

Thesis Title

**An Explorative Study of Processes of  
Reflective Function in Adaptation to  
Psychosis in Young Adults**

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## DECLARATION OF AUTHORSHIP

- I hereby declare that I am the sole author of this thesis and that the work contained herein is my own.
- This thesis, or any part of it, has not been submitted for any other degree or professional qualification
- This thesis is submitted in part fulfillment of the degree of Doctorate in Clinical Psychology at the University of Edinburgh.

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**Date**

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<b>CONTENTS</b>	<b>Page</b>
<b>1. Abstract</b>	<b>5</b>
<b>2. Introduction</b>	<b>6</b>
2.1. Adaptation to psychosis in adolescence	
2.2. Early development of reflective function	
2.3. Early emotional development and adaptation to psychosis in young people	
2.4. Purpose of study	
2.5. Research questions	
<b>3. Method</b>	<b>20</b>
3.1. Design	
3.2. Epistemological considerations	
3.3. Ensuring quality and rigour	
3.4. Researcher's position	
3.5. Research context	
3.6. Participants	
3.7. Materials	
3.8. Procedure	
<b>4. Results</b>	<b>34</b>
4.1. Process of data analysis	
4.2. Descriptive account of inductive qualitative data	
4.2.1. <i>Experiencing mental health difficulties</i>	
4.2.2. <i>Developing adolescent self</i>	
4.3. Integration of inductive and deductive qualitative components	
4.4. Descriptive account of quantitative data	
4.5. Integration of qualitative and quantitative data	
<b>5. Discussion</b>	<b>101</b>
5.1. Presentation and validation of integrated model	
5.2. Evaluation of study	
5.3. Implications of findings	
5.4. Future research	
<b>6. Conclusion</b>	<b>113</b>
<b>7. References</b>	<b>115</b>
<b>8. Appendices</b>	<b>124</b>
8.1. Letter of approval from NHS Ethics Committee	
8.2. Letter of approval form NHS Research & Development Department	
8.3. Participant Information Sheet	
8.4. Sample of coded interview transcript	

## 1. ABSTRACT

**Background:** Recovery from adolescent-psychosis critically depends on successful emotional and interpersonal adaptation. However, individuals commonly present with indicators of impaired early emotional adaptation. Childhood trauma and dismissive attachment styles are related to poorer recovery coping styles, difficult engagement and to reduced disclosure of distress. Psychological capacities for affect regulation and reflective function, which develop in the context of early attachment relationships, may be critical in influencing adaptation to psychosis.

**Objectives:** A primarily qualitative mixed-method design was employed to pursue two research questions: 1) How do young people adapt to psychosis? 2) How do processes of reflective function influence the adaptation process?

**Methods:** Two interviews were conducted with each of the 8 young people (aged 18 to 21) who had experienced clinically significant psychosis. To rate the level of reflective function with regard to attachment states of mind (attachment RF) the Adult Attachment Interview was administered. Grounded theory methodology was used to investigate young people's experience of adaptation to psychosis and the level of reflective function in their accounts (adaptation RF).

**Results & Discussion:** Two main themes relating to adaptation and adolescent individuation emerged. Moderate attachment and adaptation reflective function were linked to primarily positive adjustment and successful individuation following psychosis. Impaired attachment and adaptation reflective function were associated with unresolved adaptation and failed individuation post-psychosis.

**Conclusion:** Level of reflective function appeared to moderate adaptation and individuation processes post-psychosis and should be considered in the delivery of psychological therapies.

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## **2. INTRODUCTION**

### **2.1 ADAPTATION TO PSYCHOSIS IN ADOLESCENCE**

#### **2.1.1 Impact of psychosis in adolescence**

Schizophrenia affects between 2 to 7 people in every 1000 in the UK (McGuire et al., 1991). Although schizophrenia can occur throughout the lifespan, the vast majority of individuals (50-80%) develop schizophrenia during late adolescence between the ages of 15 to 25 (Sartorius et al., 1986). Onset peaks between the age of 15 to 19 in males and 20 to 24 in females (Häfner et al., 1993). Schizophrenia-spectrum disorders are typically preceded by a prodromal period of 1 to 2 years, during which mental health difficulties gradually develop until they culminate in psychosis. The most common prodromal signs that people report retrospectively are dysregulated affect, altered perception and social withdrawal (Norman & Malla, 1995).

Doubts surrounding the validity of the diagnosis of schizophrenia (Boyle, 1990) coupled with recent advances in the understandings of psychotic phenomena as lying on a continuum with normal experiences (BPS, 2000) and the lack of diagnostic stability in the early phase of illness (Ram et al., 1992) have led to the development of early intervention services for people with psychosis-spectrum disorders or psychotic complaints (Bentall, 2006). These complaints commonly involve the distressing experience of auditory or visual hallucinations. Strongly held unusual beliefs of a persecutory or grandiose nature may cause significant emotional distress and may lead people to engage in bizarre behaviours and to show disorganized thinking.

