently linked with a collapse in interpersonal relationships and this seems to be a major preoccupation for young people who define themselves by their social circle. A priority for services is to maximise the re-engagement of the individual with an appropriate peer group, encourage social skills and strengthen personal identity

There are many possibilities for future research. New questions might include:

- The nature of self in young people who have and haven't experienced psychosis
- How do conceptualisations of the psychotic process differ in women and in those who have not had contact with psychiatric services?
- How do conceptualisations of self and the psychotic process change over time?
- What is the function of a "psychosis as illness" position for the individual?
- Is a trauma or grief model meaningful in describing the psychotic process?

## 7. Conclusions

Eight people aged between 18 and 23 years participate in open-ended interviews exploring interpersonal relationships in the prodromal period. Using a grounded theory analysis, the research question evolved into an exploration of the meaning of interpersonal processes across the psychotic process. It emerged that the prodrome was not a meaningful construct, but that friendships provided a means of self-definition. A thematic structure was created that described a process of survival after psychosis in which the re-establishment of friends was paramount. Participants were divided by their ability to integrate psychosis into a sense of self, or an adherence to a concept of psychosis as an illness separate from self. It was hypothesised that this latter group had lost their sense of self during the psychotic process. The importance of recognising psychosis as a process inherent to the individual and not as a disease marked by discrete stages was emphasised by the findings. The research raised questions about the nature of self in young people with and without psychosis or contact with psychiatric services.

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## **9. Appendices**

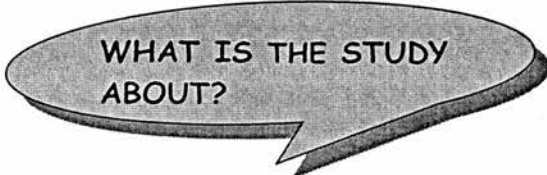
*A QUALITATIVE STUDY OF  
YOUNG PEOPLE AND  
RELATIONSHIPS*

**PARTICIPANT  
INFORMATION SHEET**

You have been invited to take part in a study exploring young people's thoughts and feelings. Please read the information below before deciding whether you would like to take part. There is no hurry for you to decide. If you have any questions, please ask your key worker.

You can contact me at the YPU:

Emily Taylor  
Trainee Clinical Psychologist  
Young People's Unit  
Royal Edinburgh Hospital  
Tipperlinn Road  
Edinburgh EH10 5HF  
Tel: 0131 537 6364



**WHAT IS THE STUDY  
ABOUT?**

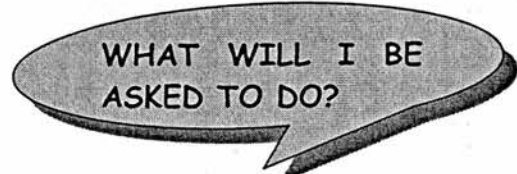
Though clinicians understand that mental health problems have a big effect on young people, there has been no research asking young people to tell their story - what they think about their experience and what it means to them.

I am interested in finding out what you think about your experience. I am especially interested in your relationships with other people and how these might have changed over time.



**WHY HAVE I BEEN  
ASKED TO TAKE PART?**

You have been asked to take part because you are aged 16-21, and have become involved with EPSS.




**WHAT WILL I BE  
ASKED TO DO?**

This project involves a series of interviews. In these interviews you will be asked about the relationships you had with family, friends and others before you became ill, and if these changed. The aim is to find out your thoughts and feelings at that time and what you think about your relationships now.


You will be able to lead the interview by talking about what is important to you. It is an opportunity for you to explore your own experience and describe it in your words. When you feel you have explored enough, the interviews will end.

The interviews will take place at the YPU. Alternatively, we can meet at your home, as long as you have a room where we will not be disturbed. It is up to you. There will be no more than 3 interviews over a period of 1-2 weeks.



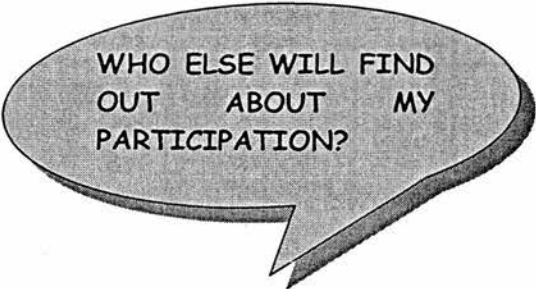
**DO I HAVE TO TAKE PART?**

No! It is up to you whether you take part. The interviews are not part of the care you receive from EPSS, and your decision about taking part will have no effect on the treatment you receive. If you decide to take part, you will be asked to sign a consent form. You will still be able to change your mind at any time, and without giving a reason.



**ARE THERE ANY RISKS OR BENEFITS?**

We hope that the interviews are interesting and helpful to you, and it could help us to develop better services for young people. If, at anytime, you are asked questions you do not want to answer or find the discussion upsetting, you can ignore a question or stop the interview. Remember, if you want to withdraw from the study, for any reason and without explanation, you are free to do so.



**WHO ELSE WILL FIND OUT ABOUT MY PARTICIPATION?**

The staff of EPSS will know so that they can help with arrangements. You can discuss the interview with them if you wish, but I will not share anything you have said unless you say something that causes concern about your safety or that of other people.

As this research is within the NHS, I am obliged to inform your GP about your participation. However, your GP will not have access to any information you give me during the study. All the information you give will be confidential - it will not be passed onto anybody else.



**WHAT IF SOMETHING GOES WRONG?**

The University of Edinburgh has approved the research and is acting as the sponsor. It will therefore provide indemnity and/or compensation should you incur any suffering (negligent or non-negligent) as a consequence of taking part in this research.



**WHO HAS REVIEWED THE RESEARCH?**

The Lothian Research Ethics committee, which has responsibility for all research conducted within the NHS, has examined the proposal and has raised no objections from the point of view of medical ethics.

**Thank you for taking the time to read this information.**



## 9.2. Appendix II: Structure of Emerging Themes

