THE UNIVERSITY OF HULL

Exploring the Experiences of Relationships and Sexuality for Individuals Diagnosed with Psychosis

Being a Thesis submitted in partial fulfilment of the requirements for the degree of

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By

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Contents

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Overview

This portfolio thesis comprises of three main parts: a systematic literature review, an empirical paper, and appendices.

Part one is a systematic literature review, exploring qualitative literature about the experiences of relationships for individuals diagnosed with psychosis. A total of seven papers were critically reviewed and analysed through Thematic Synthesis Thomas & Harden, 2008). The synthesis revealed two overarching themes: Forming relationships and Maintaining Relationships. Within those there are nine subthemes. The implications of these findings involve understanding of the importance of relationships, especially when an individual is distressed by unusual experiences.

Part two is the empirical paper, which explores LGBQ+ individual's lives with unusual experiences. These experiences were analysed using Interpretative Phenomenological Analysis (Smith et al., 2009). The analysis formed four superordinate themes and 10 subthemes within that. Theme titles were: The Experiences and Influence of Trauma; Exploring the Existence and Understanding of Unusual Experiences; The Development of Self-Identity; Relationships with Others. The findings of this empirical paper seek to understand unusual experiences and sexual identity for LGBQ+ individuals. This can improve services by helping professionals to understand and appreciate the participant's 'lens' (Burr, 2015), therefore improving the accuracy of understanding and clinical skills.

Part three is the appendices, which contains documents relating to the first two parts of this portfolio thesis. This includes a reflective statement on conducting the systematic literature review and empirical study, as well as the epistemological statement regarding the position of the researcher throughout the process.

PART ONE: SYSTEMATIC LITERATURE REVIEW

This paper is written in the format ready for the submission to:

Clinical Psychology Review

See Appendix F for submission guidelines.

The Experiences of Romantic Relationships for Individuals Diagnosed with Psychosis: A Literature Review

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Abstract

Previous research has highlighted the necessity of romantic relationships for the well-being of individuals with psychosis. However, there has been no literature review to date that explores the holistic experiences of these relationships. This review aims to explore the experience of relationships for these individuals. Seven qualitative studies from two major search databases were assessed for quality using the NICE Checklist (Spencer, Ritchie, Lewis & Dillon, 2003) and then thematically synthesised (Thomas & Harden, 2008). Results include two superordinate themes of Forming Relationships (four subthemes) and Maintaining Relationships (five subthemes). The results from this review identify evidence of societal and relational support and potential barriers, and what might be helpful from a recovery perspective. Conclusions, implications, and recommendations for future research are discussed.

The Experiences of Romantic Relationships for Individuals Diagnosed with Psychosis: A Literature Review

The following literature review critically explores the under-examined importance of intimate relationships for people with psychosis and its impact on well-being. An intimate relationship (romantic and/ or sexual) can be described as a process wherein two individuals share feelings, thoughts, and experiences to connect and learn more about one another (Reis & Shaver, 1988). ‘Psychosis’ or ‘unusual experiences’ are usually described as sensations or experiences that are culturally unusual and can cause severe distress, such as voice-hearing or visual hallucinations (Larøi, et al, 2014).

This literature review uses ‘psychosis’ and ‘unusual experiences’ interchangeably due to the researcher’s position that ‘correct’ labels can only be defined by the experts by experience, corresponding to Social Constructionist Theory used in this review (Burr, 2015). Until now, there have been few studies that explore the experiences of romantic relationships concerning populations with unusual experiences.

Evidence suggests that the onset of unusual experiences is often associated with the loss of intimate relationships (Baker & Procter, 2015) and consequential increase in loneliness and social isolation (Chrostek, Grygiel, Anczewska, Wciórka & Świtaj, 2016; Michalska Da Rocha, Rhodes, Vasilopoulou, & Hutton, 2018; Sundermann, Onwumere, Kane, Morgan, & Kuipers, 2014). Social isolation can predict inpatient admission and later severity of unusual experiences (Olver & Norman et al., 2005; Salokangas, 1997). This could lead to an increased avoidance of socialising, voice-hearing, paranoia, and loneliness that may perpetuate difficulties (Sheaves, et al, 2020).; de Jager & McCann, 2017). These factors have not been compared across different bodies of literature; therefore, it can be disputed how applicable these speculations are without the broad evidence of a literature review.

People who struggle to form and maintain intimate relationships in adulthood may have experienced insecure (neglectful or abusive) attachments from early life (Ainsworth, 1978). Individuals who experience anxious attachment may react to partnerships with expectations of rejection, dependence on others, exaggerated affect or helplessness to maintain contact and increased proximity (Purnell, 2010). Similarly, individuals who experience avoidant attachment may avoid close intimate relationships and have negative perceptions of significant others (Bartholomew & Horowitz, 1991).

Insecure attachments have been noted to increase the likelihood of developing 'psychotic experiences' (Bucci, Emsley & Berry, 2017). However, this concept is not always applicable. One study recruited participants with non-affective psychosis or related diagnoses who had previously taken part in psychosis related studies in the UK. Results found that 60% were securely attached and remarked on the over-representation of insecure attachments in previous studies (Bucci, Emsley & Berry, 2017). Therefore, there is mixed evidence to whether there is a negative impact on mental health and developing psychosis based on attachment styles and early trauma.

Another factor that could influence relationship and life-stage achievement is experiencing trauma. Sexual assault, specifically, has been related to developing unusual experiences, evidenced by high prevalence rates in populations who experience psychosis across studies compared to non-clinical populations in many studies (Bucci, Emsley & Berry, 2017; Read, van Os, Morrison & Ross, 2005; Read, Mosher & Bentall, 2004). Physical assault, including intimate partner violence, has also been associated with increased prevalence of unusual experiences (Bucci, Emsley & Berry, 2017; Boyda, McFeeters, & Shevlin, 2015). Trauma caused by stigma or discrimination also increases the risk of developing unusual experiences (Stickley et al, 2019) and further hinders achieving life goals (Corrigan, 2016).

Individuals are likely to be further discriminated against if they disclose psychosis (de Jager, Cirakoglu, Nugter & van Os, 2017). Stigma around psychosis is particularly stressful, as it is considered most disadvantaging in terms of social and economic hardship, often as a result of stereotypes and prejudice (Morgan, Reavely, Ross, Too & Jorm, 2018). Misconceptions range from being seen as dangerous, violent or behaving unpredictably; that they are incompetent and cannot look after themselves; with illness seen as a life sentence with little chance of recovery (Sheehan, Nieweglowski & Corrigan, 2017). These experiences often lead to self-stigma (de Jager & McCann, 2017) and increased prevalence of self-harm shame (Carden, 2020; Gilbert et al, 2010).

A lack of provision and understanding in supporting the intimacy needs of individuals with psychosis remains a barrier for services. There is evidence that this concept is missed in service provision (White, Haddock & Varese, 2020; de Jager & McCann, 2017; McCann, 2010; McCann, 2000). Services and policies may view sexual and intimacy needs for individuals with psychosis as unneeded in supporting well-being (Southall & Combes, 2020). This is evidenced by the use of language in public documents, such as being described as "over-sexed or under-sexed" (Gascoyne, Hughes, McCann, & Quinn, 2016, p340) or "asexual" with no rights or interest in sexuality (Hendry, Snowden & Brown, 2018, p. 1021).

The current narrative implies that relationship experiences and sexual expression of individuals with psychosis have been assumed by others as something culturally wrong or of no significant influence for professionals. They narrow the opportunity for sex education and room to discuss sex issues as a healthy part of someone's identity, if relevant to them. Additionally, whilst professionals in some studies see this as an important part of recovery (de Jager & McCann, 2017), others saw it as unnecessary (White, Haddock & Varese, 2019). Regardless, studies describe a lack of guidance, support and confidence in addressing these issues themselves with service users (Southall & Combes, 2020; White, Haddock & Varese, 2019). This could be influenced by embarrassment and discomfort about discussing sexual intimacy in the UK health system (Bucci, Emsley & Berry, 2017).

The aim of this literature review is therefore to understand the experience of forming and maintaining intimate relationships for individuals diagnosed with psychosis or schizophrenia. This literature review will gather the responses of individuals with psychosis and discuss the implications of their experiences to the current understanding. The research question is: What are the experiences of intimate relationships for individuals diagnosed with psychosis?

Method

Identification of Studies

Electronic databases were searched for relevant literature using the EBSCO host search engine between August-November 2020 and March 2021, for all psychological and health-related over the last 20 years. Research databases included APA PsycInfo, PsycArticles and Academic Search Premier. The default setting was chosen as the research aim was to search across multidisciplinary databases for the highest probability of assessing all relevant literature. For full inclusion and exclusion criteria, see Table 1.

This broad method ensured no literature was missed from the search included all papers within a relevant timeframe for credible sources. The final search terms were: “psychosis* OR schizophrenia*” AND “relationship” AND “sex*” AND “roman*”, NOT “personality disorder”, NOT “cognit*”, NOT “child”. The term ‘unusual experiences’ was not used in the search due to it not being a diagnostic label and thus not being concordant to the literature review aims.

Table 1.

Inclusion and Exclusion criteria for search strategy

Inclusion Criteria	Rationale
Psychosis, schizophrenia,	Those diagnosed with psychosis or schizophrenia were the focus of this review.
Romantic, sexual relationships	This review focussed on the experience of intimate and romantic relationships
Peer reviewed only	Only viewing primary sources to avoid secondary or unreviewed data. This allows depth of data and provides context of the authors conducting the study
Between 2000-2020	Studies from last 20 years reflect current research and experiences
Adults only 18+	Interest in adult experiences of forming and maintaining relationships
Qualitative only	Richer account of experiences
Written in English	To be readable; To avoid scripts being misconstrued

Exclusion Criteria	Rationale
No conferences or secondary data	To avoid data not relevant to the research question as it focuses primarily on accounts of lived personal experiences
None explicitly about trauma	Relationships experiences as primary focus
No quantitative only studies	The research question requires depth of lived experiences That would not be explored in quantitative research

Study Selection

As seen in Figure 1 (below), the search resulted in 2,538 studies that had at least one of the above-stated search terms in, for example including ‘psychosis’ but no other search terms. An exclusion of 2,497 studies was conducted based on titles then deemed irrelevant to the study. Such excluded papers focused on: Physical medical issues such as cancer, Obsessive-Compulsive-Disorder (OCD), Bipolar-Disorder, Panic Disorder or Personality Disorder, Rates of Depression or Anxiety, Suicide, Non-clinical populations, Criminality, Transgender issues, Substance use, Only sexual or childhood trauma or adversity, Pregnancy, or Inpatient sexual intimacy needs (forensic).

This left 41 studies being identified through electronic database searching. Five studies were excluded due to replication. The remaining 36 studies were analysed by their titles for key words and relevance to the research question and a further 15 studies were excluded, resulting in 21 studies. Irrelevant topics included: pharmacology, gender differences, prison studies, physical and sexual dysfunction or studies on personality (non-disorder specific). After that, 21 studies were assessed via abstract and 6 studies were excluded due to irrelevance, for example cognitive and behavioural experiments, identifying or developing clinical tools, measures of jealousy or socio-occupational functioning.

The last 15 studies were accessed for the full-article. Eight studies were excluded: one was excluded because the participant population were mental health professionals, not experts by experience, five studies were solely quantitative and two were not published full-text, confirmed by the author herself via email.

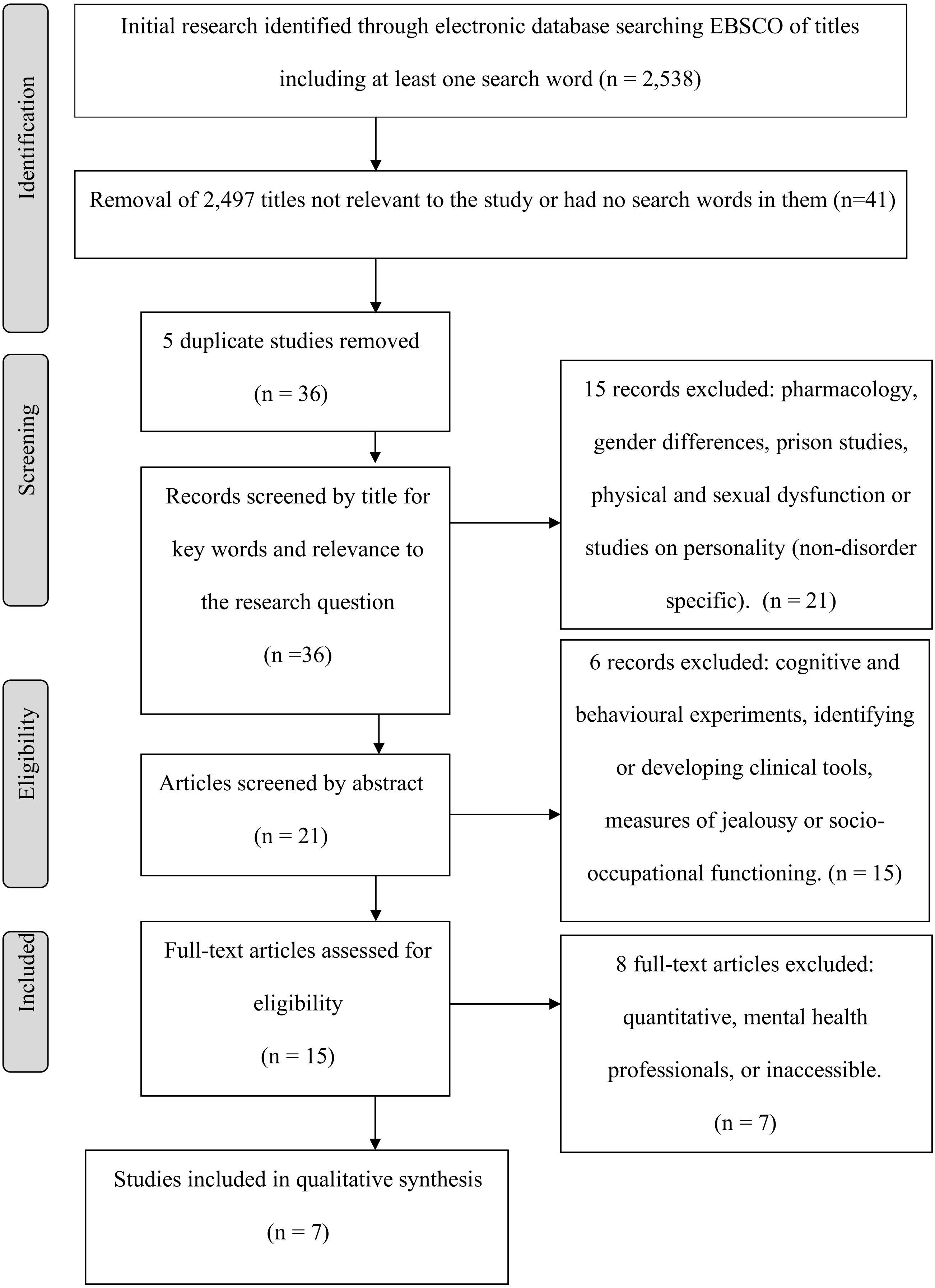

Figure 1. PRISMA 2009. Search strategy process

Data Extraction

In total, seven studies were included, published between 2000 and 2017 (see Table 2 for an overview of the studies). Six were semi-structured interviews and one was a structured interview and used a QoL measure (Östman, 2014), all reporting qualitative data.

Two studies reported on all heterosexual participants (Geiger et al, 2006; Östman & Björkman, 2013). One study reported that 73.3% of participants (McCann, 2010) and another recorded that 89% of participants were heterosexual (De Jager, Cirakoglu, Nugter & Van Os, 2017). Only two studies briefly acknowledged same sex attraction (Östman, 2014; McCann, 2010).

One study interviewed institutionalised couples who had a diagnosis of psychosis (Geiger et al, 2006) and one study interviewed three out of five partners of primary participants, who did not have a diagnosis of psychosis but a 'treated mood disorder' (Östman & Björkman, 2013).

In McCann's study (2000), eight out of eleven participants had no sexual relationships, two participants were divorced, and all participants were single at the time of study. McCann (2010) interviewed 30 people, of which one had never been in a relationship, and 40% of participants were currently in relationships. In De Jager et al's study (2017), 61% did not have a partner. Only opposite-sex relationships were recorded (one male and one female).

Four studies reported cultural diversity: a dominant White-European population of 63% (McCann, 2000) and a majority White-British population (McCann, 2010). One study reported that the sample represented the 'culturally and ethnically diverse geographical population', but gave no details (Redmond, Larkin & Harrop, 2010). One study reported 70% of couples were Jewish; the rest Jewish and Muslim partners and two couples being of mixed-heritage (Geiger et al, 2006). Three studies did not report ethnic diversity (De Jager et al, 2017; Östman, 2014; Östman & Björkman, 2013).

Quality assessment

The NICE Qualitative Quality Checklist was used to assess the seven articles, chosen due to its credibility, preferable symbol-rankings and extensive criteria (Spencer, Ritchie, Lewis & Dillon, 2003). Poor- or low-quality ratings did not result in exclusion from the review but provided context to the credibility of findings. To ensure a high level of reliability, three random papers were selected by a fellow researcher for inter-rater checking (Östman & Björkman, 2013; McCann 2000 and De Jager et al, 2017). There were no major inconsistencies between the ratings of these studies and minor disparities were discussed with other researchers until an agreement was reached.

The quality checklist (see Appendix E) had 14 areas of critique. Each area had qualitative measures of quality, which were converted into scores of 0-3 for easier comparison. Final conclusions were graded as "++", "+", "-" and referred to in Table 2 below. For detailed quality ratings please see Appendix M, Table 3. Concerning limitations, Östman (2014) was unclear in whether research objectives were achieved, and it was the only study deemed indefensible regarding rigorous design and methodology. Three studies (McCann, 2000; 2010; Östman & Björkman, 2013) were identified as unclear in terms of reliable methods as there was no mention of peer-review or rigorous methodological details. The McCann studies (2000; 2010) did not detail rigorous data-analysis and McCann's (2010) data recording was unconvincing. For example, results were organised using the interview questions as themes, not on the content of answers, and understandings were based on research from 30 years ago at the time of the paper in terms of assumptions made about individuals with psychosis. There was also no mention of triangulation of analysis to ensure rigor.

The role of the researcher was only briefly mentioned in two studies (McCann, 2000; Redmond et al, 2010). However, the conclusions for all studies were deemed appropriate to their rationale and data collection was considered appropriate in all studies. All studies involved participant quotes to evidence analysis and participant contexts were described in terms of demographics. The studies used in this literature review are of varying quality, but tentative conclusions may be drawn based on the data available as they were deemed rigorous in methodology, and primary data was gathered appropriately from participant interviews.

Table 2.