Onset of psychosis during adolescence usually causes devastating disruption to young people's lives by interfering with education, occupational functioning, family and peer relationships (Addington et al., 2002). The experience of psychosis and its treatment can lead to traumatic reactions (Birchwood, 2003). Unlike adults who experience psychosis, adolescents face the double challenge of dealing with a mental illness whilst negotiating critical developmental tasks and transitions. The impact of psychosis renders

tasks of establishing a positive identity, developing relationships and autonomy more difficult. Although one could argue that all young people with severe mental health problems face similar challenges in their adaptation, singling out psychosis as one of the potentially most disabling and stigmatizing difficulties may give us critical insights that may apply across other problems.

### **2.1.2 Predictors of outcome of psychosis**

Although much research has focused on identifying the causes of psychosis, little is known about what predicts outcome. Longitudinal studies have highlighted the heterogeneity in outcome and the difficulty with identifying informative predictors. Following a single episode of psychosis, one-third to 50% of individuals fully recover. Another third endures a remitting-relapsing course whilst between 15 to 30% suffer a chronic course of psychotic illness (Ciompi et al., 1980; Jablensky et al., 1992). Observations of late-phase recovery after 11 or 15 years support the idea that a deteriorating course is rare and that disability plateaus during the early phase (Birchwood, 1997). Longitudinal studies show that outcome following the critical period 3 to 5 years post-onset strongly predicts outcome 20 years later (Carpenter & Strauss, 1991; Harrison et al., 2001). Traditional outcome research has been best at predicting poor outcome by focusing on a number of demographic and illness-related variables. Poorer premorbid adjustment (Jablensky et al., 1992; Amminger et al., 1997); male gender (Jablensky et al., 1992); lower level of education (Geddes et al. 1994); unemployment; being single (Jablensky et al., 1992); family history of psychotic or affective illness (Murray & van Os, 1998); insidious onset (Murray & van Os, 1998); earlier age at onset (Ram et al., 1992); shorter duration of untreated psychosis (Drake et al., 2000; Norman & Malla, 2001); increased negative symptoms and poorer neurocognitive functioning (Milev et al., 2005) have repeatedly been linked to worse outcome.

No matter how robust any such statistical associations may be, some merely make tautological statements and thus fail to contribute to the understanding of psychological processes underlying emotional adaptation to psychosis. For example, following the contention of the hypothesized neurotoxic effects of

prolonged duration of untreated psychosis on poor outcome, researchers have renewed investigative efforts into the psychosocial factors involved in delayed help-seeking (Norman et al., 2005).

### **2.1.3 Psychological adaptation to psychosis**

Little systematic knowledge has been accumulated on what influences emotional recovery. A limited number of psychological concepts have been explored. Findings on the relationships between insight, recovery style, emotional difficulties, secondary disability and outcome are summarized.

The phenomenon of insight into psychosis is currently considered to entail five dimensions (Mintz et al., 2003). The extent to which an individual recognizes they have a mental illness, attributes symptoms to mental illness, complies with treatment, is aware of the social consequences of illness and is able to refer to symptoms as abnormal defines the level of insight. Poorer insight is related to increased symptoms. Alongside avolition and poor social integration, poorer insight predicted longer duration of untreated psychosis and worse short-term outcome in a first-episode sample (Drake et al., 2000). Better insight is associated with better cognitive functioning and higher levels of post-psychotic depression (Iqbal et al., 2000). Competing with a neuropsychological hypothesis is the speculation that lack of insight represents a psychological defense against the negative consequences of psychosis and preserves self-esteem (Tait et al., 2003). The definition of insight as a static state of appraisal neglects the underlying processes. Inconsistencies in the definition, assessment and explanation of this concept suggest that it currently lacks predictive utility.

Recovery style distinguishes between individuals who integrate psychosis into their wider life and assimilate it into their self-identity and those who seal over psychosis by isolating it from the rest of their lives and suppressing its memory (McGlashan, 1987). An integrating recovery style has been linked to better clinical outcome at 15 years (McGlashan et al., 1987) and at 1 year in first-episode cases (Thompson et al., 2003). Despite being originally

conceived as a stable personality trait, longitudinal studies in first-episode psychosis have demonstrated the concepts' malleability over time (Thompson et al., 2003; Tait et al., 2003). In their sample of 62 recovering patients, Tait and colleagues (2003) found a tendency to move from an integrative to a sealing over style over a period of six months. Sealing over was unrelated to symptoms and insight but predictive of poor subsequent engagement. The latter findings suggest that sealing over only begins following symptomatic recovery and may serve to avoid the confrontation with emotionally painful and egodystonic experiences related to psychosis.