Summary of Studies and Quality Ranking

Author	Method and Analysis	Research Question	Participant Demographics	Main Findings	Quality Rating
de Jager, Cirakoglu, Nugter & van Os, (2017)	Holland; four community mental health (MH) teams Semi-structured interviews (1-2hrs) Grounded theory	To explore what problems people diagnosed with a psychotic disorder experience in the field of intimacy and relationships, and what factors underlie these problems.	• 28 participants age 22-62, mean= 42. • Diagnosed with a psychotic disorder (DSM-IV) (schizophrenia or related) • 25 heterosexual, 2 bisexual (F) and 1 homosexual (M) • 6 (3F) married or cohabitating, 5 (3M) in a relationship but not cohabitating, 17 (13 M; 5F) divorced, single or widowed	1. Relationship needs & intimacy 2. Symptoms and side effects of medication 3. (Self-)stigma 4. Social skills and deficits 5. Sexual abuse	++
Östman, (2014)	Sweden; Community MH services in one of two chosen districts MANSA quality of life measure and structured interviews 'Thematic methodology' analysis	To learn how people with severe mental illness living in a community experience satisfaction with their sex lives in comparison to other life domains measured by the Manchester Short Assessment of Quality of Life (MANSA). An additional aim was to use in-depth interviews to illuminate the everyday sexuality and sex lives of this special need's population.	• 80 participants completed the nomothetic survey; 67 were single, 10 were married or cohabitating • 20 of those completed the interviews (16M, 4F) ages 33-82, mean age 50. • Diagnosis of a psychiatric illness for more than two years (WHO, 2001) • Participants had to be unable to manage their everyday lives without help from others in consequence of their psychiatric functional disabilities. • Three were in a relationship, 11 lived on their own, nine resided in assisted living.	1. Honesty and straightforwardness in sex life and relationships 2. Sexual relationships secondary in the case of severe mental illness (SMI) 3. Engagement needed for sexual functioning 4. Lack of support from care systems	++
Redmond, Larkin & Harrop, (2010)	Birmingham and Wolverhampton, UK; Community Semi-structured interviews	To explore the meaning of romantic relationships from the perspective of young people who have experienced psychosis.	• 8 participants (3F, 5M) age 21-31, mean age 25 • Sample described as culturally and ethnically diverse but no details • All had a medical diagnosis of schizophrenia • Two has previous romantic relationship, three were currently in a relationship, one had no experience in	1. Illness as incompatible 2. Relationships as normalising 3. Relationships are high risk 4. Risk reduction	++

	Interpretative Phenomenological Analysis (IPA)		romantic relationship but had significant peer relationships, and two had neither previous romantic nor peer relationships.	5. Lack of experience and resources	
Geiger, (2006)	Northern Israel; Inpatient, assisted living or half-way houses in the community Semi-structured interviews 2-3hrs Content analysis	To discover what the subjective experience of loving and being loved meant to chronic persons diagnosed with schizophrenia at different stages of their love relationship, and the impact of such a relationship on each one of the partner's mental health, and socioeconomic functioning.	• 20 heterosexual partners (10 couples) in a 'love' relationship, all diagnosed with chronic schizophrenia (DSM-IV). • Five couples lived in a mental-health institution, a sixth lived in assisted living and would come to the institution only during the day. The remaining couples resided in the community in half-way houses for the mentally ill. • Female partners- 28 to 38 years, Mean=33.5. Male partners- 22 to 60 years, Mean=43. The widest age difference between a male and a female partner was 25 years. • In 7/10 couples, both partners were Jewish. In two couples, the female partner being Muslim and the male partner Jewish whereas in the last couple both partners were Muslim. • 6/20 members in the couples had previously been married or had another partner in the past.	1. Physical appearance and attraction 2. Personal qualities 3. Outward expression of love and affection 4. Presents 5. Escape from loneliness and depression 6. Participation of joint activities 7. Sharing problems and worries 8. Expressing negative feelings 9. Future orientation, love and personal strength 10. Coping with separation 11. Sex and lack of privacy	+
McCann, (2000)	London, UK; Inpatient A structured interview (Pfeiffer & Davis, 1972) and a semi-structured interview of five open-ended questions following on from the structured	1. To discover the respondents' sexual expressions in the past and present, and endeavour to elicit their hopes and aspirations for possible sexual relationships in the future. 2. To uncover some of the obstacles to the expression of sexuality	• 11 participants (7M, 4F), 3- 18-29yrs, 6- aged 30-39yrs, 2- 40+yrs. • All had a primary medical diagnosis of schizophrenia. • 7 European, two African, one African-Caribbean, one Turkish. • 9 never married, two were divorced • All participants were single at the time of study. • Five had 6-10 hospital admissions. Two had spent 6-10 years in hospital.	1. Conceptualization of intimacy 2. Aspirations for future relationships 3. Willingness to discuss sexual/relationship concerns 4. Awareness of sexual rights in hospital	+

	interview Content analysis	for people with an enduring mental illness. 3. To explore the subjective experiences of the residents concerning their expression of sexuality.			
McCann, (2010)	London, UK; Community MH services Semi-structured interviews (1hr)	The exploration of personal experiences of the people living with and recovering from the condition. •Establish clients intimate relationship experiences; •Explore specific issues important to service users; •Uncover potential obstacles to the expression of sexuality; •Present recommendations for mental health practice, education and research	• 30 (15M) all diagnosed with schizophrenia (WHO, 1992) • Ages 22-57 (mean= 41). • A majority were White UK (46.7%) the remainder of people identified as White European (16.7%), Black African (6.7%), Black Caribbean (26.7%) and Indian (3.3%). • Other figures revealed lesbian, gay, bisexual, and transgender (LGBT) (26.7%), heterosexual (73.3%), • Currently in a relationship (40%) • Were parents (33.3%) • Most had less than 10-year contact with mental health services. The average number of previous admissions to a psychiatric hospital was five.	1. Perceptions of intimacy 2. Establishing and maintaining relationships 3. Sexual concerns and issues 4. Sexual knowledge and understanding 5. Stigma and self-esteem 6. Family planning and parenting 7. Views about prescribed medication 8. Formal and informal supports	-
Östman & Bjorkman (2013)	Sweden; Community MH services Semi-structured interviews (45-60 minutes) Thematic methodology	learn more about the ticipants sexual ationships and experience ntimacy	• 3 female and 2 male individuals took part (age range 32-41) • Of those, three partners of the participants also took part (aged 33-46). All three reported receiving outpatient treatment for mood disorders, which they said was a result of their long-lasting relationship with the patient.	1. Relationships outweigh sexuality 2. Uncertainties about one’s capacity 3. Sexual fantasies, feelings of desire, and satisfaction	-

	• All primary participants had a diagnosis of schizophrenia during adolescence or early adulthood • All participant reported being heterosexual • All currently unemployed	4. Communication and need for support in sexual matters

Data Synthesis

Thematic synthesis (TS) was chosen to transparently analyse the creation of new concepts, while preserving the primary data collected (Thomas & Harden, 2008). TS enabled the researcher to stay 'close' to the results of the primary studies as a credible and frequent form of analysis (Thomas & Harden, 2008). TS also specifically considers the differences in studies in terms of reporting styles or the interpretation of data, which is of relevance to this review's position of social construction of 'truths' (Burr, 2015).

The studies were printed and manually coded for each line in the results for the content and meaning of each sentence. The analysis process was peer-reviewed by both supervisors in terms of adhering to the quality and context of the studies and the agreement that the analytic themes appropriately synthesise the findings of the studies. The remaining themes were incorporated into codes of two overarching descriptive themes of 'forming' and 'maintaining' relationships. Codes were separated into each theme that developed, evidenced by participant quotes.

Researcher position

To ensure rigor in the analysis (Thomas & Harden, 2008) I used the reflexive position (Malterud, 2001) throughout data-analysis. As a member of the LGBTQ+ community, the researcher has a specific perception of same-sex attraction and the internal and external cultural bias regarding relationships. However, the researcher is aware that being White and female is still a privileged position compared to women of other ethnicities in the UK. These may influence being drawn to similar experiences, or some participant experiences being more understood than others. Biases were addressed through triangulation: supervision from two qualified professionals, the use of a reflective journal and a reflexive interview conducted by one supervisor and the researcher. The interview was to reflect with the supervisor in what way the researcher's experiences and values had influenced her decision at each stage of the thesis.

Results

Thematic Synthesis

The factors that influence the experience of relationships for individuals with a diagnosis of psychosis were understood using: Overarching Theme 1: Forming Relationships; and Overarching Theme 2: Maintaining Relationships. See Table 4 for subthemes. The following themes are weighted based on the quality of the literature evidencing it.

Table 4.

Themes of the literature

Overarching Theme 1: Forming Relationships		**Overarching Theme 2: Maintaining lationships**	
I.	Experiences and Impact of Trauma	I.	Building and Maintaining Trust Between Partners
II.	Perceptions of Social Ability	II.	Disclosure and the Experiences of Stigma
III.	The Effects of Mental Health and Medication on Intimacy	III.	Sexual Activity and Communication
IV.	Partners' Preferences Influenced the Desire for Relationships	IV.	Planning for the Future
V.	Social Network Norms		

1. Forming Relationships

This theme explores the factors that individuals with psychosis might experience when thinking about or when forming relationships. This theme highlights potentially unique barriers and common dilemmas experienced when trying to connect with another person romantically.

I. Experiences and Impact of Trauma

Trauma in this context was defined by participants' experiences as survivors of physical and sexual violence and was a common experience across participants. Interestingly, only one study included one participant account of childhood sexual abuse and the impact of shame and feeling 'dirty' on 'sexual matters' as an adult (Östman & Björkman, 2013). Five out of seven studies mentioned participants experiencing either sexual or physical abuse from previous or current romantic partners as adults (McCann, 2010; De Jager et al, 2017; Redmond et al, 2010; Östman & Björkman, 2013; Geiger, 2006). De Jager et al (2017) reported that one third of participants had experienced sexual assault (67% F, 21% M) and McCann (2010) highlighted several accounts of experiencing sex without consent.

> "…he was an absolutely violent man. He gave me fractured skull". (Respondent 10; McCann, 2010, p253).
>
> "I have no one to talk to about this stuff and I get worried that I may harm her." (Respondent 12; McCann, 2010, p254).
>
> "I have been divorced for 28 years from my first husband but I have lain in bed with fear for 23 years" (Married, female, 57 years; De Jager er al, 2017, p306).

Many interviewees described the impact this had on their lives (De Jager et al, 2017; Östman & Björkman, 2013; McCann, 2010; Redmon, 2010). For example, De Jager et al's participants (2017; pg306) explained that this trauma had "negative effects on their self-esteem", self-worth and trust in others. Participants elaborated that sexual trauma remains a taboo subject, based on how they rarely disclosed the trauma and its effects with their partners or supporting system (Östman & Björkman, 2013; McCann, 2010). Some reported that the interviewer was the first person they had ever told (De Jager et al, 2017). Despite uncertain degrees of quality in these studies, the number of reports of sexual trauma and its negative influence emphasises its significance.

II. Perceptions of Social Ability

Most participants in all studies explicitly doubted their social ability. Good social skills were experienced by participants as being able to connect with others and have meaningful and confident interactions.

Redmond et al (2010) reported a deprivation of confidence, energy and robustness; and meeting others was viewed as challenging and resulted in 'futile' attempts. For one participant, this meant "alienating others" as he "had no other strategy", ultimately leading to rejection (Redmond et al, 2010).

Further issues included participants expressing issues of shyness and uncertainty about physical contact with others (Östman, 2014).

> "I can't pull it off. I'm my worst enemy… when I encounter people, I have no idea what topics are interesting or if he/she will like what I have to tell… Nerves" (Married, male 42 years; De Jager et al, 2017, p306).

Many participants feared or assumed that the situation or their self-reported inadequacy would lead to negative consequences and rejection. For example, participants reported fears of "doing something wrong" and having a heightened self-awareness (De Jager et al, 2017). Some participants wanted a better ability to problem-solve, have resolutions to problems, and to belong (Östman, 2014; McCann, 2000). However, many said that there was limited opportunity:

> "You need someone, and for that you need to be part of society by having a job or belonging to a club. My illness destroys all possibilities" (Male, 36-years; Östman, 2014, p342).

In this statement, the participant appears to highlight that being part of a society requires employment and a sense of group identity via a 'club'. What is conveyed is perhaps a belief that employment not only improves social standing and social opportunity, but interpersonal skills and confidence that comes with frequent opportunity.

Prolonged social isolation appeared to be caused by participant's insecurities about dating and viewing perceived lack of experience, and therefore social skills, as an obstacle in forming intimate relationships (De Jager et al, 2017). Many participants doubted their ability to initiate conversation or create meaningful interactions with others. Participants reported struggling to read romantic signals, and a fear of "behaving inappropriately" (Redmond et al, 2010). In all studies, there was no distinction between whether these insecurities were actual deficits or only perceived by the individual. Such issues may relate more to confidence or anxiety, rather than actual skills. It was often explained because of social-anxiety or psychosis (De Jager et al, 2017). Many references in this subtheme have been assessed as high quality (De Jager et al, 2017; Redmond et al, 2010; Östman, 2014), so credibility can be assured of the comparable experiences across studies. Similarly, McCann's (2000) report about participants desiring better problem-solving was strengthened by Östman's (2014) study being more rigorous in their analysis in comparison.

III. The Effects of Mental Health and Medication on Intimacy

This theme describes how participants' unusual experiences (ideas of reference, anxiety, depression, cognition problems, fatigue and hallucinations) were obstacles in initiating or engaging in contact.

Participants reported that sexual relationships were secondary to their mental health problems (Östman, 2014). Participants reported being afraid to commit to someone because of these "negative aspects"; and an unwillingness to involve another person in their presentation or medication effects, particularly sexual activity (Östman, 2014).

> "Every day is a struggle, and there is no place for sexuality. Since the illness began, I have prioritised keeping the anxiety away from me and wrestling with my work. The main thing is I have to be strong. That's why I can't prioritise sex life" (Male, 63-years; Östman's 2014, p342).
>
> "Yes, I have been made fun of when I was unable to get an erection. That really sucks" (Single, male 53 years; De Jager et al, 2017, p305).

Some remarked that they "isolate themselves more", are "more self-absorbed" and have "little to no contact with others" and that "connecting with others used to be easier", especially concerning "taking the initiative to approach people and starting a spontaneous conversation" (De Jager et al, 2017). Furthermore, experiences such as flattened affect, social withdrawal and unusual beliefs influenced the participants' perception of intimacy, relating to the closeness to the partner (De Jager et al, 2017). Those who reported an increase in sexual desire and contact reported feelings of shame, remorse, and consequential avoidance of social contact (De Jager et al, 2017; McCann, 2010). McCann's (2010) lower quality score is in part due to a lack of further elaboration to the findings;

however, the study uses sufficiently enough direct quotes from participants to evidence themes in context of their experiences (2-6 per subtheme).

Most participants in all studies reported unpleasant effects of their medication (De Jager et al, 2017; Östman, 2014; Östman & Björkman, 2013; McCann, 2010; 2000) or mentioned the involvement of medication (Redmond et al et al, 2010; Geiger et al, 2006). Only one participant (McCann, 2010) and one couple (Östman & Björkman, 2013) appreciated their heightened sexual feelings while on medication. Otherwise, medication decreased sexual capacity (Östman, 2014) and negatively impacted daily life and sexual expression (Östman & Björkman, 2013), intimacy (De Jager et al, 2017); and self-esteem and confidence, particularly in men (De Jager et al, 2017). In the De Jager et al (2017) study, 57% reported experiencing side effects such as impotence, and erectile dysfunction. In McCann's study (2000), participants reported failing to ejaculate, and one participant said medication made her "angry and violent". Participants remarked on the urgency of needing to research these effects on the lives of individuals taking medication long-term (McCann, 2010). Overall, mental health symptoms and medication effects cause additional stressors in forming relationships. It is interesting to note that medication featured in all studies, when that was not explicitly what the research was exploring. This may highlight the significant involvement medication has on individuals with unusual experience, and perhaps on the interest of researchers.

IV. Choosing a Partner and the Desire for a Relationship

Relationships were romantic and sexual in nature, and this held the focus for all studies. Relationships were thought of as having both positive and negative outcomes as a 'normal' life stage and these perceptions arguably influenced partner preferences for each interviewee. Even if individuals had not experienced a relationship, they knew what they desired in a partner. Only one study included participant responses about desirable physical traits, and only some participants considered this important (Geiger et al, 2006). Other couples had different priorities and expressed desire for their partners who were over-weight and missing teeth but would like them to shower more often (Geiger et al (2006). Participants in relationships found themselves more concerned about their own appearance, where this had previously been neglected (Geiger et al, 2006).

> "He has a nice-looking face; the problem is his body. Is it possible to help him? To explain to him about the food he eats? I want a man who is athletic. He would be happy if you could help him lose weight" (Geiger et al, 2006, pg6).

Six studies included descriptions of desirable personality traits. Participants desired partners to be protecting and kind (Geiger et al, 2006), thoughtful and considerate (Redmond et al, 2010), honest, straightforward, confident, accepting, respectful, empathetic, a good listener, understanding and "someone you can talk to about anything" (Östman, 2014). Some participants felt that good partners would support them with their mental health (De Jager et al, 2017; Redmond et al, 2010). Others described it as: "to be in love was to be aware and take care of their partner's needs" (Geiger et al, 2006).

There were expectations that future partners could be a source of support and a protective factor, and participants in current relationships described partners being just that (De Jager et al, 2017). Eight out of 28 participants reported that having a relationship led to a reduction of distress or helped motivate them to seek help (De Jager et al, 2017). Two interviewees recalled how monitoring of distress "through a second pair of eyes" can be beneficial:

> "She is the rock that I lean on. She drags me through hard times and won't leave me hanging. I can really talk to her. That is such an amazing feeling" (married, male, 42years; from De Jager et al, 2017, pg304).

However, some focused on the negative expectations or experiences of relationships. Participants highlighted a fear of losing their identity and 'merging' with their significant other, such as being overly influenced by a partner and losing individuality (Jager et al, 2017; McCann, 2010; Redmond et al, 2010). Mistrust or previous trauma may influence how an individual could fear being manipulated or "used" (Redmond et al, 2010) by someone important to them. Some participants described an all-consuming anxiety, "sacrifices needing to be made", having less time, less independence, needing to adapt to their partner's needs, "unacceptable to just be yourself", and the fear that regardless of any efforts to adapt, it will lead to rejection (Redmond et al, 2010). Some participants expressed issues with respecting their own and other's boundaries, in particular women regarding sexual boundaries (De Jager et al, 2017). This is understandably met with some participants regarding the risk not being worth it (Redmond et al, 2010).

> "When I was younger, I let people walk over me. Or I would keep pushing my own boundaries. Especially with boys… I kept wanting to please the other" (Single, Female, 34 years; De Jager et al, 2017, pg306).

> "So if I like him that much and I'm not feeling secure… then I probably try to be a bit more how he wants, just to please him…" (Isobel, Redmond et al, 2010, pg11).

Similarly, participants were concerned about their ability to give in a relationship. For example, some were worried about their inability to be sexually involved in their relationship (Östman & Björkman, 2013); however, the study itself has been critiqued for the lack of context and exploration as to what this meant for participants. In one study, 25% of interviewees had experienced how relationship problems or a broken heart had triggered onset of unusual experiences, and therefore would prefer a "quiet" and "stable" partner (De Jager et al, 2017), though it is unclear how many participants used those characteristics or if this was a summarised assumption of preference from the analysis or interview stage.