Birchwood (2003) highlighted the paradox that people diagnosed with a non-affective psychotic illness in fact experience a high degree of emotional disturbance including depression, anxiety, trauma-related symptoms, suicidal ideation, substance abuse and general distress. Post-psychotic depression and social anxiety are associated with humiliation, shame, entrapment, loss and negative self-evaluation (Iqbal et al., 2000; Gumley et al., 2004; Karatzias et al., 2007). Entrapment, in particular, is thought to negatively affect recovery as the individual appraises their present and future situation as hopeless and outside of their control. Other secondary disabilities resulting from self-stigma hinder recovery by undermining a person's self-esteem, social status and social rehabilitation (Phelan et al., 2000). Gumley & Schwannauer (2006) therefore argued that psychosis can be viewed as stressful life event, which triggers depression or anxiety as the person becomes aware of its negative interpersonal and social consequences. Karatzias and colleagues (2007) supported this claim by demonstrating that negative beliefs about psychotic experiences and low self-esteem maintained anxiety and depression in psychosis.

In summary, most previous emotional adaptation research suffered from a narrow focus on controversial concepts such as insight and compliance, which prioritized a clinician over a patient perspective. Clinically, it would be more helpful to identify the processes that bring about and maintain negative appraisals such as entrapment, loss, humiliation, shame and avoidant strategies such as 'sealing over'.

#### **2.1.4 Recovery from psychosis**

Traditionally, quantitative research has focused on outcome operationalised in terms of reduction in symptoms, hospitalizations or improvement in functioning (Lehman & Steinwachs, 1998). Outcome studies have been criticized not only for failing to make meaningful predictions about outcome but also for bypassing personal meaning and subjective experience of people experiencing psychosis. The growing recognition that partial or full recovery from psychosis is in fact possible has given rise to new treatment models. Recovery is defined as a complex, non-linear and personal process with potentially heterogeneous and idiosyncratically defined outcomes. It is therefore best studied through in-depth explorations of people's lived experience (Dorrer, 2006). An increasing number of qualitative studies into recovery from severe mental illness have been published over the last decade. Due to the paucity of studies exploring young people's experience of recovery, relevant studies on both adult and adolescent populations were reviewed.

Common themes and processes of what promotes psychological recovery have emerged from this research. Based on a review of 36 original articles and review papers, Andresen and colleagues (2003) defined the following four tasks of recovery: (1) finding hope, (2) re-establishing identity, (3) finding meaning in life, and (4) taking responsibility for recovery. Research undertaken since this review has echoed the same themes. Recovering self and identity, re-engaging socially, building meaningful relationships, finding the right services and treatments and developing coping strategies promoted recovery in a sample of 67 Scottish adults with severe mental illness (Brown & Kandirikirira, 2006; Brown & Kandirikirira, 2007). Paternalistic and coercive treatment systems, indifferent professionals, medication side effects and psychiatric symptoms are reported to impede recovery (Jacobson & Greenley, 2001; Mancini et al., 2005). The reconstruction of a competent and enduring sense of self has been found to be a critical aspect of recovery (Deegan, 1996; Davidson & Strauss, 1992). Davidson & Strauss (1992) argued that mental illness often leads to a loss of self. Their research showed

that self-reflection and action helped participants redefine their sense of self anew with mental illness as a non-dominant part of it.

Three pieces of qualitative research are reviewed in more detail as they are the only to propose stage models of the recovery process.

The only longitudinal qualitative study by Spaniol and colleagues (2002) assessed 12 individuals with schizophrenia-spectrum disorders at 4 to 8-month intervals over a 4-year period. They distinguished between four phases in the recovery process. In the first phase of recovery, the individual feels 'overwhelmed by disability' and confused. The person lacks self-confidence and is isolated from others. The second stage of 'struggling with disability' is characterized by finding an explanation for illness, learning to cope, fear of failure and building strengths. The third stage of 'living with disability' involves the individual managing the disability, developing a stronger sense of self, meaningful roles and generally living a satisfying life within the limitations of disability. The final fourth stage of 'living beyond disability' is reached when the individual is able to lead a meaningful life unlimited by disability. Participants showed differential course and speed of developmental progression through those stages. Some moved along more rapidly whilst others tended to recover at a slow, steady pace with longer plateau periods of consolidation. Others fluctuated or even declined. Some participants had remained at the first stage of 'being overwhelmed by disability' for decades. Barriers to recovery were substance abuse, being of non-Caucasian race, poverty and an earlier age at onset. Participants explained that having past experiences of leading an 'adult life' facilitated hope, and self-efficacy whereas individuals with an onset in late adolescence had no such experiences to fall back on.

Based on their review of qualitative recovery research including Spaniol's study, Andresen and colleagues (2003) proposed a five-stage model of psychological recovery from schizophrenia. The initial stage of 'Moratorium' is marked by denial, confusion, hopelessness, identity confusion and self-protective withdrawal. During the 'Awareness' stage people have a first glimmer of hope that recovery of self beyond mental illness is possible. The

actual recovery process is initiated in the 'Preparation' phase. Strengths and weaknesses of the intact self are assessed. Individuals seek information about mental illness, services, skills and how they can reconnect socially. The 'Building' phase involves taking risks in working towards personally valued goals, developing resiliency and taking responsibility for managing illness and life. 'Growth' is marked by being confident in one's ability to stay well and to be resilient in the face of setbacks.