Some participants tended to feel "flawed" and wanted a partner who was sympathetic and non-judgemental; and considered this to be more attainable if the partner had similar experiences (Redmond et al, 2010). Experiences of, or anticipated, mutual understanding and acceptance from partners of similar mental health difficulties was associated with a lower and therefore less daunting threshold of self-disclosure (De Jager et al, 2017).

However, some participants feared that partners of similar mental health issues may have an increased need for personal support or may lack the capacity to provide support themselves (Redmon, 2010). If both partners are struggling, participants reported that it could “take up too much space” and self-disclosure could reduce intimacy (De Jager et al, 2017). Some explicitly stated they did not want to date someone also “mentally ill” (De Jager et al, 2017; Redmond et al, 2010; McCann, 2010), seemingly not in-line with their idea of a good romantic partner. These perceptions were sufficiently quoted across the higher quality papers, conveying a general sense of unease amongst participants about mental health generally, perhaps due to their own negative experiences.

> “I wouldn’t mind meeting somebody from one of these centres who has an insight with you. I really would prefer somebody who is not mentally ill…” (Respondent 4; McCann, 2010, p254).

V. Social Network Norms

Social networks for participants involved romantic partners, family, close friends, and community, in-patient or assisted living staff. Many participants described experiencing pressure to meet developmental social stages (De Jager et al, 2017; Östman, 2014; McCann, 2010; 2000, Geiger et al, 2006) and achieving them was considered by everyone as ‘normal’ (Redmond et al, 2010). Relationships were an essential part of being ‘human’ (McCann, 2010) and that others saw it as a sign of recovery (Redmond et al, 2010).

> “I think they’d be pleased for me ‘cos I found someone… I’m not just hiding behind my mental health problems… I’m getting on with life and doing things just like any other young woman” (Leane; Redmond et al, 2010, pg9).

When discussed, participants mentioned very structured and traditional ideas about relationships, such as going on dates to cinemas, pubs or going dancing to meet people (Redmond et al, 2010; McCann, 2000). Many participants associated relationships with resolving loneliness (Geiger et al, 2006). Participants reported that relationships increase self-confidence, positive feelings about themselves, experiencing reduced isolation and “balance of life” (Redmond et al, 2010). Participants described their own and their partner’s families either hoping they would form a relationship or being over-involved, controlling, and judgemental. Comparatively, participants in other studies reported that family were ‘generally on-hand’ for everyday life situations but did not provide help regarding sexuality (Östman, 2014; Östman & Björkman, 2013). The strength of this perception is varied to the strength of quality across papers. In this subtheme, six out of seven papers highlighted the positive resource of friends, family and staff. However, these papers have a low-quality rating, making these insights uncertain as to their strength against the more evidenced reports of negative experiences from higher quality studies.

> “My mum used to say they’re not good enough for you… and used to try… to try and put me off relationships” (Leane; Redmond et al, 2010, pg10).
>
> “If I didn’t think the family liked me then that’d be a barrier… if there was part they weren’t interested in or they didn’t think I was good enough for her, or that I was worthwhile…” (Nathan; Redmond et al, 2010, pg8).

Two studies inquired as to professional support and participants disbelieved services would provide them with support regarding sexual needs (Östman, 2014; McCann, 2000). Similarly, participants’ sexual knowledge and social development were not seen as important or useful in ‘recovery’ during treatment as well and participants reported poor sex education when young (McCann, 2000).

To conclude, the first theme highlighted factors that influence the ease and ability in forming romantic and sexual relationships. Factors such as trauma and the perceived social ability of an individual influences the confidence of instigating interactions. Mental health and medication further impact participant’s ability to connect with others and social support differed in being over-involved or critical. These factors therefore contribute to what kind of person participants would want to form relationships with, often wanting kind and understanding people as a priority.

2. Maintaining Relationships

This theme highlights the navigation of a relationship for individuals experiencing psychosis and identifies further unique life stages that may not be shared by non-clinical populations. The results highlighted less evidence in the literature regarding the maintenance or success in relationships for individual with psychosis, compared to the problem-orientated focus in Theme One.

I. Building and Maintaining Trust Between Partners

This sub-theme describes the growing bond between people and participants feeling safe enough to disclose their diagnosis to their significant other without feared negative reactions or consequences.

Once individuals have successfully formed a relationship, all seven studies described needing the relationship to gradually progress so that trust can build between the couple. For example, interviewees experienced initial reluctance to get emotionally involved without knowing the other person (De Jager et al, 2017; Redmond et al, 2010; McCann, 2010). This stemmed from several different factors relating to trust as a safety measure, such as not wanting to get hurt or used or to ensure “things developed at a manageable pace” (Redmond et al, 2010). There seemed to be an aspect of wanting control over the development and wanting to be comfortable in each stage.

> “I think trust is really important. If you can’t trust them then you have no basis for anything because nothing can build up from that.” (Isobel, Redmond et al, 2010, p11).

Others showed a distrust with themselves, for example in their ability to manage a relationship and their unusual experiences (De Jager et al, 2017; Redmond et al, 2010). This preferred slow process might be due to personal preferences, or from experiencing trauma in previous relationships, stigma, or presentations such as extreme suspiciousness in others. Redmond et al (2010) described how many participants emphasised how a careful approach is rewarding. Friendships were considered a good gateway into relationships and starting as friends was considered less daunting (Redmond et al, 2010).

II. Disclosure and the Experiences of Stigma

Participant's experiences of disclosing their psychosis to others had mixed responses (Östman, 2014). Some participants had positive experiences of this (De Jager et al, 2017), whereas others experienced negative consequences, such as stigma or rejection from significant others (McCann, 2010; De Jager et al, 2017). Stigma was described as a community or person perceiving something as negative in another's identity, such as psychosis (De Jager et al, 2017).

Throughout the studies, participants reported having to decide whether to disclose their diagnosis. Self-disclosure can be accidental as a person's presentation and medication effects cannot always be hidden (De Jager et al, 2017; Redmond et al, 2010). However, this experience caused additional stressors about the fear of being judged and the impact on self-esteem, navigated by the level of trust and understanding in the relationship at the time. Disclosure was often associated with shame and embarrassment. Other participants strived to completely avoid social contact and thus avoid the likelihood of self-disclosure, to protect against potential rejection (De Jager et al, 2017).

> "The word psychosis will not come out of my mouth. If I were in a happy relationship, perhaps I would tell her at some point. If she would be very easy to talk to, I would tell her" (Divorced male, 42 years; De Jager et al, 2017, p306)

Three out of seven studies explicitly mentioned experiencing stigma or prejudice, which prevented forming relationships. Participants feared or experienced stigma from family and partners (De Jager et al, 2017; Östman & Björkman, 2013; McCann, 2010). Participants who had experienced stigma were more likely to be reluctant to contact and trust others (De Jager et al, 2017).

Some were more able to disclose their mental health due to believing that others are similar in having some difficulties (De Jager et al, 2017). However, de Jager et al (2017) did not report how many of their participants reported this positive perception of disclosure. Whilst they did include a short quote, "everyone has something", and a wider context to experiences, it does not contribute strong enough evidence compare to other experiences.

There were also experiences of stigma from the wider system or community (Östman & Björkman, 2013). For example, participants in McCann's (2010) study reported fears of others being able to tell of their mental health through their presentation, which led to feelings of shame and hesitance to meet new people.

> "I notice that people are afraid to approach me because of my mental illness, so they avoid me. I notice that they walk away from me and that isn't easy" (single, male 45years; from De Jager et al, 2017, p305-306).
>
> "I am reluctant [to approach women] because I'm afraid they all know that I am not well. I am very reluctant to go next to my own Kurdish people because of the shame I feel (Respondent 16; McCann, 2010, p254).

III. Sexual Activity and the Use of Communication

This theme describes experiences of intercourse, the importance of communication, and other physical expressions of intimacy, appearing in all studies. Intimacy between romantic, long-term partners was always preferred than with strangers or short-term interactions (McCann, 2010).

Participants enjoyed listening to music or eating together, holding hands, saying "I love you", and gift giving (Geiger et al, 2006). Participants said that being loved and appreciated "made them feel good" and experienced a "warm feeling" (Geiger et al, 2006). All participants described intimate relationships as needing closeness and hugging and kissing that does not necessarily lead to sexual expectations (Östman & Björkman, 2013). Participants highlighted that intimacy was "not purely about sex" (McCann, 2010) and most preferred both an emotional and physical closeness to another person (De Jager et al, 2017).

The topic of intercourse had mixed responses. In all studies, sexual intercourse appeared to be understood as vaginal penetration with a penis, but there were no discussions as to what participants or researchers defined as 'sex'. Therefore, the evidence can be questioned as to whether these speculations about experiences and perceptions have the same understanding of what sex is and thus, what experiences are homogeneous.

Participants wanted to have a connection or an already established relationship with someone before they engaged in sexual activity; and described the necessity of feeling engaged with another (Östman, 2014). Participants highlighted that communication and mutual support are vital, but were absent for most participants (Östman, 2014). Some reported their need for sex to feel connected to their partner: "without sex there is no bond" (Geiger et al, 2006).

Confidence and self-esteem also affected sexual activity. Men tended to report lower satisfaction in sex relations than women (Östman, 2014) and more issues in sexual performance (McCann, 2010; De Jager et al, 2017). Generally, participants expressed being self-conscious with sexual acts (Östman & Björkman, 2013; Redmond et al, 2010). Participants wished to be more sexually active in encounters but failing this they wanted their partners to be more active (Östman & Björkman, 2013). Some discussed in the interview that their partners (also present) were avoiding sex due to the other's mental health episodes (Östman & Björkman, 2013).

Individual identities, such as religion, also contributed to sexual activity. Geiger et al (2006) linked religion to 'sexual freedom', defined perhaps as the freedom to have sex without needing to consider religious values. Male participants of Islamic faith described their sexual intimacy with partners being determined by their religious beliefs and 'freedom' for female partners. For example, 5/10 couples did not have sex based on religious and cultural traditions of marriage (Muslim and Jewish tradition).

Some female partners chose to have 'sexual freedom' and described sex as a "natural thing when in love", which was like other reports of sexual activity (Geiger et al, 2006). However, participants often described no space to express intimacy, a general lack of privacy and staff chose to ignore or avoid acknowledging service user needs; also outlined in four other studies (Östman & Björkman, 2013, McCann, 2010; 2000; Redmond et al, 2010). Generally, those in secure or institutionalised settings were more restricted and unsupported in successful relationships. The secretive and disallowed relationships people successfully developed on wards appeared to create a sense of shamefulness or obscenity about something that would be more likely supported by social networks in the community.

> "It is allowed, but not in… In the institution, I do not know! In the rooms it is forbidden. You have sex where you can find a place. There are places where there are mattresses, you can go there" (Andre; Geiger et al, 2006, p15).

Communication with intimate partners was often described as avoided or unhelpful (Östman & Björkman, 2013), such as reacting to rumours of infidelity with aggressive anger and jealousy, including one interviewee who had hit his female partner, and reported she was fearful of him (Geiger et al, 2006). In this study particularly, there were concerns about ethical considerations, such as the procedure of legality following this disclosure of violence against another person. The authors do not comment on the safety of their participants and those potentially at risk of harm. This, and the role of the researcher, were the only issues identified when rating quality for this paper; which may translate to simply not including the context of the study and how it may impact participants.

Male participants in particular frequently chose not to share negative feelings or issues regarding the sexual relationship with their partners and some preferred talking to professionals, such as social workers, about distressing subjects (Geiger et al, 2006) with some turning to family or close friends (Östman & Björkman, 2013). Many participants nurtured a positive-focused relationship by expressing love and care for the other (Geiger et al, 2006). It is unclear how beneficial these preferences are to maintaining their relationships. However, many participants experienced a lack of support from services and clinicians (Östman & Björkman, 2013; Geiger et al, 2006). Participants reported not feeling able to discuss sensitive issues with others, and many in one study agreed they lacked sexual knowledge (McCann, 2010) in terms of consent, physical illness or abnormalities caused by unprotected sex (McCann, 2000; Geiger et al, 2006) or abortions (Redmond et al, 2010; Geiger et al, 2006) and the associated shame.

IV. Planning for the Future

Four of seven studies included future expectations for relationships and life stages. Three of these papers held mainly bleak outlooks for the futures of participants (De Jager et al, 2017; Östman & Björkman, 2013; McCann 2010), and the remaining studies did not explore future desires or expectations at all.

Some participants envisioned how the 'future' involved heterosexual norms of marriage and having children (Östman & Björkman, 2013; De Jager et al, 2017), suggesting an expectation to experience socially-normed life stages. Geiger et al (2006) was the only study to highlight positive plans, which included how participants originally felt unsure of love, but were then motivated for achieving life stages in future. One participant stated she wanted to finish her university degree and likened this to gaining her confidence and dignity back (Geiger et al, 2006). Here, the researcher position and further context, for which all studies have been critiqued to be lacking, would have been useful in determining whether future plans were expected from participants and explicitly asked about, or whether it came from participants wanting to express these perceptions regardless of whether the researcher had considered it for the interview.

All four studies reported desires for the future: but also negative, and likely not-unrealistic assumptions. To some participants, the future meant leaving the provided accommodation and being unable to maintain the relationship that was nurtured by physical proximity and assisted-living than in the community (Geiger et al, 2006). Stories included a natural decline in a relationship, experiences of infidelity and financial control over female participants who wanted to be more independent from their male partners (Geiger et al, 2006). Some participants wanted to have children but acknowledged the barriers to this, and one participant experienced miscarriage and the likelihood of future children being removed from her care (McCann, 2010).

> "Maybe it's too late now. We're trapped in this place" (Respondent 12; McCann 2010, pg255).
>
> "Well, two kids died. At the moment, because of my illness- in case I get sick and they get put into a home… no children" (Respondent 4; McCann 2010, pg255).

This overarching theme highlights the factors involved in maintaining relationships for participants with psychosis. Trust was very important, likely due to disclosure and mental health or medication effects. Stigma often arose from disclosure, which could negatively impact self-worth and confidence. Physical intimacy was often considered vital in feeling loved; whereas communication was considered unneeded, or participants used other sources of support, such as family or services. Participants were often not asked about their futures and tended to take a pessimistic view.

Discussion

Interpretations

The aim of this literature review was to understand the experiences of relationships for people diagnosed with psychosis. The research question was: What are the experiences of relationships for individuals diagnosed with psychosis? The results formed the distinct superordinate themes of Forming and Maintaining Relationships which explored participants' perceptions and experiences. In Forming Relationships, many participants carried a history of surviving previous abuse, and described the difficulties connecting with others because of this. Most studies included an account of this and its impact on their lives afterwards, supporting current literature about its prevalence among individuals with psychosis (Read, Os, Morrison & Ross, 2005). However, because none of the papers focused on sexual trauma, it was only briefly mentioned. The studies offered breadth of experiences, however perhaps lacked the depth required for each experience to improve the overall quality and therefore strength of evidence of these papers.

All studies (De Jager et al, 2017; Östman, 2014; Östman & Björkman, 2013; Redmond, 2010; McCann 2010; Geiger et al, 2006; McCann 2000) reported inadequate social skills, though there was no distinction between perceived or actual ability. Many accounts highlighted a lack of opportunity to change this; tentatively supporting previous research about social rank and psychosis (Bucci, Emsley & Berry, 2017) and the social restrictions from services in achieving this (White, Haddock & Varese, 2019). Notably, there was no exploration of earlier experiences in relationships, potential trauma or neurodiversity that could provide context to these perceived difficulties, other than their 'psychosis'.

Similarly, the desire to be 'normal' stemmed from the expectation of life stage achievement. Acquiring a romantic partner and decisions such as marriage and having children were associated with wellness and success for participants and their families, supporting the Family Life Stages model (McGoldrick & Shibusawa, 2012). However, reports of staff responses to participants wanting partners or intimacy suggests staff do not share these expectations and harbour negative perceptions of forming and maintaining relationships for individuals diagnosed with psychosis, like other literature concerning mental health practitioners (White, Haddock & Varese, 2019). This may correspond to studies being unclear on the context of participant's perceptions about staff opinions. For example, studies did not provide a specific example of a negative experience with staff or services, but rather broad summaries.

All studies mentioned that the effects of psychosis (episodes or experiences) and medication were major barriers to forming relationships; but there appeared a lack of opportunity to explore how this could be changed. Additionally, many studies reported preferences for the participants desired partner being accepting and non-judgemental. This preference appeared to relate mainly to deciding when to disclose their diagnosis when the relationship is still new. The inclusion of medication effects may relate to the significance on participant's lives, but also a potential position of the researcher regarding pharmaceuticals.

Finally, participants' social and professional network appeared unable to support or discuss sexual needs. Only a few accounts reported being able to rely on family or close friends, or partners. Though services were acknowledged in several studies (Östman, 2014; Östman & Björkman, 2013; McCann, 2010; 2000; Geiger et al, 2006) and therefore interpreted as significant to participants, there was only one account of useful service resources or staff support from a social worker (Geiger et al, 2006). Some participants said staff were too busy, but most said staff ignored or avoided discussing sexuality in community and in-patient settings.

Trust and disclosure were identified as important factors in maintaining relationships in all seven studies. It appeared this was a necessary step to continuing relationships, and it is understandable that some participants were fearful of this stage going wrong, leading to an avoidance of relationships completely. Sexual activity was mostly enjoyed and experienced in a maintained romantic relationship and many participants reported successful relationships before their psychosis became unmanageable. The literature seemed to assume an incompatibility between forming and maintaining relationships and individuals with unusual experiences. Because of this, there was only four papers that discussed the future (De Jager et al, 2017; Östman & Björkman, 2013; McCann 2010). Only one study Geiger et al, 2006) discussed positive expectations for the future, whilst other accounts expressed desires that participants concluded were unrealistic.

Limitations and Recommendations

This literature review is limited by the quality of some studies due to the lacking details regarding the researcher's position to their participants and location of recruitment (inpatient or community). Some studies were also indefensible regarding vague methodological descriptions that would be difficult to replicate. Further issues included reports having a small amount of participant quotes to evidence their themes. Therefore, only tentative conclusions can be made based on the limited evidence gathered.

Limitations also include how these holistic experiences differ depending on race, ethnicity, culture, gender, sexuality, disability (Burnham, 2018; Crenshaw, 2017). The experiences mentioned can only be tentatively applied to individuals with psychosis, as there are many different 'diagnoses', presentations and experiences within that label that differ broadly. Therefore, the assumptions about an individual's experience should be cautiously considered when understanding their distress, and professionals should take these into consideration for interventions and empowering the voices of service users and experts by experience. For example, findings may not be applicable for individuals with psychosis from different cultures living in the UK or LGBTQ+ identities, who arguably face further barriers (Gevonden et al, 2014; Corrigan et al, 2009).

Themes unique to the above-mentioned participant population may include medication and mental health effects on intimacy needs for participants and their partners, which influence their confidence and ability to enjoy their relationships. Choosing a partner and their experience of social networks may also be unique, as they have experienced the barrier of disclosing an extremely misunderstood and stigmatised mental health label and experience to others, often resulting in fear and rejection. Similarly, the experience of stigma and discrimination highlight the unique position of being an individual with unusual experiences. Finally, planning for the future presents a unique challenge for individuals who may struggle to find occupation and achieve life stages, especially for those in institutionalised settings.

With regards to the current study, it is important to reflect on the methods used. Utilising generic, but broad subject, databases enabled a wide-ranging search; however, including a discipline specific database, such as PsycInfo, might have found additional relevant papers.

Similarly, Thematic Synthesis positions the researcher to interpret the results ‘closely’ and ‘transparently’, to facilitate quality interpretations and hypotheses (Thomas & Harden, 2008). For example, if the position centred itself on discovering ‘truths’, rather than the social constructionist perception, the researcher might arrive at more concrete narratives of explaining distress, which could provide more specific recommendations for clinical services. As such, with this literature review exploring the concept as new and holistic, it was deemed necessary to provide more open interpretations so that it can be flexible in its helpfulness. Furthermore,

Recommendations for clinical work include acknowledging that individuals diagnosed with psychosis want and need relationships, proven vital for recovery, well-being, and part of being human (Bucci, Emsley & Berry, 2017). It has been reported that services are not encouraged to promote support for relationship needs (White, Haddock & Varese, 2019). Staff, similarly, were described as lacking confidence and perhaps avoidant of discussing this with service users, which may relate to a lack of guidance, with sex and romance being taboo subject in health-care settings (White, Haddock & Varese, 2019).

Therefore, services could review sexual safety policies and what they involve. This should also be in-line with the formulation of care and risk management, including individuals more at risk of exploitation or unwise decision-making. Community support might include: family interventions (National Collaborating Centre for Mental Health, 2014), Hearing Voices Groups (Ruddle, Mason, & Wykes, 2011) and the Hearing Voices Network (Longden, Read, & Dillon, 2018) for meeting others with lived experiences of voice-hearing without medicalisation of distress, as well as interventions to tackle shame (Morrison, Burke, Murphy, Pyle, Bowe & Varese et al., 2016) and social recovery (Fowler, Hodgekins, French, Marshall, Freemantle & McCrone et al, 2018).

More specifically, recommendations can be made for services to address the psychological impact of sexual trauma. The NICE guidance for schizophrenia (2014) suggests that CBT and family interventions should be offered. This should include an opportunity for the individual to explore their lived experiences that may precipitate or perpetuate distress from unusual experiences, and the impact this has on relationships. Literature regarding trauma and psychosis are becoming more robust, suggesting associations that abuse (of all kinds) are linked to developing unusual experiences. It is therefore considered appropriate that service users be offered therapy to support them in making sense of the impact of the sexual trauma. Finally, the Long-Term Plan (2019) highlights the ever-growing recognition of the usefulness of a trauma-focused approach in services. A trauma-informed lens would increase opportunities to be asked and to become aware of the impact of trauma on distress.

Redmond et al (2010) identified “a vicious cycle” where participants felt inexperienced, leading to anxiety and fear, and creating an inability to “approach novel situations”, and thus, on-going stress and inexperience which do not disconfirm insecure beliefs. Services should therefore consider opportunities for habituating individuals to social experiences to gain confidence in building relationships and support with others. Some examples of this include Cognitive Behavioural Therapy (CBT) with incorporated social skills training (Turner et al, 2018; Addington, Saeedi & Addington, 2006). Additionally, participants and partners in Östman and Björkman’s study (2013) wished for access to treatment options that did not just diagnose a dysfunction but integrated treatment as a couple.

Implications for further research

Several areas in this review have been identified to expand on in future research. One example is the lack of positive narratives about successful relationships for individuals diagnosed with psychosis. Previous literature had highlighted barriers to and the negative aspects of mental health on social functioning. However, authors may now anticipate negative or lack of experience in relationships. This may prevent the exploration of what works, what helps and how individuals can successfully form and maintain relationships. Such examples can support clinicians and service users to problem-solve and map positive change.

Additionally, in the last twenty years medication appears to be an on-going issue for sexual expression and self-esteem for individuals taking medication for psychosis. From the literature, it seemed to be the norm and something that cannot be changed. Perhaps medication effects do not outweigh the benefit of ‘managing’ their symptoms. However, the impact of social and sexual deprivation must be considered when these such things continue to perpetuate distress and isolation. Future research could aim to find alternatives to medication and prioritising the social and psychological support in the whole system.

Lastly, future research should endeavour to improve the robustness of qualitative research so that the evidence used can make stronger conclusions. Robust evidence, details of rigour and more homogeneous findings, based on specific individual factors, can provide services and practitioners with more insight into their current guidance and way of working.

Conclusions

It can be tentatively concluded from the limited literature that individuals diagnosed with psychosis continue to experience barriers to forming and maintaining relationships. They are rarely encouraged or supported by their social networks despite social pressures to adhere to life stages. This includes services, even though literature argues its absolute necessity in recovery and well-being for this population. Despite these barriers, this review supports how individuals with psychosis can form and maintain positive relationships that benefit improve quality of life. The review also suggests how more robust research can support services and future guidance around this need.

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PART TWO: EMPIRICAL PAPER

This paper is written in the format ready for the submission to:

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See Appendix E for submission guidelines

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The Experiences of Psychosis for LGBTQ+ Individuals

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Abstract

To date there has been no literature published exploring the experiences of non-heterosexual individuals and unusual experiences. This study aims to investigate these experiences. Six participants who identified as non-heterosexual were invited to share their experiences and perceptions in a semi-structured 60-minute online interview. Participants were recruited via social media. Interviews were analysed using Interpretative Phenomenological Analysis (IPA) and four superordinate themes emerged: 1. The Experiences and Influence of Trauma; 2. Exploring the Existence and Understanding of Unusual Experiences; 3. The Development of Self-Identity; 4. Relationships with Others. These were then interpreted to improve the understanding of these experiences and to offer better-informed services in future.

Foreword

There are some disparities between the use of terms when referring to the LGBTQ+ community. Literature has previously only explored lesbian, gay and bisexual experiences (referred to as LGB). In this study, lesbian, gay, bisexual and queer sexual identities are explored (referred to as LGBQ+), however there are also general connections made to the entire community, which include transgender identities (LGBTQ+).

Transgender individuals were excluded from recruitment for this particular study as gender identity was not the focus of the study. To include it would have made the scope too broad and the results potentially less meaningful. See methods section for more information.

Please note that three participants self-identified as non-binary, so will be referred to with their preferred pronouns: ‘they/ them’.

Readers should also understand ‘coming out’ and ‘being out’ is the experience of making a person’s non-heterosexuality known to others, and being openly non-heterosexual in a public or private space.

The Experiences of Psychosis for LGBTQ+ Individuals

This study aims to explore the experiences of individuals who identify as non-heterosexual who also have unusual experiences. ‘Unusual experiences’ refers to an individual who sees, hears or believes things that would be considered unusual in their cultural context (Morgan, Reavley, Ross, San Too & Jorm, 2018). This study uses ‘psychosis’ and ‘unusual experiences’ interchangeably due to the researcher’s position that ‘correct’ labels can only be defined by the experts by experience, corresponding to Social Constructionist Theory used in this review (Burr, 2015). Research suggests that the content and meaning of unusual experiences are influenced by what has happened to individuals, for example trauma from stigmatisation; but also, from wider contextual factors like sexuality, gender, and ethnicity (Blechner, 2011; Corrigan et al, 2009). This also has an influence over making sense of the experience and their distress. Social Constructionism Theory details how identities (such as sexuality or gender) are socially created to describe an individual, giving them value and meaning (Burr, 2015). Sexual minority identities include self-given ‘labels’, for example: gay, lesbian, bisexual, or recently reclaimed ‘queer’.

Different identities (Burnham, 2018) such as sexuality and gender can be defined into a powerful dominant group and a non-dominant group within them (Privilege, Domination, and Oppression Wheel; Morgan, 2018). With sexual identities, heterosexual is the dominant group which perpetuates narratives of what is ‘normal’, whilst stigmatising less dominant sexual identities (Price & Feinman, 1995). Some specific examples of the impact of this societal structure include homosexuality being legally considered a mental illness until 1974 in the UK (Goodwach, 2005).

The certain characteristics described above have less social power and higher social inequality (Price & Feinman, 1995). Inequality in society is maintained by the dominant group to retain power, often through the exploitation and oppression of non-dominant groups. It therefore increases the likelihood of mental and physical health issues for non-dominant identities, outlined in the Minority Stress Model (Meyer, 1995; 2003). Minority stress relates to the distress a person experiences throughout the lifespan due to social barriers related to their minority identity (Newcomb & Mustanski, 2010). It offers an explanatory framework for the association between sexual minority status and mental health difficulties. The model also suggests that having a positive minority identity and having support from the minority community moderates the effects of such stress (Gevonden et al, 2014; Pilling et al, 2017).

Research has shown that LGB individuals suffered being legally discriminated against in the UK until very recently (Safren, 2009; Meyer, 2003). This includes previous laws specifically prohibiting same-sex marriage, it being more difficult to adopt children, and not being able to visit same-sex partners in hospital until 2007 (Pichankis & Goldfried, 2004).

When distress about sexual orientation is experienced by LGBTQ+ individuals, it has been found to be related to external causes (stigma and discrimination), rather than their sexuality itself (Safren, 2006; Pachankis & Goldfried, 2004). General risk factors for developing mental health issues for young people include school stigma, not being accepted by their community, LGB victimisation, and ‘coming out’ before age 16 (Rimes et al, 2019). Simply being LGBTQ+ increases the risk of developing severe mental health problems, including psychosis (Rimes et al, 2019; Gevonden et al, 2017; Bolton & Sereen, 2011; Chakraborty, McManus, Brugha, Bebbington & King, 2011; Corrigan et al, 2009; Rivers, 2001).

Literature across decades suggests that LGBTQ+ people utilise mental health services at higher rates than the general population (Bell & Weinberg, 1978; Liddle, 1999; Morgan, 1992; Bradford, Ryan & Rothblum, 1994; Pachankis & Goldfriend, 2004). However, despite best intentions, services fail to meet the needs of this population. Safren (2009) argued that non-heterosexual service-users have different life experiences compared to heterosexual clients as they do not receive the same expected treatment from services due to their sexual identity. This includes hyper-focusing on sexuality when the issue lies in negative cultural perceptions a client learns from an early age (Pachankis & Goldfried, 2004). Additionally, LGBTQ+ people have been found to present with unique life experiences from heteronormative populations in the therapeutic context (Pachankis & Goldfried, 2004), which cannot be understood with mainstream psychological understandings of distress.

Individuals with experiences of psychosis can also be significantly disadvantaged in society in terms of social and economic hardship (Morgan et al, 2018). This includes employment discrimination due to their mental health, which impacts an individual's positive self-identity, solidifying internal stigma and hopelessness (Morgan et al, 2018; King et al, 2008). Research has shown that disclosing 'severe mental health' in adulthood can lead to further ostracization or discrimination (Jager, Cirakoglu, Nugter & Os, 2017). Data from 27 countries showed that nearly half of participants, all of which had been diagnosed with psychosis or bipolar disorder, considered themselves treated unfairly by family and friends, with 29% reporting discrimination when finding and keeping a job (Harangozo et al, 2014).

Those who identify as LGBQ+ or have unusual experiences may encounter negative connotations. Combined, it can cause further life stress, stigma, and isolation (Pilling et al, 2017). In Östman's study (2014), some participants felt that being homosexual and experiencing psychosis was perceived as a 'dual barrier' to accessing relationships (Östman, 2014). This is further reinforced by a quote in Pilling and colleagues' (2017) study: "…god forbid if you have both'. Intersectionality theory reinforces this as it states that different identities which are discriminated against (such as ethnicity, gender, and sexuality) can overlap in a singular person to create a more harmful experience of discrimination (Crenshaw, 2017). This model is important to consider, as every individual is not just one identity, but many overlapping identities which influence their context and experiences.

There is a gap in existing literature considering the overlap between having unusual experiences and being LGBTQ+. The inclusion of LGBTQ+ participants has been non-existent in mainstream psychology research, unless their sexual identity is the focus of the study. It is important to acknowledge that LGBTQ+ individuals are not just their sexual identity but have other identities as well that influence their lives and context. Research with LGBTQ+ participants also tend to focus on 'mental health' generally, which may not be useful for specific experiences.

This study aims to understand unusual experiences and sexual identity for LGBQ+ individuals. This can improve services by helping professionals to understand and appreciate the participant's 'lens' (Burr, 2015), therefore improving the accuracy of understanding and clinical skills. This could help shape day-to-day interactions and service provision in future, by using documented experiences to frame therapeutic interventions and develop rapport. The research questions are: What are the experiences of psychosis for LGBQ+ individuals? How do they make sense of their experiences?

Method

Design

This study used qualitative data gathered through semi-structured interviews to investigate the personal experiences of LGBQ+ individuals with unusual experiences. Interpretative Phenomenological Analysis (IPA) guided the interpretation of the interview process, analysis, and context of the study (Smith, Flowers & Larkin, 2012). IPA prioritises the exploration of how an individual tells their story and how they make sense of the world. IPA also highlights the context in which the data is gathered, and the position of the researcher, in relation to data interpretation (Smith, Flowers & Larkin, 2012). The explicit statement of the researcher position will be discussed later.

Participants

Initial recruitment was attempted via NHS services, but this was unsuccessful. This approach was then adapted, and university ethics acquired to recruit via non-NHS routes. This included Facebook LGBTQ+ groups, and Reddit forums set up for sharing LGBTQ+ or unusual experiences. See Appendix K for the advertisement.

As per IPA guidelines, the study aimed to recruit 6-9 participants (Smith, Flowers & Larkin, 2012). 12 individuals emailed the researcher with initial interest. However, seven signed the consent form and six attended the online interview due the six not responding to following emails and thus were interpreted as withdrawing interest. The study required individuals with similar experiences in which to gather cohesive themes and this was adhered to during recruitment. All participants met the inclusion criteria, as defined in Table 1.

Participants were excluded if they were not fluent in English due to the potentially abstract nature of the interview questions being misinterpreted. Individuals were excluded if they did not identify as experiencing same-sex attraction. They were also excluded if they were under 18 years old or had a learning disability due to the legal ambiguity of consenting to a sensitive research topic. Transgender individuals were excluded due to this experience being too broad and different to same-sex attraction. Individuals were also excluded if they did not have 'psychosis' or 'unusual experiences', or if another mental health presentation, for example post-traumatic stress disorder (PTSD) flashbacks, was their most common experience.

Table 1.

List of Inclusion and Exclusion Criteria

Inclusion	Exclusion
• Fluent in English	• People not fluent in English
• Non-heterosexual (lesbian, gay, queer, bisexual, pansexual and others)	• Individuals identifying as heterosexual or otherwise only attracted to the opposite sex
• Over 18 years old	• Under 18 years or learning disabled
• Experience of psychosis (e.g., unusual experiences or beliefs	• No experience of psychosis or predominant co-occurring experiences e.g., PTSD, extreme mood swings etc
• UK based	• Transgender individuals

The social media advertisement led to 12 individuals expressing interest in taking part, but only six progressed to interview. All participants were White British, non-religious, assigned female at birth, and living in the UK at the time of study. For further participant information see Table 2. The lack of gender, age and ethnic diversity may have influenced the strong themes relating to personal experiences and perceptions.

Table 2.

Participant Demographics

Pseudonym	Age	Gender Identit	Sexuality	Mental health experiences	Employment Status
Cassie	29	Cis-gender (female)	Lesbian	Experiences of psychosis	Long term sick from work
Rachel	24	Cis-gender	Bisexual	Anxiety, stress disorder, depression, seeking a diagnosis for OCD and experiences of hallucinations	Employed
Alex	19	Non-binary (neither gender)	Pansexual/ bisexual	Depression, anxiety, PTSD, eating issues, first episode psychosis, ADHD	Student
Willow	25	Non-binary	Queer	Non-specific psychosis PTSD, OCD, psychotic depression	Employed
Riley	25	Non-binary	Bisexual	BPD diagnosis and depression, hallucinations	Sick leave
Eryn	33	Cis-gender	Pansexual	Dissociative identity disorder, diagnosis of psychosis	Self-employed

Note. Acronyms for self-described mental illnesses in Table 2 are as follows: Obsessive-Compulsive-Disorder (OCD), Post-Traumatic Stress Disorder (PTSD), Attention-Deficit-Hyperactivity-Disorder (ADHD), Borderline-Personality-Disorder (BPD).

Procedure

The advertisement included a university email in which interested people could contact the researcher about the study as a point of consent to be contacted. The researcher then arranged to contact the individual over telephone and discuss the study and consent to take part. The consent form was subsequently emailed and signed, and a semi-structured online interview date decided. Interviews were recorded and transcribed. Participants were reminded that they could remove their data from the study until the start of analysis.

Online interviews ranged between 55 minutes and 1 hour 10 minutes. Each interview began with information about the anonymisation process and the structure of the interview. During the interview, the researcher checked-in with the participant and for any signs of distress or discomfort. After the interview, the researcher asked for the participant to decide on a pseudonym and whether they would like a copy of the report when complete. Participants were given a sources of support sheet after the interview with contact numbers in case they experienced distress. The discussion topics for interview were:

- How someone identified sexually
- What their experiences of their sexual identity are
- How they came to experience psychosis and what that experience of psychosis was like
- How they made sense of these experiences.

See Appendix J for interview questions.

Researcher's Position

To ensure rigor, I used the reflexive position (Malterud, 2001) throughout data-analysis. As a bisexual woman, I have a specific perception of same-sex attraction and the internal and external cultural bias. For example, my personal experiences of being a sexual minority resulted in me relating to the lived experiences of the participants and potentially projecting my perceptions. For this study, I was conscious of my own experiences of marginalisation, and remained open and non-leading in interview and analysis topics of how or if participants were marginalised. I also acknowledged the stigma and heterosexism (Herek, 1995) internalised in me from my cultural context. I was also aware that being White, and female is still a privileged position compared to women of different ethnicities living in England; and I acknowledged that there were no participants from other ethnicities or cultures. This position may influence being drawn to similar experiences, or some participant experiences being more understood compared to a population where I less identified with. Biases were addressed through triangulation: supervision from two supervisors the use of a reflective journal and a reflexive interview conducted by one supervisor.

Results

Smith, Flowers and Larkin (2012) outline a 7-step process of conducting Interpretative Phenomenological Analysis. During analysis, the researcher kept in mind Heidegger's Hermeutic Phenomenology as a further reference as well (Peoples, 2021). Heidegger described this position as bringing together objective and subjective dimensions of experiences as lived and made sense of, rather than creating abstract concepts and hypothesis from them (Peoples, 2021). This position also uses lenses and makes personal biases explicit, corresponding to this thesis' positioning with Social Constructionism (Burr, 2015).

Interviews were transcribed by hand within 48 hours of completing the interview. Stage One and Two was devoted to reading, re-reading and noting down initial thoughts or points that stood out. An example of this was certain inflections of speech or what event had happened, and how they seemed to have interpreted it. Stage Three included developing the notes into more cohesive emerging themes. Stage Four brought specific examples, such as recounting a memory of verbal abuse from a stranger, into a general theme of stigma. At Stage Five, I had repeated the last four stages for the remaining five transcripts and began looking for patterns across papers. I had gathered approximately 50 small themes within each transcript to create 20 larger themes across transcripts, such as 'breakdown' and 'acceptance'. The final IPA stage was to look deeper. Narrowing down the later themes required the researcher to immerse further into the language used, experiences and interpretations of each participant in order to help determine which were the most prevalent themes; and from there were grouped into superordinate themes that encapsulated their similarities. Four superordinate themes were identified from analysing the experiences and sense-making of LGBTQ+ participants with unusual experiences (see Table 3).