Barnett & Lapsley (2006) interviewed 40 young adults between the ages of 18 and 29 with severe mental health problems about their recovery. The thematic analysis of accounts revealed three categories of recovery. Most young people with psychosis fitted into the category of 'surviving day by day'. They struggled to make sense of their experience, were hopeless, socially isolated and unable to live independently. Their lives appeared to have stagnated because they lacked the appropriate support and resources to pursue future plans. Instead they lived life day by day. Despite a high prevalence of trauma histories, medication was the primary treatment. Half the participants fell into an intermediate 'moving forward' group, which was characterized by gradual slow progress with occasional setbacks. Most had taken some steps towards realizing goals but remained isolated. Some had begun making sense of their experiences. There was an emerging sense of hope and of being able to control illness with medication. Few young people with psychosis belonged to the category of 'living well', which was associated with positive adjustment. Understanding and accepting mental health difficulties allowed young people to reengage with a wider social network and to take steps towards achieving their goals beyond mental illness. A major methodological criticism of their study is that the use of a predetermined interview schedule introduced a priori ideas, which may have biased results.

All three studies highlight the developmental aspects involved in the recovery process. However, they fail to describe the characteristics of those on the extremes of the continuum. The question arises what psychological factors differentiate the group of individuals who remain at the 'overwhelmed by disability' (Spaniol et al., 2002), moratorium (Andresen et al., 2003) or

'surviving day by day' stage (Barnett & Lapsley, 2006) from those who move forward and achieve integration, acceptance, and control of mental illness.

The need for mental health services to intervene early and to provide person-centred care has led to the establishment of early intervention services for young adults experiencing psychosis. Whilst the potential benefit of early intervention to young people could be significant, many 'seal over' their experiences and engagement remains a major challenge to services. Boydell and colleagues (2006) found that young people with a first episode of psychosis delayed seeking help because they ignored symptoms and attempted to hide them from others for fear of stigma and causing undue anxiety in parents.

Some grounded theory studies have introduced the idea that adolescent individuation may impact on adaptation to psychosis without putting forward more detailed hypotheses (Barker et al., 2001; Hirschfeld et al., 2005) The six young men interviewed by Hirschfeld and colleagues (2005) offered multiple explanations for the overwhelming and threatening perceptual experiences occurring during psychosis. Profound changes relating to loss, loneliness, stigmatization as well as to growth and maturation were reported. The challenges of negotiating adolescent role transitions and achievement of autonomy were further magnified by the impact of psychosis.

To add to the existing knowledge base of factors helping and hindering recovery from adolescent-psychosis, it may be useful to examine the influence of specific developmental constructs.

## **2.2 EARLY DEVELOPMENT OF REFLECTIVE FUNCTION**

### **2.2.1 Attachment in psychosis**

Observational studies of mother-infant behaviour in response to separation led to the development of attachment theory (Bowlby, 1969). Current models of adult attachment distinguish between secure/autonomous, two types of insecure (preoccupied; dismissive) and disorganized styles (Main et al., 2002). These four attachment patterns are thought to reflect relatively enduring internal working models of self and others, which guide affect regulation and interpersonal relating throughout life. According to Bartholomew (1990), models of self and other can be either positive or negative. Self can be viewed as worthy or unworthy of love and attention. Others can be seen as reliable and caring or rejecting and neglectful. For instance, seeing self as worthy but others as rejecting and unreliable is related to a dismissive attachment style.

Working models of self and other are constructed and internalized through the caregiver's containment and mirroring of the infant's emotions and intentions (Winnicott, 1991). After the 'mother object' has been internalized through responsive caregiving in early attachment relationships in a process called primary individuation (Mahler, 1974), the young adult faces the challenge to separate the internalized object from the actual object during secondary individuation in order to live independently from caregivers (Blos, 1967). Any inadequacies in early mirroring and thus any defects in the early self organization derived from primary individuation are thought to manifest as blocks in or regression of development at the point of secondary-individuation. Insecure internal working models of self and others acquired in early attachment relationships manifest as over- or underdeveloped attachment strategies to regulate negative affect in adolescence (Kobak & Sceery, 1988; Rosenstein & Horowitz, 1996).

Insecure and disorganized attachment styles have been broadly linked to the development of childhood and adulthood psychopathology without detecting

associations to any specific disorder (Jones, 1996; Lyons-Ruth & Jacobvitz, 1999). Individuals with psychosis-spectrum disorders commonly present with insecure or disorganized attachment styles, predominantly of the dismissive type (Dozier, 1990; Dozier & Lee, 1995; Dozier & Tyrrell, 1997). In keeping with a bias towards self-reliance and a rejecting view of others, dismissive psychosis patients are less likely to disclose distress and tend to reject treatment (Dozier, 1990). In contrast to preoccupied patients, dismissive individuals minimize and deny distress despite experiencing more psychotic symptoms (Dozier & Lee, 1995). The relative non-specificity of insecure attachment styles has led researchers to believe that attachment security as such is less important to later emotional adaptation than the psychological capacities that develop in the context of early attachment relationships (Fonagy et al., 2003).