Table 2.

Listed IPA Themes

Superordinate Themes	**Subthemes**
1. The Experiences and Influence of Trauma	I. "… Just having mentally ill parents- it just fucks you in your own way" II. "I was kind of outed against my will to a lot of people at school…" III. "I don't know how to say it without upsetting you- but like assaults and shit"
2. Exploring the Existence and Understanding of Unusual Experiences	I. "I don't know if I'm allowed to say the word crazy…" II. "…If you don't fit into your box then- you don't get treated for the right thing"
3. The Development of Self-Identity	I. I'm just in a better place as well- whether that's because it got better or whether that's a by-product I don't know" II. "We all experience it as queer people- but it probably didn't help the psychosis- I didn't even think of the connection until just now"
4. Relationships with Others	I. "… And I remember sitting down and talking to my dad about it- and him saying— you love who you love" II. "It caused- a lot of –problems- and like really ruined the relationship quite a bit but then once I started getting like the vocabulary to describe- what was happened and how I was feeling- I could vocalise it to them? And then- they knew what was going on" III. "I've gravitated towards erm like- found it easier to make friends with- have been gay?"

1. The Experiences and Influence of Trauma

Trauma was understood by all participants to be a major event or time which caused significant distress and perhaps influenced the development of a negative or fragmented sense of self. Participants wondered whether these events impacted not only their unusual experiences but their sexual identity too.

I. "… Just having mentally ill parents- it just fucks you in your own way"

This subtheme related to shared family trauma or experiences of distress that the individual grew up around, as well as the narrative or sense-making they experienced at the time. Participant experiences suggested that the family narrative informed their perceptions of themselves, often making sense of their unusual experiences through relating it to family mental health issues.

Three participants stated they grew up with mental health issues in the family. Cassie referred to mental health conditions in the paternal family side and explained that her experience of family distress meant she was better informed when she too developed unusual experiences. Willow briefly spoke about their father being "depressed" and attempting suicide when they were young. Riley stated that their brother "has bipolar" and recounted the experience of witnessing his aggressive presentation and how their parents struggled to manage his distress and other two children. Riley appeared traumatised by witnessing their brother's distress and their parents struggling to cope, assuming their parents would also be burdened by Riley's disclosure of psychosis.

> "I didn't think anything happened to me until a couple of years ago and then like worked it out- like my dad is depressed there was suicidal attempts when I was young… just having mentally ill parents- it just fucks you in your own way- or not dealing with that or not understanding that that's what your brain had to deal with- because when you're a child you don't process things well" (Willow)
>
> "Me mam and dad have just run out of a bit of steam- dealing with me brother and me sister? And me brother had eh- psychotic symptoms so—it's already got a stigma attached

> to it because- they were quite aggressive psychotic symptoms so—I don't- a bit of us is that- I don't wanna be that *burden*" (Riley)

Individuals that were 'burdened' by other distressed family members as a child did not want to be put in their same position by disclosing unusual experiences as an adult. It may then be suggested that the context of the family's mental health or trauma, or how they make sense of things, influences an individual's sense of 'reality' and how they learn to manage distress.

II. "I was kind of outed against my will to a lot of people at school…"

Social stigma was experienced as bullying or discrimination depending on the age of the participants at the time, predominantly due to their sexuality. This contributed to feelings of mistrust in others, influencing negative perceptions of themselves and increased self-doubt. This subtheme highlights marginalisation at different stages of participants life from peers, family, and their wider community (employers and strangers).

Experiences of bullying during primary or secondary school was stated by four out of six participants. Bullying included being ostracised or singled out as 'other' from a young age. Though not explicitly stated, it was considered by all four participants that distressing periods influenced the participant's trust in themselves or others.

> "I was constantly accused of being gay- I'm 5 foot 9 and I've been this height since I was 11… I was quite boisterous and… just a bit off- kilter…people picked up on it…I was always accused of being a lesbian… full on mocked for it all the time?" (Cassie)
>
> "My mental health got- better than it had been in secondary school? Cos I was- bullied in secondary school… was just a bit quiet and weird? In terms of what people thought of me?" (Rachel)
>
> "I was kind of outed against my will to a lot of people at school… some of the things that were kind of mentioned was that I'm just saying I'm gay… because I knew that I wouldn't

> be able to get a guy… that was the kind of doubt in my mind ok what if I'm not actually gay what if I'm just lying to myself?" (Alex)
>
> "People would say are you a girl or a boy? And I remember…I liked people questioning that- but I didn't like the kids…bullying me for it" (Eryn)

Four participants described experiencing discrimination from their mid-late teens, and this seemed to be a natural progression from being bullied to being discriminated against due to their appearance or expressions of sexuality (for example, holding hands with their same-sex partner). Discrimination was from a range of people, from close relationships at the time, such as male ex-partners and parents, to work relationships and interactions from strangers. The participants appeared to interpret the discrimination from close relationships as micro-aggressive and invalidating.

> "Me mam and dad were like well they can't come over and stuff like that but- like- my brother and sister who were straight were allowed people over- so I was a bit like- singled out- and I was quite aware of it it… was kind of- right we know you've got a girlfriend but- there's this big family event but you can't plus one- because you would be bringing a girl" (Riley)

Interactions with strangers or colleagues was considered more threatening to safety, and participants felt targeted, mostly by men. Participants also associated meeting new people and being in public as a source of fear, especially when disclosing their sexuality specifically, not knowing how it will be received. Humour was used perhaps to deflect from the concern about being attacked due to their sexuality.

> "So it's quite scary being like- being 15 years old and being shouted at by two 40 year old men for- having a girlfriend- 's quite scary- so I couldn't really do anything to them could I? [laughs] I couldn't push them off us or anything" (Riley)
>
> "I worked in a shop and- there happened to be another gay woman so- there was jokes made about- like a threesome with a manager" (Riley)

III. “I don’t know how to say it without upsetting you- but like assaults and shit”

Trauma was mostly described as sexual assault experiences, and then abuse suffered from ex-partners. Participants also suffered abuse from the general public due to stigma about their appearance. This subtheme differs from the above subtheme due to its specific focus on sexual assault upon participants, and the abuse survived from previous intimate partners that they were sexually involved with.

All participants grew up perceived as female, irrespective of chosen gender identity later in life. This homogeneity seemed to influence their experiences and mistrust of men. This included a generalised view of ‘men’ as untrustworthy or dangerous, which was confirmed through experiences of being discriminated against, sexually assaulted, or abused in relationships by heterosexual, cis-gendered men.

> “…like dyke and stuff like that?... woman and woman relationships it’s a lot of- sexual abuse that you get?... how dare I walk past this man with- my girlfriend and he’s offended because I’ve got a girlfriend… he thought I was attacking them for being male?” (Riley)

All acts of violence from men related to sexual acts or the participant’s expression of sexuality. Three participants reported sex-related trauma. Eryn explored in therapy how her dissociation began at around three-years-old after a sexual assault. Alex experienced sexual assault around one year ago in a nightclub:

> “…but the trauma being committed by a man did cement the inherent- distrust of straight men…confirmed that all men kinda want one thing and that’s something I’ve had to unlearn” (Alex)

The ‘inherent’ or learnt association of the dominant group, heterosexual men, has an association with fear and subversion towards groups with less power. This potentially unhelpful stereotype may have previously served as a survival mechanism against future abuse, which influences how they are currently unsure whether their hesitance to date, or even be near men stems from this.

> "When I was a teen there was some sexual—Er—you know- I don't know how to say it without upsetting you- but like assaults and shit" (Willow)

The quote from Willow may imply that there is a general taboo around talking about sex trauma and feeling the need to be wary of how they tell others and worrying that the researcher would find this news distressing. Alternatively, it may be difficult for Willow to disclose, and they may have been finding the right detached words to avoid reminding themselves of the experience. This interpretation was made perhaps due to previous disclosures to other LGBTQ+ individuals, like many participants said they have done, and experiencing their vicarious distress upon hearing it. Perhaps the interviewee did not want a repeat of this.

2. Exploring the Existence and Understanding of Unusual Experiences

This theme recounts participant's experiences with their psychosis. The experience of psychosis appeared to begin with a significant event or period of the participant's life which led to extreme distress, and most commonly the beginning of voice-hearing or visual hallucinations. Significant events included bereavement, bullying or discrimination, and sex-related trauma or abusive relationships. These factors appeared to play into paranoia and self-doubt.

I. "I don't know if I'm allowed to say the word crazy…"

Many participants described a key event where they defined the start of their psychosis. Cassie, Rachel and Alex described their onset or 'peak' of extreme distress and unusual experiences as a "breakdown" alongside stressful periods, while other participants explained it as a natural progression from other mental health issues (depression or anxiety).

Participants had similar experiences of psychosis or episodes. Paranoia was commonly experienced about other's intentions, for example a current partner working with her abusive ex-partner (Eryn); or their male flatmate tampering with food when they started university (Alex). It also seemed that everything they paid attention to, such as light fixtures being slightly skewed (Eryn) or the flatmate eating their (Alex's) food in the cupboards, served the function of confirming these paranoid beliefs, making them seem more real and justified at the time. All participants described previous paranoia as very real at the time, but that ‘coming out of it’ they could see they were ‘very unwell’.

> “My mind started protecting itself I’d say? Erm by making me really really mistrustful of men and that developed into a—a paranoia I would say—and looking back on it now it seems- I don’t know if I’m allowed to say the word crazy [laughs] erm but it seems—it doesn’t make sense to an objective- to a logical mind” (Alex)

Here Alex described their paranoia as protective and built a survival mechanism against a whole identifiable group to avoid danger. Additionally, Alex appeared reluctant to label their paranoia, and perhaps then themselves, as ‘crazy’. It suggested that ‘crazy’ was a description used with negative connotations.

Being ‘in it’ was considered very ‘real’, leading to the individual questioning what was and was not real in other areas of their lives, which included their sexuality. Internal stigma from same-sex attraction or gender-dysphoria, as well as hallucinations, fed into so much distress that one participant felt that ending her life would be easier.

> “You’re sat at 2am in the morning 1- thinking bugs are crawling under your skin and 2- your brain’s going ‘weeell you’re not a boy, you’re not a girl you’re just fucked and even if you are- even if you think you’re a trans man well that’s fucking weird and your family are gonna disown you- but you’re not- but you’re also not a girl so maybe you should just kill yourself” (Willow)

This quote conceptualises the sheer panic experienced during this time in Willow’s life, and perhaps towards the end a sense of hopelessness about the many parts of themselves they were struggling with at the time, exacerbating their distress. Also interesting is the association that feeling bugs crawling over them and the questioning of identity connotes that both are ‘not real’ and criticism over worrying about imaginary things may have come into play, emerging as assumptions that their family will disown them. Of course, it is also poignant to highlight how real this outcome might be for

LGBTQ+ individuals now, so it can be considered not unrealistic, despite the potential catastrophising it may imply.

II. "…If you don't fit into your box then- you don't get treated for the right thing"

This theme refers to the attempted use of services to manage and reduce distress from unusual experiences. All participants had previous/ current involvement with public services and/or current involvement in private therapy. Participants shared stories of negative experiences with health-care staff in both general health and mental-health services.

All participants felt that their experiences and understandings were minimised by professionals, and that the services prioritised 'box-ticking' over their individual needs and identity. This may be due to being on a referral pathway that did not encompass their whole experience, being referred to many different services, or interventions that were impersonal and irrelevant. Some participants (Alex, Eryn, Riley, Willow) also felt that their sexuality was given too much attention when that was not the issue and that discussing issues not 'related' to the referral pathway was discouraged. For example, Willow had a psychotherapist at 16 suggest to them that their sexuality and gender questioning was due to their unusual experiences. They described this as unhelpful and reductive.

Eryn recounted feelings of disorientation in remembering services and their reasons for referrals, and staff anxiety about the many factors that influenced her mental health. Perhaps being treated this way by professionals and service pathways further solidified a self-identity as not conforming to the norm or being unmanageable in their identity and experiences.

> "it's that box- ticking in services it's like- if you don't fit into your box then- you don't get treated for the right thing- like- for example- I can get treated- for the trauma that I experienced as a child- but I can't at the same time- have therapy—about—erm— coming to terms with- my sexuality or- you know it's kind of like one thing or the other you- you can't kind of- explore everything which I find- really difficult" (Eryn)

Riley perceived some staff as unprofessional and invasive regarding their sexual identity. They felt invalidated by staff using common misconceptions of 'mental disorders' to make sense of their difficulties, such as always struggling with relationships due to 'BPD' (borderline personality disorder), despite Riley not identifying with that. What stood out to Riley was being told 'you're never going to love someone', which appeared to be still painful, implied by the pause they took after saying such emotive words. Following from that, saying they have given up implies exhaustion and grief regarding these experiences, and trauma they wish not to risk repeating.

> "…cos then it turned into- it was a lot of comments about—am I happy in the relationship? Um—what do you- like what do you do in bed? If it's two women- then it turned into- well you've got borderline and that's- relationships are a big thing in that so you're never gonna love someone so that- like- that- I've just give up with that" (Riley)
>
> "Well I told him [GP] about my experiences and he was like oh so you wanna murder people?" (Willow)

Willow was contacted to see a GP due to medication changes that no one seemed clear about, through which after explaining their voice-hearing, the GP reacted very negatively. The nonchalance suggested in this quote may highlight the social stigma even medical professionals are not immune to. The lasting effects this seemed to have on Willow, who recounted this event from the past, may perpetuate mistrust in services for other LGBTQ+ individuals.

3. The Development of Self-Identity

All participants developed an understanding of their same-sex attraction from a young age. This involved self-exploration, questioning and battling against external and internal stigma throughout their lives.

"I'm just in a better place as well- whether that's because it got better or whether that's a by-product I don't know"

This subtheme emerged as a natural progression of homogenous experiences regarding either always knowing they experienced same-sex attraction, or a slower realisation. The timeline usually was influenced by external and internal stigma.

All participants reported being made aware of the idea of being 'gay' or 'lesbian' from a young age, but this was often with negative or perverse connotations. The term 'bisexual' was discovered in secondary school, but also with negative characteristics, such as being 'greedy'. All participants now felt confident either having distinct labels, for example "lesbian", or a broader definition, such as 'queer'. All participants noted that initially they found that labels did not cohesively fit their sexual identity, leaving some to frantically search for what fit, whereas others were comfortable using labels as a loose definition.

> "It was a matter of finding a new label that fit-and when I was younger um-- that was something that I was very very preoccupied with…I'd spent- hours poring over the different labels" (Alex)

All participants mentioned that having time to better understand themselves appeared to be the starting point of distress reduction.

> "…So erm I've had a lot of time to think and go through things… I don't think I've taken the time- ever- to just sit back and think like what do I want- who do I want to be? (Cassie)
>
> "The recovery part has just been- getting older and being able to sort of manage your own brain and your experiences and not feel so trapped in a world where you can't handle it erm-yeah I mean I'm just in a better place as well- whether that's because it got better or whether that's a by-product I don't know" (Willow)

These accounts provided a positive narrative of progress and management of distress from both sexual identity and unusual experiences. Experiences ranged from unhelpful rumination over these aspects, for example with Alex, or in Cassie's case, and suggested avoidance of exploring her identity.

> "We all experience it as queer people- but it probably didn't help the psychosis- I didn't even think of the connection until just now"

Cassie, Rachel, Riley and Eryn viewed their unusual experiences as being, in part, caused by stigma and stress (internal and external) related to their sexuality. Willow had not considered the impact of their previous experiences on their mental health until the interview, whereas Eryn and Alex did not make a connection between them.

> "…at the time…I didn't wanna connect it- but looking back- I can kind of imagine that the looks I would get- as a young- well I still do- but as a young queer kid who's also paranoid that people are like monitoring them and sort of looking at them- it probably didn't mesh well… go down the street get the bus or a train and people would give me looks and talk about me which is you know whatever- we all experience it as queer people- but it probably didn't help the psychosis- I didn't even think of the connection until just now" (Willow)

Willow stating that they did not want to connect the two things implies a denial of relatedness. This is perhaps borne from societal narratives of sexuality being caused by 'mental illness', rather than the consequences of experiencing the stigma associated with both. Here, Willow connects how being othered by the public encouraged paranoid beliefs, and how common it is for queer individuals of any age to feel out of place. Perhaps what may be most distressing is experiencing it from a young age, when people have fewer coping mechanisms and confidence to protect against this.

Some participants had rejected narratives in late teen- to early adulthood about how same-sex attraction was a consequence of psychosis (Eryn, Willow, Riley). Previous attempts to make sense of links may have fallen into a narrative that blames sexuality for the development of unusual experiences, rather than unavoidable stigma, which may have influenced participant's being able to accept any influence.

4. Relationships with Others

All participants commented that support from therapists, family, partners, and the queer network validated their experiences (for their queer identity, being a trauma survivor and/ or someone with unusual experiences). This helped them develop their own understanding of these experiences, resulting in them feeling empowered and in control. The use of social support may have been the deciding factor in breaking the perpetuating cycle of distress.

I. "… And I remember sitting down and talking to my dad about it- and him saying— you love who you love"

Family narratives, where diverse sexuality was normalised (Rachel, Alex, Willow, Eryn), positively influence a participant's comfort in belonging to a group or identity. 'Coming out' was mentioned by all participants, mainly relating to parents- and being accepted by family appeared to relate to anticipated acceptance in other contexts and acceptance of self.

Eryn attributes her confidence in her sexual identity with the acceptance from her father (single parent), who had passed away. This experience was deeply meaningful to her and was perhaps the most grounding experience. Because of this, she attributes never having had distress regarding her sexuality.

> "I remember a boy asking- to go out with me and I was- totally disgusted by the whole thing- was just like ugh! No—and I remember sitting down and talking to my dad about it- and him saying— you love who you love and you like who you like and just because you don't like this one boy doesn't mean you don't like boys- and just because you-- had a real big crush on [celebrity] [laughs] doesn't mean that your huge crush on- a man at the time I don't know- is invalid- so from then on –I—knew- that I didn't fit into being gay or straight- I was just- me" (Eryn)

Additionally, Cassie and Alex specifically recounted that after their 'breakdown', they went to stay with their family again for a brief time. This suggests that participants seek safety of family to recover.

"I went and lived with- some family in [town] for a year and things settled quite a lot while I was there" (Cassie)

"[MH service] …very keen for me to move back in with my mum for a couple of months erm so I did that- and then I was able to kinda come back erm- better but still not- fully (2) sorted and even now I'm still not fully sorted [laughs] but working on it" (Alex)

II. "It caused- a lot of –problems- and like really ruined the relationship quite a bit but then once I started getting like the vocabulary to describe- what was happened and how I was feeling- I could vocalise it to them? And then- they knew what was going on"

Two participants were in relationships with heterosexual men. Rachel, who has been in her current relationship for over three years, reported that sexuality (bisexual) influences her relationship with him. She reported unconsciously wanting to appear 'straight' by appearing more 'feminine' while in public with him, and found that when dating women, she would dress more 'masculine' and said that her androgenous appearance allowed her to blend in more to appear 'straight-passing'. However, Rachel then consciously strived to emphasise their queer sexuality as a rebellion to her internal stigma making her conform. Eryn's six-year relationship caused some discomfort in that being in a 'straight-passing' relationship made her sexuality (pansexual) feel invalidated because she felt invisible or rejected from queer spaces.