### **2.2.2 Reflective function**

Inherent in the development of self-organization through early mirroring is the parallel development of a procedural knowledge of minds. Fonagy and colleagues (2002) argue that internal working models need to contain a representational processing system that allows to infer mind states of self and others including emotions, beliefs, intentions and desires to predict own and others' behaviour. This capacity to understand self and others in terms of mental states is known as mentalizing. The simultaneous containment and validation of distress by a caregiver communicates to the distressed child a first sense of separateness of mental states between self and caregiver. As formal operational thought develops during adolescence, maturation of mentalization occurs. Impaired mentalizing capacity or reflective function subsequent to severe maltreatment is evident in borderline personality disordered individuals (Fonagy, 1995) and juvenile offenders (Levinson & Fonagy, 2000). Early abuse, neglect or engulfment are likely to disrupt the development of a mentalizing stance. Interrupted development of mentalization can result in states of psychic equivalence or pretend modes. In psychic equivalence, the inner experiential world is equated with the external world. Consequently, experience becomes too real and affect

overwhelming, which leads to fragmentation of self. In pretend mode, own mental states are dissociated from external reality and from the rest of inner experience. Experience becomes unreal and underwhelming, as the individual is detached from it. Self presents as an illusory rigid and stable façade. Reflective function facilitates an appearance-reality distinction, which may be of particular relevance to psychosis. Mentalized affectivity refers to the meta-cognitive ability to reflect on one's own emotions, which in turn enables the individual to self-regulate affect. The ability to reflect on mind states and to regulate emotions may therefore play a critical yet largely unexplored role in the adaptation process to psychosis.

### **2.3 EARLY EMOTIONAL DEVELOPMENT AND ADAPTATION TO PSYCHOSIS IN YOUNG PEOPLE**

As was noted earlier, psychosis typically develops during adolescence, at a time when critical developmental tasks such as separation and individuation are negotiated. Psychoanalytic thinking has long viewed adolescent processes and psychosis as intrinsically linked (Blos, 1979). More recently, Harrop & Trower (2003) put forward a hypothesis of how psychosis manifests as a result of blocked adolescent development. They drew on existentialist philosophy, object-relations theory and cognitive-behavioural therapy to illustrate how the existential imperative to individuate can be blocked by a fear of de-idealising, rebelling against and being rejected by parents or peers. Two threats to self-construction are described in relation to early mirroring experiences. Unavailability or failure in mirroring a child's feelings, needs and to securely contain distress leaves the self unconstructed and insecure. The implicitly communicated message of being unworthy of attention is internalized as a negative self-evaluation. Separation from others therefore poses a threat to self, which is to be avoided at the cost of individuation. In contrast, intrusive mirroring imposes the other onto the self thus producing an alien self. The alien self fears further engulfment by others. The urge for self-construction is often defended through violent anger. They noted that psychotic adolescents were excessively self-focused and often projected their mind states onto others, which hindered their ability to de-idealise others and thus to individuate. This example of failed separation of self-other

representation resembles Fonagy's concept of 'psychic equivalence' and impaired reflective function (Fonagy et al., 2002). Despite proposing a compelling structural model of development of psychosis, Harrop & Trower failed to elaborate on the impact of blocked adolescence on adaptation. Questions arise about how psychosis affects adaptation in general, and developmental tasks of late adolescence in particular. Based on their clinical accounts, Harrop & Trower therapeutically focus on shifting from self-focus to other-focus, which resembles mentalization-based interventions (Bateman & Fonagy, 2004). Mentalization in adolescents with psychosis is however poorly understood and requires investigation.

Although reflective function has not been studied in this population, some researchers have examined the narrative quality of recovery accounts. Incoherent narratives showed incomplete meaning-making and poor integration. Lysaker and colleagues (2003) also noted that most narratives of schizophrenia patients lacked reference to self as agent but showed an ability to reflect on others' mental states in relation to others. Narrative approaches to psychosis argue that being able to construct a coherent narrative of self as agent of one's actions is thought to facilitate positive adaptation (Thornhill et al., 2004). Incoherence due to a lack of metacognitive monitoring and poor mentalizing during the adult attachment interview is indicative of insecure and disorganized attachment (Hesse, 1999).

One of the few studies to investigate early emotional adaptation in relation to recovery and service engagement was conducted by Tait and colleagues (2004). Compared to 'integrators', 'sealers' were more insecurely attached to their parents, had a more insecure attachment attitude, viewed themselves more negatively and felt more insecure about their identity. 'Sealers' tended to perceive parents as providing little care and as being abusive, which corroborated earlier findings by Drayton and colleagues (Drayton et al., 1998) and tied in with the high prevalence of childhood trauma in psychosis (Read et al., 2003). The authors concluded that individuals with a sealing over recovery style had formed cognitive schema of others as rejecting, unreliable and possibly harmful in the context of neglectful or abusive parental attachment relationships and had carried these over into relationships with

others including professionals accounting for poorer engagement. 'Sealing over' was therefore formulated as being adopted "(...) by individuals whose psychological resources ('resilience') to deal with this potentially traumatic event [psychosis] are impoverished by virtue of an anomalous development trajectory." (Tait et al., 2004, p.413)

## **2.4 PURPOSE OF STUDY**

Taken together, current theories outline how commonly reported childhood adversities and inadequate parenting might be associated with insecure or disorganized attachment, failed separation-individuation and negative self-evaluation. Less is known about how these processes affect adaptation, particularly in those individuals who remain isolated, confused and overwhelmed by mental illness. The conscious negative appraisal of psychosis as loss, humiliation and entrapment appears to lead to anxiety and depression. The avoidant strategy of sealing over psychotic experiences is thought to shield the individual against the realization of the negative consequences of psychosis and thus leads to avoidance of services. Considering the lack of research and the need to effectively promote recovery in adolescents with psychosis, it seems relevant to explore the adaptation process and to investigate the influence of psychological capacities of reflective function and affect regulation as indicators of early emotional adaptation.

The present research pursued two aims:

1. To develop initial categories for the construction of a grounded theory about young people's adaptation to psychosis.
2. To develop initial suggestions for relationships between processes of reflective function and adaptation to psychosis.

## **2.5 RESEARCH QUESTIONS**

The following two research questions were pursued in the present study:

1. How do young people adapt to psychosis?
2. How do processes of reflective function influence adaptation to psychosis in young people?