Willow and Riley had been in relationships with women for over four years respectively and reported stigma from not being straight-passing that contrasted to other participants relationship experiences. These two participants appeared to consider the LGBTQ+ community as more involved in their identity than other participants.

Willow has highlighted how their partner acts as a point of reference for checking in with whether an experience is unusual or not, helping to ground Willow and perhaps increase their confidence in recognising it themselves.

> "a couple of weeks ago I wasn't sure if something existed or not- coz I could hear voices- and I was like babe can you put the podcast down and she's like hm it's not playing and I was like ah ok I'm gonna go to bed now [laughs] so yeah…like that it was fine because I knew ok I'm hearing things, it's late at night anyway, I'll go to bed and by the morning it'll be ok" (Willow)

Eryn and Rachel did not discuss how their male partners' support them, though briefly inferred that they did; for example, Eryn said "and obviously my husband's really supportive". Willow's, and Riley's partners being understanding, and patient was stated to be highly valued in the relationship. Being able to talk to their partners, to articulate their experience and sense-making helped form their narratives and evidenced that love is available. There were times though that both participants inferred feeling that they were a burden to their partners, despite ongoing physical support and their long-term relationship. Both of their partners also had mental health issues (also female and queer), so it was a dual responsibility of co-support.

> "When I first started getting symptoms in the relationship- erm—it didn't- it caused- a lot of – problems- and like really ruined the relationship quite a bit but then once I started getting like the vocabulary to describe- what was happened and how I was feeling- I could vocalise it to them? And then- they knew what was going on- so it was all to do with- if I didn't tell them what was going on-- I probably just looked like- an angry-- horrible person but- once they knew- it kind of- they knew when to back off and- stuff like that? (Riley)

Talking about these experiences appeared to strengthen the relationship and understanding of each other, allowing for a safe space of what support they needed for them both.

III. "I've gravitated towards erm like- found it easier to make friends with- have been gay?"

All participants reported queer friends as their most valued and long-term support network. Rachel actively sought out queer friends after realising she "needed more" than what her childhood straight friends were providing (shared experiences and validation) and liaises between the two for different needs. Similarly, Alex described that they've "surrounded" themselves with "other gay people".

The other participants found it a coincidence that nearly or all of their friends were queer in some way. For example, Cassie has two close lesbian friends, who were vital in supporting her, especially after her family 'took a step back' after her breakdown and apparently did not want to be involved from then on.

> "I've basically surrounded myself with lesbians as I've got older [smiling] I've gravitated towards erm like- found it easier to make friends with- have been gay? And obviously that's been a subconscious thing I've not actively tried to do that- it's just where I've fallen- [friend's name] is gay as well- erm- so it's been really nice having them two to talk through and- getting their advice and yeah that's been like- really reassuring- through everything actually that's been really positive" (Cassie)

It appeared that sharing experiences in regard to sexuality was vital for Cassie in making friends, suggesting a role in validation and shared positive narrative. The use of 'gravitated' and 'surrounded' feels very protective, evidenced by other participant accounts of queer cohorts being a 'safety bubble' against negative interactions from people that do not identify as queer.

Nearly, if not all queer friends of the participants had experienced mental health difficulties and had (mostly negative) experiences of being in mental health services. Instead, participants experienced friends supporting each other with difficulties associated with sexuality and mental health. It was mainly in adulthood that their friends were able to support each other, whereas they had all previously struggled with their own sexuality and mental health. Discussing these parts of themselves in safe spaces allowed their narrative to develop and settle as familiar and manageable.

> "…but they were struggling with their own sexuality at that point I don't whether that was- that- they had no capacity to give to anyone else but it was still shit… I couldn't get the support I wanted from my peers, because everyone was having an issue- with depression,

> anxiety and psychosis is quite a scary thing for people to handle, especially young…it's not fair on them so people are scared of it, people don't understand it" (Willow)
>
> "I've got a few friends that have a certain diagnosis as that like- give- hallucinations as a symptom so—it's kind of- I've got a nice little resource pool from a [laughs] group of friends that like-- relate to each other which is nice so—we're not just given like a generic leaflet and sent away- we're like- actually relating and using personal experiences- erm—so probably more than anything- apart from- erm private therapy I think friends- is probably been the most valuable" (Riley)

Participants who had heterosexual friends often found that queer friends were more comfortable talking about mental health issues, relating perhaps to the many individuals that experienced it. Here, depression and anxiety may be commonplace, however psychosis was still considered taboo and as Riley said, it is the "last big- forbidden" concept.

Participants explained to queer friends that they had 'sleep issues' or 'trauma' and tried not to use words like 'voice-hearing', 'hallucinations' or 'paranoia', often associated with psychosis and schizophrenia, to avoid negative reactions. Participants who disclosed their experiences as 'psychosis' and similar terms were met with either discomfort and fear, or family members being worried on their behalf. Only people who were very close and trusted knew the whole extent of distressing experiences, suggesting a recurring experience of being 'othered' in some way.

What was also important was visibility and support from wider networks. Cassie commented on the LGBT Foundation charity that helped set up a safety-plan while she was living with her abusive ex-partner and made sure someone called her every day. Rachel shared her story of being discriminated against due to her androgyny using the local LGBT newsletter, noting that it allowed her to process it. She also mentioned how 'queer households' (queer individuals that lived together) provided a 'safe space' for her queer friends and work colleagues locally. Having a community of queer friends validated their sexual identity, providing a sense of pride regarding their sexual identity, perhaps to suppress their internalised negative associations and ‘othering’ they have had to endure from a young age.

> “Being gay doesn’t just come with liking the same sex it comes with a hell of a lot of pride and history and a lot of culture urm-so as I became more aware of it it kind of felt like I’d just slotted in there anyway” (Alex)

Discussion

Interpretation

The research questions for this qualitative study were: What are the experiences of psychosis for LGBQ+ individuals? How do they make sense of their experiences? The results formed distinct superordinate themes: 1. The Experiences and Influence of Trauma, 2. Exploring the Existence and Understanding of Unusual experiences 3. The Development of Self-Identity, and 4. Relationships with Others.

Theme 1. The Experiences and Influence of Trauma

The experiences in this theme support already existing literature, indicating that trauma is related to the development of unusual experiences (Blechner, 2011; Corrigan et al, 2009). Participants recounted family distress, suicide attempts, sexual-assaults, abusive relationships, bullying and discrimination. Jager et al (2017) found that over 50% of participants had experienced sexual trauma and, like the findings of this study, participants had told few or no-one about this experience. More specifically, in a review of 75 studies (Rothman, Exner, & Baughman, 2011), sexual trauma was found to have life-prevalence in 12-54% for gay and bisexual men and 16-85% of lesbian and bisexual women compared with the 2-3% of heterosexual men and 11-17% of heterosexual women. However, this was an American study and thus can be disputed how generalisable this vague estimated figure is. The reviewed papers varied regarding sexual assault definitions, recruitment and sampling techniques, and the measurements used for assessing sexual assault. Homogeneity can be questioned in terms of dissimilar procedures, and therefore whether they collectively evidence what the review is suggesting.

There are similar reports for experiences of discrimination based on LGBTQ+ identity and unusual experiences. In one study, 68% reported experiencing public stigma based on their ‘psychotic disorder’, and more than 33% had experienced rejection from friends and sexual partners after an ‘episode’ or after disclosing unusual experiences (Jager et al, 2017). It can be suggested that adversity causes distress for LGBTQ+ individuals of all ages (Rimes et al, 2019; Jager et al, 2017; Safren, 2009;

King et al, 2008; Pichankis & Goldfried, 2004). However, there has been no literature to date investigating discrimination for LGBTQ+ individuals throughout their life. Therefore, conclusions regarding life prevalence of adversity for this population is evidenced and credible only by comparing studies of LGBTQ+ individuals with different age ranges, rather than a specific research inquiry.

Adverse life events are more likely to be experienced by non-dominant social groups, who are most affected by social inequalities (Price & Feinman, 1995). Being a heterosexual woman results in increased risk of sexual assault compared to a heterosexual man, and being a gay woman increases that risk even further (Pirlott, Rusten & Butterfuss, 2016). Some participants in this study also experienced this, with suggestions that it still affects them and their identity currently (Crenshaw, 2017).

Theme 2. Exploring the Existence and Understanding of Unusual experiences

The development and experience of unusual experiences were explored. The theme identified how perpetuating cycles of distress and attending to external stimuli unconsciously confirmed unusual beliefs and served to increase paranoia, at the expense of the individual. Participants also reported being gradually convinced by their voices and abusive partners which sought to exploit the trust placed in them (Blom & Mangoenkarso, 2018; Corrigan et al, 2009). This increased the participants' self-doubt and ability to identify what was real. Participants may also have had difficulty in regulating difficult or distressing emotions, perhaps influenced by trauma (de Jager, van Greevenbroek, Nugter, & van Os, 2018; Chakraborty, McManus, Brugha, Bebbington, & King, 2011). It also suggested that service-involvement only reinforced negative perceptions of others by othering participants based on their intersectional identities and minimising their distress (White, Haddock & Varese, 2019). White et al (2019) refers to staff training as a useful step in making services more accessible for LBTQ+ individuals and in reducing stigma. However, Harangozo et al (2014) pointed out in their study that even when staff believe that they are 'doing a lot to reduce stigma', this is not often the case and

LGBTQ+ service users still report stigmatisation. It can be argued whether studies need to focus on more direct intervention than just general training.

In de Jager et al's study (2017), participants found that in an 'episode' they experienced more self-doubt and that affected their confidence in knowing their sexual identity (18%) and their gender identity (7%). It was noted during this study's interviews that the participants had not only questioned their sexuality but also gender identity. The participants in this study did not identify as transgender, but half identified as non-binary, as well as lesbian, bisexual, pansexual or queer in sexuality. It is considered normal and valid by the researcher that participants explored their identity, and perhaps the LGBTQ+ space more than any other promotes this. It can be suggested that unusual experiences worsen the experience of identity questioning rather than cause identity confusion or questioning.

Exploring sexuality and gender (Crenshaw, 2017; Burnham, 2018) must not be seen as a consequence of psychological difficulties, but how social marginalisation of one's identity can affect their ability to conclude and be confident in who they are. To reject this means to reject their exploration of themselves and who they have found themselves to be, which for marginalised groups, invalidates and further perpetuates discrimination.

Theme 3. The Development of Self-Identity

This theme perhaps concludes the last two themes in how these experiences influence the developing self-identity and the use of socially constructed labels (Burr, 2015); and how this influences their sense and human need of belonging. Participants had negative experiences of ostracisation in earlier life related to minority stress (Meyer, 1995, 2003), but with time came a greater sense of control over their external world. They began to have more positive experiences with communities they identified with and learnt what support they found useful. This appeared to influence their internal world, reducing self-doubt and criticism, and develop into a positive self-identity (Meyer, 2003). The additional social context of LGBTQ+ being celebrated in more spaces with time, likely also positively impact these individuals. This however is not universally experienced and it should also be noted that an individual's environment and social system is just part of the variables that help explain mental health.

Theme 4. Relationships with Others

Theme four focused on the influence and perceptions of relationships with others. Participants solidifying themselves in a group identity was helpful, and the support appeared tailor-made for their needs. The participant's internal world, mental health and experiences as non-heterosexual were validated by others in later life, supporting a positive internalised self-identity and pride in who they are. This resonates with the Community Psychology (CP) approach in highlighting the empowering sense of belonging for marginalised groups (Nelson & Prilleltensky, 2005). Also embodied is the notion that "we become who we are through relationships" and that marginalised groups are unjustly restrained from positive relationships and life strategies when faced with being marginalised by dominant groups and organisations (Nelson & Prilleltensky, 2005). What is perhaps not considered is internal characteristics such as 'resilience', which could add further depth to individual experiences. However, the study aimed to keep the previously unexplored focus broad so that future research could explore such topics in detail.

Limitations of the Study

The study originally recruited via NHS mental health services, but was completed via social media recruitment. As described by participants in this study, experiences of minimisation and exclusion from services regarding queer identities may have influenced service-users' sense of safety and made them less likely to 'out' themselves to staff. One consideration of the study was whether staff felt able to discuss sexuality with service users, highlighting public discomfort with this topic. Social media platforms conversely felt safer, perhaps due to the increased anonymity and control over contacting the researcher.

The researcher also considered the role of identifying with participant's sexual identity (being 'in' the community), of being a similar age and sex-at-birth. The researcher considered the participant use of ‘us versus them’ narratives. Though not necessarily a limitation, it is important to consider the impact of these similar demographics in regard to how the researcher talked to the participants about the study before participation, then during the interviews, and consequently the analysis and written report. The researcher had a specific ‘lens’ (Burr, 2015) in which she approached the study. These factors will have influenced the stories the participants shared, how they were described, and their motivations behind it. Being an outsider to this community would provide the opportunity for an alternative perspective into experiences, whilst acknowledging that everyone has internalised heteronormative stigma.

The researcher also considered this argument: “the act of defining the experiences of all lesbians and gay men by the characteristics of the most privileged and powerful members of that group is an oppressive act” (Green, 2000). The participants were notably White British, born in the UK with English accents, and were physically able-bodied. The study therefore is limited to the intersectionality of these identities and cannot and does not represent experiences and sense-making from other intersectional experiences, such as being LGBTQ+ and having immigrated from the UK in their lifespan or having learning or physical disability.

A previous study reported that a limitation of theirs was that their participants (15 gay men and lesbian women) were ‘atypical’ because “all participants were publicly out about their sexual orientation” (Corrigan et al, 2009). This study also (unintentionally) included participants who were publicly ‘out’ about their sexuality. This may also affect the representation of other queer individuals. Whilst it may be less atypical to be ‘out’ in the UK than twelve years ago, there are still many individuals who do not feel safe enough across the world to accept and express their sexual or gender identity.

Critique of the present study was considered in regards to methodology. The study recruited via social media (Facebook, Reddit and Tumblr), which limited the sampling pool specifically from the older generation among others. This could explain why the participants were similar in ages. The study interviews had to be online due to COVID-19 restrictions. Thus, the study potentially lacked more information in regards to participant body language, whether they were in the house alone, whether they were completely open, and so on. This method had a better opportunity to reach a wider population due to avoiding travel issues, but the aspect of online interviews themselves could influence what was said, for better or for worse. Alternatively, a somewhat removed method may have been beneficial for a participant, feeling more able to open up to a stranger on a screen.

Finally, IPA does not seek to generalise, so triangulating data with questionnaires would not be appropriate. However, this is potentially a limitation for services seeking to quantify these experiences in order to deliver interventions. These findings are hopefully the first foray into research looking at this issue, and that further research might want to explore the transferability of these findings to the wider population.

Recommendations and Implications for Future Research

Recommendations for future research in this field include recruiting in anonymous or queer social media spaces, rather than health services. Alternatively, researchers should plan for longer term recruitment periods via health services. Also consider the impact of how being perceived as being ‘in’ or ‘outside’ the community will affect the likelihood of participation and how the research and researcher is being perceived by LGBTQ+ individuals.

Suggestions for future research topics include exploring the influence of sexual trauma on the experience of queer sexual identity. This includes questioning whether participant’s experiences and fear impact their potential sexual or romantic interest in the gender which related to the trauma; and, the psychological distress they experience in recognising this connection.

Future research could also explore professionals’ experiences of talking about sexual identity with clients in services. Previous research has explored mental health practitioner’s perceptions of service-user’s relationships (White, Haddock & Varese, 2019) but not concerning same-sex relationships or with non-heterosexual service-users. This could enrich the current literature about the stigma being expressed in services unknowingly.

Finally, research should also explore what inclusive and progressive models there are that would benefit marginalised groups seeking support from mental health services. Feminist Therapy, as an example, seeks to highlight a person's intersectional minority identities and experiences such as sexuality, gender, ethnicity, and disability (Brown, 2018). The emergence of this therapy into mainstream care could support individuals with making sense of their experiences and developing positive change in their lives and social context. It also provides a space where their identities are explicitly talked about, instead of minimised or attributed to their mental health difficulties (Safren, 2009; King et al, 2008). Staff in dominant groups could also benefit, becoming more comfortable talking about these experiences (White, Haddock, Varese & Haarmans 2021; White, Haddock & Varese, 2019).

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PART THREE: APPENDICES

Appendix A. Reflective statement

As I stare at the blank page for this statement, I feel an acute sense of déjà vu. This feeling of needing to articulate *exactly* what I mean, and how I am going to do so, stayed with me throughout planning and conducting this thesis. The entire concept of 'thesis' has connotations of pressure, and energy, to which I was fearful I would not be able to maintain. My main concern has been, not whether I could do the study, but whether I would be able to actually write coherently what I wish, and to the satisfaction of many different readers. Also, I ponder as to how well this thesis will age, and whether in 10 years' time this has been of some use to the community in which I belong to. My identification with some parts of participant's identities adds a pressure to 'get it right'; but also, to not say that I am 'The Voice' of LGBTQ+ representation. My concern also rests with social consciousness, and how many LGBTQ+ individuals have been the 'subject' of much 'science' and psychology where the question has been 'why are you like this?'. Such historical studies immediately pathologised an entire group of marginalised people due to just existing. I feel the weight of psychology's morose history against this community as I write this. To summarise, what has maintained the energy and pressure is exactly this weight, and the personal and professional responsibility to make sure the future is more inclusive and kinder to as many people as possible.

Development of the idea

My interest in unusual experiences and beliefs originated in my first year Early Intervention in Psychosis placement on the Clinical Psychology Doctorate. This interest was maintained by how there is no concrete definition of why or how this presentation exists (though there are a lot of suggestions) unlike the more common and accepted explanations to why people become 'anxious' or 'depressed'. The reading material at the time also held my attention to psychosis, such as the book Models of Madness (Read, Mosher & Bentall, 2004) an impassioned articulation of how the diagnosis 'schizophrenia' was invented and often coincided with social marginalisation in the western world. I wanted to keep learning, and what better way to learn of people's experiences than by doing a thesis on exactly that. However, there was already a lot of literature about 'psychotic experiences', so I explored what was missing. Personally, I was already aware of the hidden figures and lives of LGBTQ+ individuals and communities globally, so perhaps naturally I landed on this idea. After researching current literature, I was reaffirmed that there was almost nothing on personal, qualitative experiences of LGBTQ+ identities and mental health experiences. My supervisors and I decided to make it explorative, rather than too-focused, due to the very limited research that already exists.

Conducting the research

It is interesting that I commented on anxiety and depression in the earlier section before I had conducted the interviews. What a coincidence, I thought, that anxiety and depression come up for so many participants. Or rather, why is it *not* a coincidence? My personal LGBTQ+ relationships that discuss mental health so openly was something I had not thought of until the interviews, now I wonder if this is the same in every queer space- the sharing of distress and pain. Similarly, I was then caught between falling into interviewing participants as another 'queer' person, and fighting internally to decide how best to approach interviewing. In my reflective writing, after my first interview, I called myself naive to assume I could interview someone without considering the very nature of conversation itself would be influenced by our sexuality and also our gender.