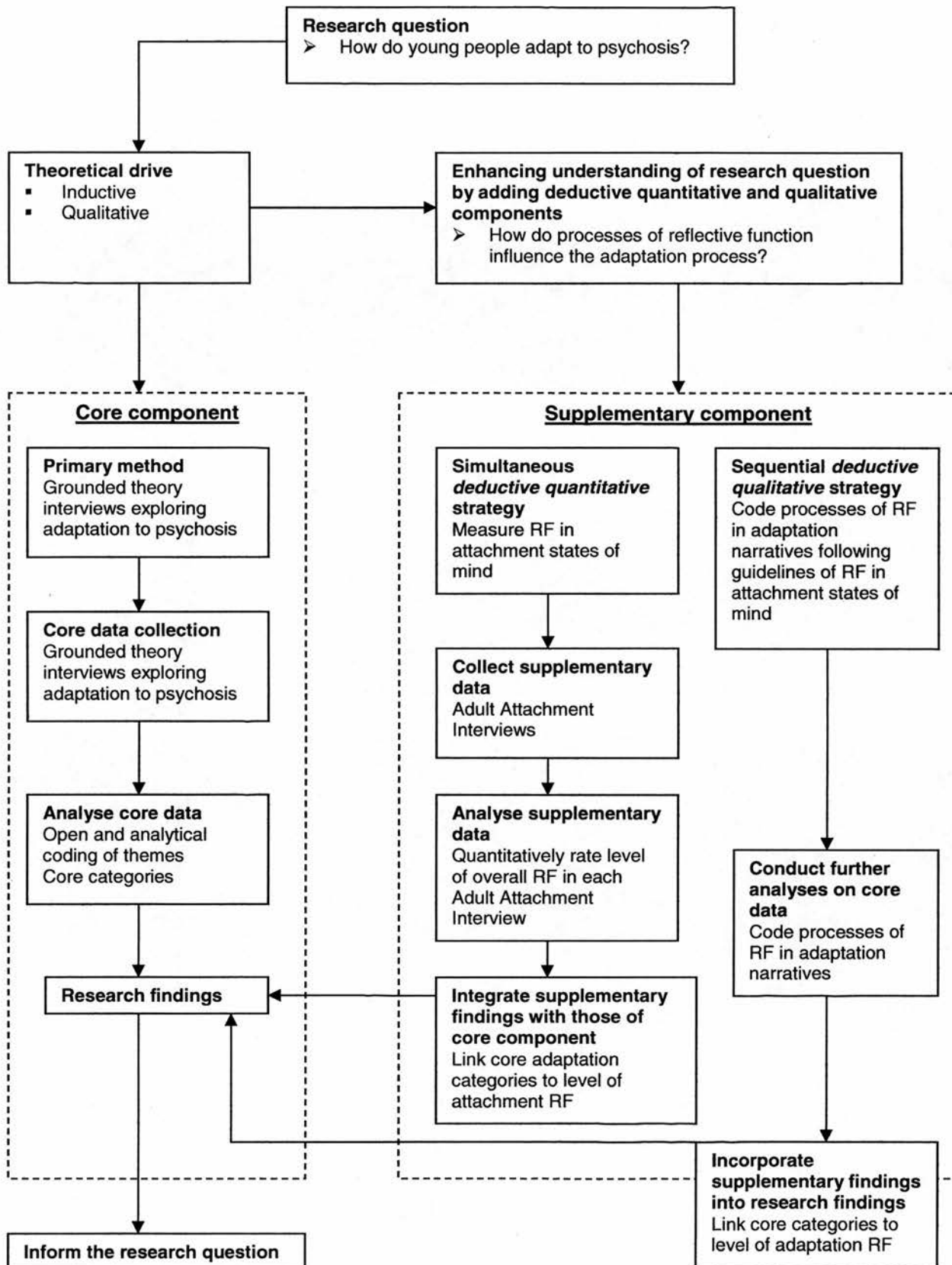
### **3. METHODS**

#### **3.1 Design**

##### **3.1.1 Mixed-methods methodology**

The present study employed a mixed-method design with greater priority given to the qualitative component (QUAL+quan) to best address the research questions (Creswell, 2003; Morse et al., 2006).

The diagram below (Figure 1) illustrates the design of the present study according to pathways for integrating qualitative and quantitative data outlined by Morse and colleagues (2006, p.286). Morse et al. (2006) emphasize the role of theoretical drive in maintaining validity in mixed methods research. Theoretical drive refers to the overall inductive or deductive direction of the inquiry. Based on the principal research question which investigates the processes involved in adaptation to psychosis, a qualitative core component was chosen, which was primarily inductive. To answer the secondary research question on how processes of reflective function influence adaptation to psychosis in young people, a deductive drive was added by introducing a supplementary qualitative component and a supplementary quantitative component. The core component was thus conceptualized inductively. The supplementary components were conceptualized deductively. The integration of supplementary components into the core component resulted in an overall inductive drive. The process of data analysis and integration is detailed in the results section.



**Figure 1.** Diagrammatic representation of process of mixed-method design of study (Adapted from Janice Morse, 2005).  
**Note:** RF – Reflective Function; Attachment RF – Categorical level of Reflective Function based on rating overall Adult Attachment Interview; Adaptation RF – Qualitative level of reflective function in grounded theory interviews on adaptation

### **3.1.2 Social constructivist grounded theory**

A social constructivist version of grounded theory (Charmaz, 2006) was used as the primary qualitative methodology to construct hypotheses about the processes involved in young people's adaptation to psychosis. Unlike the hypothetico-deductive approach (Popper, 1934) adapted by experimental psychology, grounded theory offered an inductive method that allowed to generate theory from data. The constructivist version takes a reflexive stance towards the research process in that it acknowledges the active role of the researcher in the generation and interpretation of participants' accounts. Theory does not simply 'emerge' from the data but is a context-dependent interpretation of the data made by the researcher. Themes are elicited through a dynamic and interactive process and are therefore a reflection of participants' and researcher's meanings and actions (Charmaz, 2006).

Most researchers acknowledge the inductive and deductive aspects of grounded theory, which arise from the continuous interaction between data, researcher and literature throughout the research process (Strauss & Corbin, 1998; Dey, 1999; Barbour, 2001; Charmaz, 2006). In this study, an explicitly deductive component was added to examine how key themes were related to predetermined categories of processes of reflective function (Fonagy et al., 1998).

In-depth, open-ended interviews with an evolving focus were thought to be best suited to capture the lived experience of young people. Sampling was non-probabilistic and criterion-based.

## **3.2 Epistemological considerations**

Although some psychologists advise against mixing methodologies (Harper, forthcoming; Boyd & Gumley, under review) for fear of 'method slurring' (Baker et al., 1992), others embrace 'methodological ecumenicalism' (Charmaz, 2006, p.121). Mixed-methods or composite analysis approaches have been recognized for providing a deeper understanding of researched phenomena than can be attained with a single form of data. The present

choice of mixed-methods is based on a pragmatist perspective, according to which the value of a method is determined by how effective it is in helping to answer the research question (Tashakkori & Teddlie, 2003)

The researcher addressed the research question from an epistemological and ontological stance of 'critical realism' (Bhaskar, 1989). In keeping with this stance, the researcher perceived knowledge to be context-dependent and thus biased by socio-political and personal circumstances of both researcher and participants. Critical realism accepts neither a constructionist nor an objectivist ontological stance. Instead, its epistemology is in keeping with constructivism (Charmaz, 2006), which takes the view that social phenomena are produced by processes that are real but that are not directly accessible through observation and are discernible only through their effects. The task of the researcher is to reveal the nature of individuals' experience by constructing hypotheses about their mechanisms. The researcher aims to reveal truth about an aspect of the real world but is limited in doing so by her own subjectivity and the context-dependent nature of accounts.