Empirical

The analysis of the raw data that I had gathered was a genuinely enjoyable process, as I had long awaited information in which to explore something of great interest to me. The analysis followed the guidance of Smith et al (2012) and led me smoothly into each stage. As I wrote the results section, a journey arose among the experiences of individuals, and I felt as along-side their narratives as possible while being immersed in writing. At one point, as I wrote down quotes to evidence my points, I could *feel* their intensity, their reasons of saying or not saying. So immersed I was that I wrote the entire results section in one day. The themes spoke to me of a story, born from adversity or unkind narratives, to a young person struggling to know themselves fully whilst also battling against societal stigma about an aspect of themselves they may have only just started discovering. The discussion section was harder, as I struggled to emerge out of the participant's experience and adopt an academic lens: how can I reduce their rich experiences to a theory? A binary concept? It is mournful to be so limited in language as with feeling.

Systematic literature review

Whilst the ethical approval was underway (and would be for over a year), I focused my attention to the task of finalising the objective for this review. I knew I wanted the focus to remain on psychosis, and that it needed to relate to the empirical in some way… Eventually, after considering other broad subjects, such as marginalised ethnic individuals and psychosis, I settled nicely on how relationships were experienced by individuals with psychosis. Again, this area had been scarcely studied, despite ever growing literature that consistent social support heavily impacts well-being across all populations. With this knowledge came frustration, as I am conscious of the difference in the amount of community-centred research versus diagnostic, individualistic and often over-medicalised research, correlated with either no improvement or worse statistics for mental health in the last decade. This has been what has driven me to pursue this review, as I feel it is important that relationships and positive social roles are considered a large part of a person's recovery.

Appendix B. Epistemological statement

This study was ontologically subjectivist and used an interpretivist position. This position argues that "the material reality is reducible to the psychic reality" (Hanly, & Fitzpatrick-Hanly, 2001). It can be attributed to explaining a participants reality: perceptions and 'truths' about the world are a construct of their mind based on their previous experiences and from their perspectives, which may or may not be homogeneous with other individuals. Subjectivism arguably struggles to differentiate between 'affects and fantasies' interfering with a participant's and the researcher's own perceptions and ones that facilitate them (Hanly, & Fitzpatrick-Hanly, 2001). Because the position argues neither one reality or a truth to uncover, it can become difficult to separate what is and what is not when faced with making conclusions. The goal of this position is to consider what could have influenced why a client chooses to either hide or reveal an aspect of the self (Hanly, & Fitzpatrick-Hanly, 2001).

The study also adopted a Hermeneutic (Kinkaid, 2021) phenomenological epistemological position (Peoples, 2021). The Hermeneutic framework makes use of lenses (Peoples, 2021) that make personal bias and judgements explicit, opening the opportunity to consider researcher power and authority (Burr, 2015). Also considered is the participants 'daesin' and how their preconceived knowledge about experiences and interpretations changed as the interview progresses.

IPA (Smith et al, 2012) requires constant reflection from myself into what processes they experience while analysing the data. Such work aims to publish work that is as reflective as possible on the participant's and my own experiences.

Appendix C. Sample extract of data analysis

Appendix D. Data Extraction Forms

General Information: title, authors, type of publication	
Study Characteristics: aim, design, inclusion/ exclusion	
Data Analysis Plan	
Participant Characteristics: age, gender, ethnicity, socio-economic status *Detailed in results section after data analysis plans	
Results: **1.**	
Discussion	
Study conclusions	

Appendix **E**. Quality Appraisal Checklist for Qualitative studies (NICE, 2012)

	Comments	**Conclusion**
Study identification: Include author, title, reference, year of publication		
Key research question/ aim:		
Theoretical approach		
1. Is a qualitative approach appropriate? For example: Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings? Could a quantitative approach better have addressed the research question?		Appropriate Inappropriate Not sure
2. Is the study clear in what it seeks to do? For example: Is the purpose of the study discussed – aims/objectives/research question/s? Is there adequate/appropriate reference to the literature? Are underpinning values/assumptions/theory discussed?		Clear Unclear Mixed

Study design		
3. How defensible/rigorous is the research design/methodology? For example: Is the design appropriate to the research question? Is a rationale given for using a qualitative approach? Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? Is the selection of cases/sampling strategy theoretically justified?		Defensible Indefensible Not sure
Data collection		
4. How well was the data collection carried out? For example: Are the data collection methods clearly described? Were the appropriate data collected to address the research question? Was the data collection and record keeping systematic?		Appropriately Inappropriately Not sure/ inadequately report
Trustworthiness		
5. Is the role of the researcher clearly described? For example: Has the relationship between the researcher and the participants been adequately considered? Does the paper describe how the research was explained and presented to the participants?		Clearly describe Unclear Not described

6. Is the context clearly descred? For example: Are the characteristics of the participants and settings clearly defined? Were observations made in a sufficient variety of circumstances Was context bias considered		Clear Unclear Not sure
7. Were the methods reliable? For example: Was data collected by more than 1 method? Is there justification for triangulation, or for not triangulating? Do the methods investigate what tey claim to?		Reliable Unreliable Not sure
Analysis		
8. Is the data analysis sufficiently rigorous? For example: Is the procedure explicit – i.e., is it clear how the data was analysed to arrive at the results? How systematic is the analysis, is the procedure reliable/dependable? Is it clear how the themes and concepts were derived from the data?		Rigorous Not rigorous Not sure/ not reported
9. Is the data 'rich'? For example: How well are the contexts of the data described?		Rich Poor Not sure /not reported

Has the diversity of perspective and content been explored? How well has the detail and depth been demonstrated? Are responses compared and contrasted across groups/sites?		
10. Is the analysis reliable? For example: Did more than 1 researcher theme and code transcripts/data? If so, how were differences resolved? Did participants feed-back on the transcripts/data if possible and relevant? Were negative/discrepant results addressed or ignored?		Reliable Unreliable Not sure /not reported
11. Are the findings convincing? For example: Are the findings clearly presented? Are the findings internally coherent? Are extracts from the original data included? Are the data appropriately referenced? Is the reporting clear and coherent?		Convincing Not convincing Not sure
12. Are the findings relevant to the aims of the study?		Relevant Irrelevant Partially relevant

13. Conclusions For example: How clear are the links between data, interpretation and conclusions? Are the conclusions plausible and coherent? Have alternative explanations been explored and discounted? Does this enhance understanding of the research topic? Are the implications of the research clearly defined? Is there adequate discussion of any limitations encountered?		Adequate Inadequate Not sure
Ethics		
14. How clear and coherent is the reporting of ethics? For example: Have ethical issues been taken into consideration? Are they adequately discussed e.g., do they address consent and anonymity? Have the consequences of the research been considered i.e., raising expectations, changing behaviour? Was the study approved by an ethics committee?		Appropriate Inappropriate Not sure /not reported
Overall assessment		
As far as can be ascertained n the paper, how well was the dy conducted?		++ + –

Appendix F. Guideline for authors for the systematic literature review and empirical paper

CLINICAL PSYCHOLOGY REVIEW: GUIDE FOR AUTHORS

Submission checklist

You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details. Ensure that the following items are present: One author has been designated as the corresponding author with contact details:

- E-mail address
- Full postal address

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- All figures (include relevant captions)
- All tables (including titles, description, footnotes)
- Ensure all figure and table citations in the text match the files provided
- Indicate clearly if color should be used for any figures in print

Graphical Abstracts / Highlights files (where applicable)

Supplemental files (where applicable)

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Appendix G. Ethical and R&D approval

Appendix H. Information sheet

INFORMATION SHEET FOR PARTICIPANTS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

What are the experiences of non-affective psychosis for LGBQ+ individuals?

I would like to invite you to participate in a research project which forms part of my doctoral thesis. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take the time to read the following information carefully and discuss it with others if you wish. If you would like to take part or find out more information first before deciding, please email the researcher (contact information at the end of the document). I will reply to your email as soon as I can, and offer a telephone call to discuss the study and answer any questions you may have. You may then consent to be sent a consent form to sign before arranging to take part in this study.

What is the purpose of the study?

The purpose of the study is to explore the experiences of LGBQ+ individuals (lesbian, gay, bisexual or 'queer' i.e., a form of romantic or sexual attraction to at least the same sex), who also have unusual experiences or beliefs, such as hearing voices or schizophrenia/ psychosis. LGBQ+ individuals who agree to participate will help the psychological field in continuing to develop a better understanding of the diverse experience of mental health. Please note that being LGBQ+ is **not** considered a mental illness, nor a cause of mental health issues.

This study may contribute to an understanding of psychotic experiences for LGBQ+ individual. Research until now has documented unusual experiences within predominantly heterosexual populations, resulting in much of the information we know about what we call 'psychosis' consisting of only one group's perceptions or opinions. LGBQ+ individuals will support the psychological field to develop a better understanding of the diverse experience of mental health.

Why have I been invited to take part?

Included: You are being invited to participate in this study because you identify as LGBQ+ **and** you also have a diagnosis of 'Non-affective Psychosis'.

Excluded: Due to the interview questions relating to personal experiences and meaning, you must be fluent in English in order to take part. Only individuals over the age of 18 can take part.

Individuals unsure of, or who identify as a gender/ sex other than the one assigned at birth are unfortunately excluded due to the further unique life experiences this adds to a person's life.

I want to understand a broad set of experiences, so this study is not necessarily related to a diagnosis, but may relate to your experiences.

What will happen if I take part?

If you choose to take part in the study you will be asked to accept a phone call from the researcher so that you can ask any questions you may have and to potentially arrange a time and date that suits you for the interview, should you still have interest in taking part. This will take place via video-telephone online interview on a secure software. The interview will last approximately one hour and you will be given time to ask further questions and get comfortable before it begins.

The following section of the interview involves answering some questions that will prompt different discussions, but the overall flow of the interview will follow what you are comfortable talking about. This will encourage more of a conversation than a question-answer format.

You will be asked to provide your personal account of your life and experiences regarding your sexuality and unshared experiences or beliefs. This may include experiences of services, but this is not the focus. You can decline answering a question provided it does not involve information about potential risk to you or someone else. In relation to possible disclosures of risk, appropriate procedures will be carried out to ensure your safety. You will be informed of this decision during the interview should it arise and supported through the occurrence.

The interview will be recorded only after you have agreed to take part. If you do not consent to take part then the interview will not begin. Your data will be analysed for themes among yourself and other participants concerning significant events, ideas or feelings. They will be anonymised.

Audio (or video if not conducted face-to-face) recording for the interviews are necessary to gather everything that is said and how it is said in order for it to be accurately analysed. Your personal information (name and contact information) will also be collected in order for the research team to contact you if necessary and to send you a copy of the final report if you wish. Myself and my supervisors will be the only ones who have access to your personal details.

The researcher cannot guarantee confidentiality if information is disclosed indicating that the participant or other people are at current risk.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to. Choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact me (details at the end of the document) if you have any questions. You do not have to decide to take part now nor when you contact me about the study.

If you decide to take part, I will ask you to verbally consent during the initial telephone call. After that, you will be emailed or posted a consent form to sign. Once this form has been sent back to me the online-interview can be arranged. You can withdraw consent to take part at any point during the interview process or withdraw your data until the point of data analysis.

You may prefer to be informed of the cut-off date after which you can no longer withdraw from the study. In order for the research to remain reliable, you will not be able to see or alter the interview data you provide following written consent.

What are the possible risks of taking part?

I, the researcher, will call you after your email to me discuss potential participation, any questions you may have, consent to take part, and arranging the interview date and time. The interview will be arranged at a time best suited to you.

The interviews are not intended to cause participants' distress; however, the interview may become distressing due to the sensitive nature of some questions or your experiences. Should you experience any distress, myself, or your care coordinator (if you have one) could be contacted to offer support should you want it. If you would like information about relevant services of support you will be offered a 'sources of support' sheet to take away as well.

What are the possible benefits of taking part?

There are no immediate personal benefits to participants, though you may find it helpful to discuss your life experiences and their meaning. This interview is an opportunity to share your experiences and what it means to you regarding your sexuality and mental health; to have your story heard by a professional audience. Future health-care may be better tailored to more diverse populations and LGBQ+ individuals as well.

Data handling and confidentiality

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR).

- We will need to use anonymised information gathered from you for this project. This information will involve anything said during the interview (there will be a clear beginning and end). The researcher and two supervisors will be the only person to have access to identifiable information and will only be used to contact you and then destroyed post-study. All other material will be anonymised. The information provided will be used to do the research or to check your records to make sure that the research is being done to a specific standard. Anyone who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number, allowing complete anonymity.

- The final report will include direct quotes from participants; which will be anonymised. The interview recording, transcript, and report will be allocated a pseudonym, which means data will not be identifiable. No quotes will be used that could identify participants, for example: location or specific events.

- Your personal information will be kept separate from research data and in a secure location (locked cabinets in the research supervisor's office), accessible only to the researcher and supervisors. Once the interview begins, no information disclosed during it is confidential as it may be used in the final report. Additionally, should there be concern of risk to yourself or others, the researcher is obliged to inform the service immediately and you will be notified of this.

- The research data collected will be retained for 10 years and is still anonymised throughout this period. Personal data will be retained until the end of the study and then destroyed.

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a 'task in the public interest'. You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you. Information about how the University of Hull processes your data can be found at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection.aspx

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What if I change my mind about taking part?

You are free to withdraw until the point of data analysis and without having to give a reason. Withdrawing from the study will not affect you in any way or the care you are receiving.

When data analysis begins, the withdrawal of your data will no longer be possible as each participant's data is crucial to gathering themes. If you choose to withdraw from the study before analysis begins, your data will not be kept.

What will happen to the results of the study?

The results of the study will be summarised in the final report. The results will be used in my thesis for my Doctorate in Clinical Psychology with the aim of publishing to the University 'Hydra' database and academic journals and conferences. Participants can obtain a copy of the published research by requesting a copy be sent to you via the personal information provided. The results will be publicly available. Anonymised quotes from the interview will be used, which will not identify you in any way.

Who has reviewed this study?

Research studies are reviewed by a Research Ethics Committee to protect your interests. This study has been reviewed and been given a favourable opinion by the Faculty of Health Sciences Ethics Committee, University of Hull.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:

Emily Magowan (Researcher): 07977022698; e.magowan-2018@hull.ac.uk

University of Hull contact address: Aire building, University of Hull, Cottingham Rd, Hull, HU67RX

What if I have further questions, or if something goes wrong?

If you wish to make a complaint about the conduct of the study, please contact the University of Hull using the details below for further advice and information:

Email address of my supervisor(s):	Dr Chris Sanderson:	c.sanderson@nhs.net
	Dr Anjula Gupta:	anjula.gupta@nhs.net

Thank you for reading this information sheet and for considering taking part in this research.

Appendix I. Consent forms

Version number and date: V6 15.01.21

IRAS ID Enter IRAS Project ID

CONSENT FORM

Title of study: What are the experiences of non-affective psychosis for LGBQ+ individuals?

Name of Researcher: Emily Magowan

Please **put your initials** in all the boxes to fully consent to taking part in the study:

1. I confirm that I have read the information sheet dated 15.01.21 V6 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw until data analysis begins without giving any reason. I understand that once the researcher has started analysing the data, I cannot withdraw my anonymised data. I understand that the data I have provided up to the point of withdrawal will be retained. I understand that if my data is withdrawn before analysis this means all data about me (personal information and research data) will be destroyed, as the information will not be used. ☐

3. I understand that the research interview will be audio recorded and that my anonymised quotes may be used in research reports and conference presentations. I understand that there will be one copy for the participant to keep and one copy for the researcher to keep in a secure location. ☐

4. I give permission for the collection and use of my data to answer the research question in this study ☐

5. I agree to take part in the above study.

____________	____________	____________
Name of Participant	Date	Signature
____________	____________	____________
Name of Person taking consent	Date	Signature

Appendix J. Interview questions

1. The experience of both labels

I. How would you identify yourself?

II. Can you tell me what your sexuality means to you?

III. How do you understand the unusual experiences you have?

IV. What is your experience of both these areas of your life? How does it feel?

V. Do you find that your sexuality affects your unusual experiences in any way – or vice versa? If so, can you tell me more about that experience.

How has that affected you, others, feelings, thoughts, actions?

2. How they make sense of it

I. How did you come to identify with your sexuality?

II. Has this experience or label changed? If so, why?

III. How did your unusual experiences start and develop?

IV. How did you originally feel about your sexuality?

V. How did you originally feel about your unusual experiences?

VI. What could have influenced this?

VII. How do you feel about your sexuality now?

VIII. How do you feel about your unusual experiences now?

IX. How do you understand your experience of your sexuality? How do you understand or make sense of your unusual experiences?

Appendix K. Social Media Advertisements

Would you like to take part in my doctoral thesis study? The purpose is to explore the unusual experiences (for example: psychosis, schizophrenia, or hearing voices) of individuals who have romantic and/ or sexual attraction to the same biological sex (for example: gay, lesbian, queer, bisexual). Your participation will include several opportunities to ask questions and explore whether to take part, and then after written consent, complete a 60 minutes interview.

The study may contribute to a greater understanding of psychotic experiences for LGBQ+ individuals. Previous research has focused mainly on heterosexual populations in trying to understand psychotic experiences, which may not be the same as non-heterosexual individuals. The study therefore aims to publish people's experiences that will, in future, help to inform a more accepting and person-centred approach to health-care and understanding of unusual experiences.

Please note gender identity is considered a different experience than sexuality and is unfortunately excluded. Additionally, being LGBTQ+ is **NOT** considered related to mental illness or a cause of mental health issues.

Attached is a participant information sheet, which has more information on and researcher contact details. Please consider taking part in my study.

Attached PIS below

Appendix L. Sources of Support Sheet

Sources of support and information regarding your mental health or your identity as LGBQ+

Stonewall:
A national charity for providing LGBTQ+ related, up-to-date information, advice and support.
https://www.stonewall.org.uk/help-and-advice
Freephone, 9:30-4:30 Mon-Fri: 0800 050 2020

MESMAC charity in Hull, York & Leeds:

- Free, rapid and confidential HIV testing
- Condoms and lubricant
- Consultancy
- Counselling
- Information and resources
- Meeting rooms and training space
- Outreach to the commercial gay scene, cruising areas and public toilets
- Support for individuals and community groups
- Training

https://www.mesmac.co.uk/about-us/what-we-do
Telephone: 01482 291190

Mental Health Response Service – Hull and East Riding

The trust is the main provider of specialist mental health services. Individuals in crisis can access their services 24/7 through the Rapid Response Service on:

Telephone: 01482 301701

The Samaritans
Call free on: 116 123
Email on: jo@samaritans.org (response time 24hrs)
Write a letter: Chris
Freepost RSRB-KKBY-CY-JK
PO Box 9090
STIRLING FK8 2SA

You can seek support from the Care Co-ordinator from any potential mental health service you are registered with as well.

You can also seek advice from your GP if preferred.

Appendix M. List of tables and figures

Literature Review

Table 3. Inclusion and Exclusion criteria for search strategy

Inclusion Criteria	Rationale
Psychosis, schizophrenia,	Those diagnosed with psychosis or schizophrenia were the focus of this review.
Romantic, sexual relationships	This review focussed on the experience of intimate and romantic relationships
Peer reviewed only	Only viewing primary sources to avoid secondary or unreviewed data. This allows depth of data and provides context of the authors conducting the study
Between 2000-2020	Studies from last 20 years reflect current research and experiences
Adults only 18+	Interest in adult experiences of forming and maintaining relationships
Qualitative only	Richer account of experiences
Written in English	To be readable; To avoid scripts being misconstrued

Exclusion Criteria	Rationale
No conferences or secondary data	To avoid data not relevant to the research question as it focuses primarily on accounts of lived personal experiences
None explicitly about trauma	Relationships experiences as primary focus
No quantitative only studies	The research question requires depth of lived experiences That would not be explored in quantitative research

Figure 2. PRISMA 2009. Search strategy process

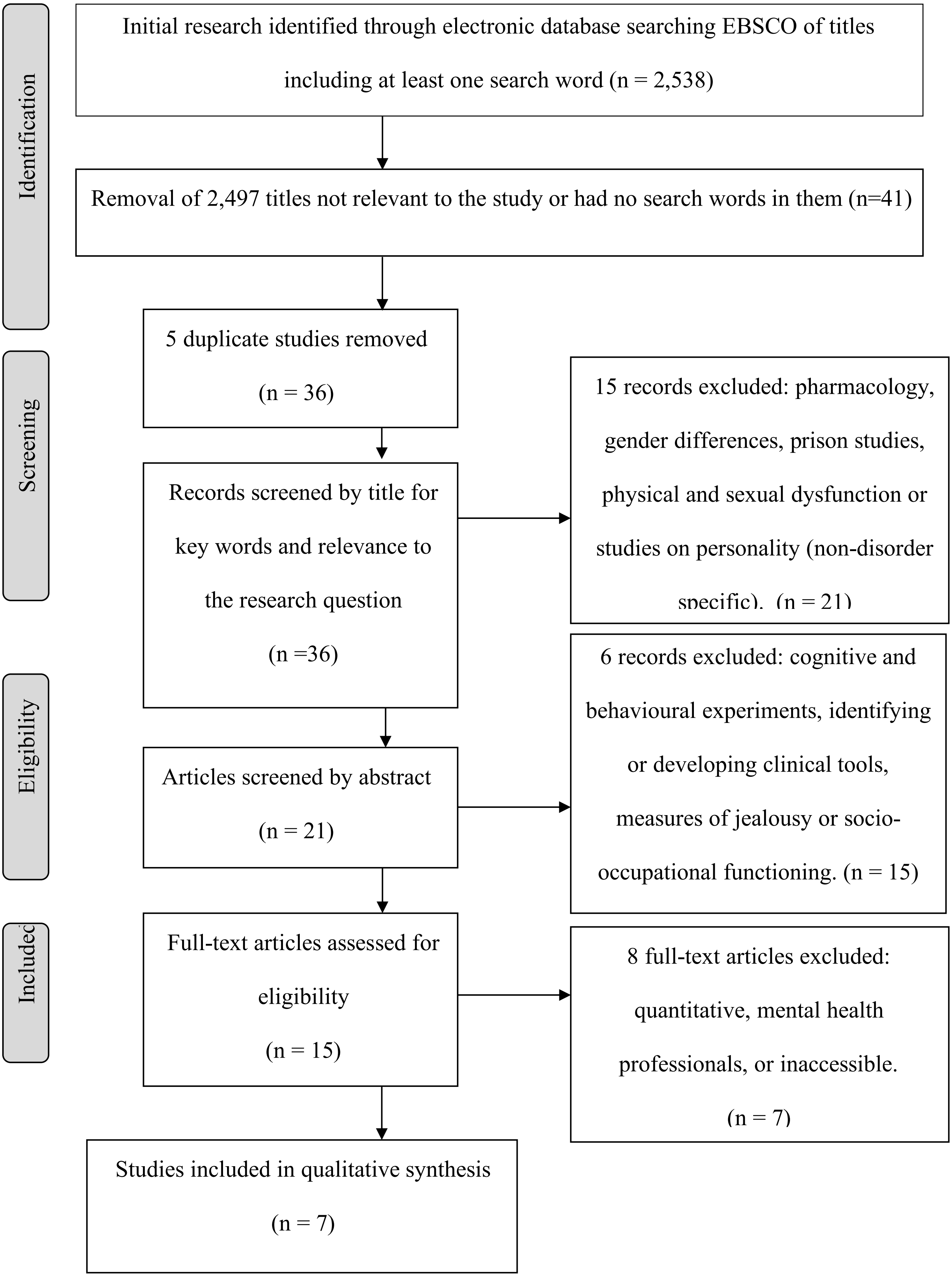
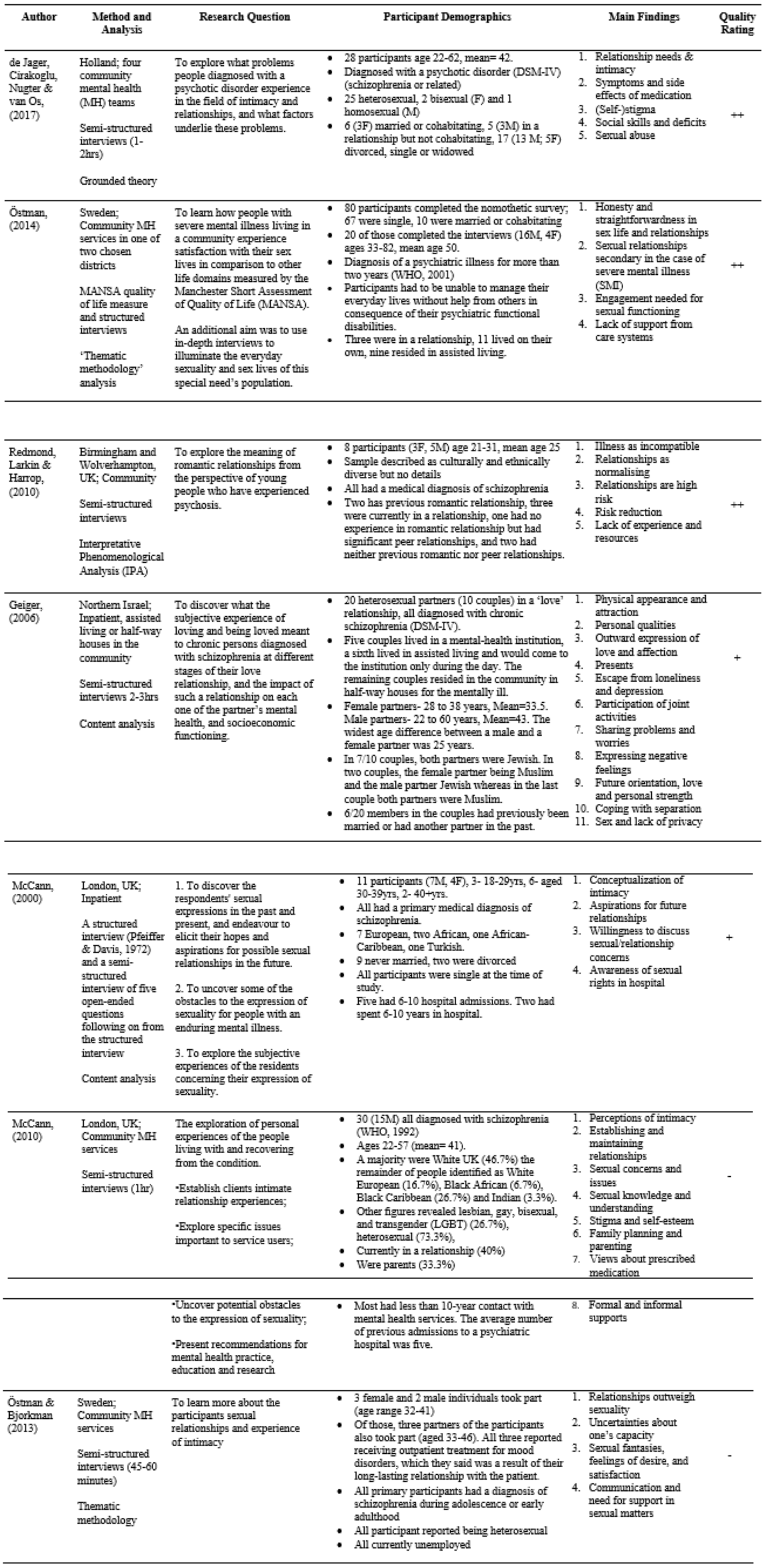


Figure 3. PRISMA 2009. Search strategy process

Table 2. Summary of Studies and Quality Ranking



Author	Method and Analysis	Research Question	Participant Demographics	Main Findings	Quality Rating
de Jager, Cirakoglu, Nugter & van Os, (2017)	Holland; four community mental health (MH) teams Semi-structured interviews (1-2hrs) Grounded theory	To explore what problems people diagnosed with a psychotic disorder experience in the field of intimacy and relationships, and what factors underlie these problems.	• 28 participants age 22-62, mean= 42. • Diagnosed with a psychotic disorder (DSM-IV) (schizophrenia or related) • 25 heterosexual, 2 bisexual (F) and 1 homosexual (M) • 6 (3F) married or cohabitating, 5 (3M) in a relationship but not cohabitating, 17 (13 M; 5F) divorced, single or widowed	1. Relationship needs & intimacy 2. Symptoms and side effects of medication 3. (Self-)stigma 4. Social skills and deficits 5. Sexual abuse	++
Östman, (2014)	Sweden; Community MH services in one of two chosen districts MANSA quality of life measure and structured interviews 'Thematic methodology' analysis	To learn how people with severe mental illness living in a community experience satisfaction with their sex lives in comparison to other life domains measured by the Manchester Short Assessment of Quality of Life (MANSA). An additional aim was to use in-depth interviews to illuminate the everyday sexuality and sex lives of this special need's population.	• 80 participants completed the nomothetic survey; 67 were single, 10 were married or cohabitating • 20 of those completed the interviews (16M, 4F) ages 33-82, mean age 50. • Diagnosis of a psychiatric illness for more than two years (WHO, 2001) • Participants had to be unable to manage their everyday lives without help from others in consequence of their psychiatric functional disabilities. • Three were in a relationship, 11 lived on their own, nine resided in assisted living.	1. Honesty and straightforwardness in sex life and relationships 2. Sexual relationships secondary in the case of severe mental illness (SMI) 3. Engagement needed for sexual functioning 4. Lack of support from care systems	++
Redmond, Larkin & Harrop, (2010)	Birmingham and Wolverhampton, UK; Community Semi-structured interviews Interpretative Phenomenological Analysis (IPA)	To explore the meaning of romantic relationships from the perspective of young people who have experienced psychosis.	• 8 participants (3F, 5M) age 21-31, mean age 25 • Sample described as culturally and ethnically diverse but no details • All had a medical diagnosis of schizophrenia • Two has previous romantic relationship, three were currently in a relationship, one had no experience in romantic relationship but had significant peer relationships, and two had neither previous romantic nor peer relationships.	1. Illness as incompatible 2. Relationships as normalising 3. Relationships are high risk 4. Risk reduction 5. Lack of experience and resources	++
Geiger, (2006)	Northern Israel; Inpatient, assisted living or half-way houses in the community Semi-structured interviews 2-3hrs Content analysis	To discover what the subjective experience of loving and being loved meant to chronic persons diagnosed with schizophrenia at different stages of their love relationship, and the impact of such a relationship on each one of the partner's mental health, and socioeconomic functioning.	• 20 heterosexual partners (10 couples) in a 'love' relationship, all diagnosed with chronic schizophrenia (DSM-IV). • Five couples lived in a mental-health institution, a sixth lived in assisted living and would come to the institution only during the day. The remaining couples resided in the community in half-way houses for the mentally ill. • Female partners- 28 to 38 years, Mean=33.5. Male partners- 22 to 60 years, Mean=43. The widest age difference between a male and a female partner was 25 years. • In 7/10 couples, both partners were Jewish. In two couples, the female partner being Muslim and the male partner Jewish whereas in the last couple both partners were Muslim. • 6/20 members in the couples had previously been married or had another partner in the past.	1. Physical appearance and attraction 2. Personal qualities 3. Outward expression of love and affection 4. Presents 5. Escape from loneliness and depression 6. Participation of joint activities 7. Sharing problems and worries 8. Expressing negative feelings 9. Future orientation, love and personal strength 10. Coping with separation 11. Sex and lack of privacy	+
McCann, (2000)	London, UK; Inpatient A structured interview (Pfeiffer & Davis, 1972) and a semi-structured interview of five open-ended questions following on from the structured interview Content analysis	1. To discover the respondents' sexual expressions in the past and present, and endeavour to elicit their hopes and aspirations for possible sexual relationships in the future. 2. To uncover some of the obstacles to the expression of sexuality for people with an enduring mental illness. 3. To explore the subjective experiences of the residents concerning their expression of sexuality.	• 11 participants (7M, 4F), 3- 18-29yrs, 6- aged 30-39yrs, 2- 40+yrs. • All had a primary medical diagnosis of schizophrenia. • 7 European, two African, one African-Caribbean, one Turkish. • 9 never married, two were divorced • All participants were single at the time of study. • Five had 6-10 hospital admissions. Two had spent 6-10 years in hospital.	1. Conceptualization of intimacy 2. Aspirations for future relationships 3. Willingness to discuss sexual/relationship concerns 4. Awareness of sexual rights in hospital	+
McCann, (2010)	London, UK; Community MH services Semi-structured interviews (1hr)	The exploration of personal experiences of the people living with and recovering from the condition. •Establish clients intimate relationship experiences; •Explore specific issues important to service users; •Uncover potential obstacles to the expression of sexuality; •Present recommendations for mental health practice, education and research	• 30 (15M) all diagnosed with schizophrenia (WHO, 1992) • Ages 22-57 (mean= 41). • A majority were White UK (46.7%) the remainder of people identified as White European (16.7%), Black African (6.7%), Black Caribbean (26.7%) and Indian (3.3%). • Other figures revealed lesbian, gay, bisexual, and transgender (LGBT) (26.7%), heterosexual (73.3%), • Currently in a relationship (40%) • Were parents (33.3%) • Most had less than 10-year contact with mental health services. The average number of previous admissions to a psychiatric hospital was five.	1. Perceptions of intimacy 2. Establishing and maintaining relationships 3. Sexual concerns and issues 4. Sexual knowledge and understanding 5. Stigma and self-esteem 6. Family planning and parenting 7. Views about prescribed medication 8. Formal and informal supports	-
Östman & Bjorkman (2013)	Sweden; Community MH services Semi-structured interviews (45-60 minutes) Thematic methodology	To learn more about the participants sexual relationships and experience of intimacy	• 3 female and 2 male individuals took part (age range 32-41) • Of those, three partners of the participants also took part (aged 33-46). All three reported receiving outpatient treatment for mood disorders, which they said was a result of their long-lasting relationship with the patient. • All primary participants had a diagnosis of schizophrenia during adolescence or early adulthood • All participant reported being heterosexual • All currently unemployed	1. Relationships outweigh sexuality 2. Uncertainties about one's capacity 3. Sexual fantasies, feelings of desire, and satisfaction 4. Communication and need for support in sexual matters	-

Table 3. Summary of Quality Ratings

Article	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**Total**
De Jager et al 2017	2	2	2	2	0	2	2	2	2	3	2	2	2	2	++
Östman 2014	2	2	2	2	0	2	2	2	2	3	2	2	2	2	++
Redmond et al 2010	2	2	2	2	2	2	2	2	2	2	2	2	2	2	++
Geiger et al 2006	2	2	2	2	0	2	2	2	2	2	2	2	2	0	+
McCann 2000	2	2	2	2	2	2	1	0	1	2	2	2	2	2	+
McCann 2010	2	2	2	2	0	2	1	0	0	1	0	2	2	2	-
Östman & Björkman 2013	2	0	0	2	0	0	1	2	1	0	1	2	2	0	-

Table 4. Themes of the literature

Overarching Theme 1: Forming Relationships		**Overarching Theme 2: Maintaining Relationships**	
I.	Experiences and Impact of Trauma	I.	Building and Maintaining Trust Between Partners
I.	Perceptions of Social Ability	II.	Disclosure and the Experiences of Stigma
II.	The Effects of Mental Health and Medication on Intimacy	III.	Sexual Activity and Communication
III.	Partners' Preferences Influenced the Desire for Relationships	IV.	Planning for the Future
IV.	Social Network Norms		

Empirical Paper

Table 1. List of Inclusion and Exclusion Criteria

Inclusion	Exclusion
• Fluent in English	• People not fluent in English
• Non-heterosexual (lesbian, gay, queer, bisexual, pansexual and others)	• Individuals identifying as heterosexual or otherwise only attracted to the opposite sex
• Over 18 years old	• Under 18 years or learning disability
• Experience of psychosis (e.g., unusual experiences or beliefs	• No experience of psychosis or predominant co-occurring experiences e.g., PTSD, extreme mood swings etc
• UK based	• Transgender individuals

Table 2. Participant Demographics

Pseudonym	Age	Gender Identit	Sexuality	Mental health experiences	Employment Status
Cassie	29	Cis-gender (female)	Lesbian	Experiences of psychosis	Long term sick from work
Rachel	24	Cis-gender	Bisexual	Anxiety, stress disorder, depression, seeking a diagnosis for OCD and experiences of hallucinations	Employed

Alex	19	Non-binary (neither gender)	Pansexual/ bisexual	Depression, anxiety, PTSD, eating issues, first episode psychosis, ADHD	Student
Willow	25	Non-binary	Queer	Non-specific psychosis PTSD, OCD, psychotic depression	Employed
Riley	25	Non-binary	Bisexual	BPD diagnosis and depression, hallucinations	Sick leave
Eryn	33	Cis-gender	Pansexual	Dissociative identity disorder, diagnosis of psychosis	Self-employed

Table 4. Listed IPA Themes

Superordinate 1. The Experiences and Influence of Trauma	Superordinate 2. Exploring the Existence and Understanding of Unusual Experiences
I. "… Just having mentally ill parents- it just fucks you in your own way" II. "I was kind of outed against my will to a lot of people at school…" III. "I don't know how to say it without upsetting you- but like assaults and shit"	I. "I don't know if I'm allowed to say the word crazy…" II. "…If you don't fit into your box then- you don't get treated for the right thing"
Superordinate 3. The Development of Self-Identity	Superordinate 4. Relationships with Others
I. "I'm just in a better place as well- whether that's because it	I. "… And I remember sitting down and talking to my dad about it- and him saying— you love who you love"

got better or whether that’s a by-product I don’t know” II. “We all experience it as queer people- but it probably didn’t help the psychosis- I didn’t even think of the connection until just now”	II. “It caused- a lot of –problems- and like really ruined the relationship quite a bit but then once I started getting like the vocabulary to describe- what was happened and how I was feeling- I could vocalise it to them? And then- they knew what was going on” III. “I’ve gravitated towards erm like- found it easier to make friends with- have been gay?”