### **3.3 Ensuring rigour and quality**

As has been pointed out by Harper (forthcoming) and Boyd & Gumley (under review), many qualitative studies fail to explicitly evaluate their research according to suggested criteria. To optimize the reliability and validity of data collection and analysis the following general criteria (Elliott et al., 1999; Yardley, 2000) and specific principles outlined by Boyd & Gumley (under review) for grounded theory studies in psychosis were aspired to: (1) sensitivity to context, (2) commitment and rigour, (3) transparency and coherence. Sensitivity to context requires the researcher to take into account the sociocultural context of interviewer, interviewee, their relationship and other aspects of the physical and social environment, in which the research takes place. Commitment and rigour demand of the researcher to immerse herself in the topic studied and provide a clear method for coding data. Most importantly, it demands depth and breadth of data analysis by means of triangulation and cross-validation. Initial interpretations of themes in the data

should be cross-validated by means of checking of coding structure, multiple coding of transcripts by colleagues, constant comparison between data and existing literature, carrying themes forward into subsequent interviews and participant validation. Transparency and coherence can be ensured by being transparent about methodology, the research process, the researcher's reflexive stance and by providing a clear and powerful narrative with contextualized quotations.

### **3.4 Researcher's position**

The researcher carried out this study as a doctoral thesis for her clinical psychology training whilst in her late 20s. She has no personal experience of psychosis but has witnessed peers developing related problems during secondary school. Over the past 6 years, she has been involved in conducting quantitative research in psychosis and has been working with people experiencing psychosis across different clinical settings. Whilst investigating the etiology of psychosis, she has become interested in understanding the developmental and psychological mechanisms involved. In her clinical work with young people with psychosis, she is motivated to apply innovations in psychological understanding of a previously 'untreatable' illness to instill hope and to promote recovery. Her training in clinical psychology facilitated establishment of rapport with individuals experiencing psychosis by listening to their stories in an empathic and non-judgmental manner. Academic training in sociology and psychology may have influenced the qualitative data analysis in that the author had a tendency to interpret data in relation to sociological and psychological constructs.

### **3.5 Research context**

The present research was conducted in the context of the author's final year psychosis placement at the local adolescent psychiatric services. All participants attended the local early psychosis service. The local service is an early intervention service consisting of a multi-disciplinary team

comprising psychiatry, nursing, occupational therapy and psychology. The service offers individual, family and group support to young people between the ages of 14 and 21 who have experienced a psychotic episode. The service can stay involved over a period of 3 years following the first episode, which is considered to be critical in determining long-term outcome (Birchwood et al., 2000).

### **3.6 Participants**

The study included 8 young people between the ages of 18 and 21, who had experienced clinically significant psychotic symptoms and were attending the local early psychosis support service. Young people with a significant or severe intellectual impairment were excluded from the study. To reduce bias in the interviews, none of the participants had been involved in any direct or indirect psychological work with the author.

To protect participants' anonymity in keeping with guidelines published by Qualitative Health Research ([www.ualberta.ca/~qhr/guidelines.htm](http://www.ualberta.ca/~qhr/guidelines.htm), accessed 1<sup>st</sup> April 2007), demographic information is presented for the group as a whole in Table 1 below. Demographic information was gathered as part of the interview. The present sample consisted of 4 females and 4 males. Participants' psychiatric diagnoses fell within the spectrum of psychotic disorders including schizophrenia-like psychosis, bipolar disorder and psychotic depression. The onset of mental health difficulties had disrupted the education of six participants. One participant completed 5<sup>th</sup> year at the in-service school. Another participant was planning to return to university following a period of leave of absence. Three had remained out of education since leaving school, one of whom was contemplating returning to college. One young person had successfully returned to school to sit Standard Grades. Seven out of 8 participants were living with their parents. The parents of the participant living alone were providing daily support with household chores, service attendance and medication compliance. Three young people had been involved with psychiatric services prior to their psychotic episode. Five out of 8 participants had experienced one inpatient

admissions related to psychotic symptoms. The remaining 3 participants had only ever been treated as day- or outpatients. All participants had been involved with the local early psychosis service between 7 months and 3 years (Mean: 1 year 8 months). Two participants were in transition to adult psychiatric services. All received neuroleptic medication and psychosocial support.

**Table 1.** Demographic information for participant sample

Demographic information	Number of participants N=8
Sex	4 male 4 female
Age	18-21 (mean 18.63) years
Ethnicity	7 White Scottish 1 Black Scottish
Level of education	3 school until 16 1 taking Standard Grades 1 Highers 1 completed 5th Year 1 Highers, started undergraduate
Employment status	3 unemployed, on benefits 2 part-time college students 1 full-time pupil 1 full-time student on leave of absence
Living situation	4 living with parents and siblings 3 living with parents 1 living alone
Age at onset psychosis	8-19 (mean 15.3) years
Age first CAMHS involvement	11-18 (mean 15.2) years
Age first Psychosis Service contact	16-18 (mean 17.2) years
Psychotic episodes	8 one episode
Admissions	3 no admission 5 one admission

## **3.7 Materials**

### **3.7.1 Adult Attachment Interview**

The Adult Attachment Interview (AAI; George, Kaplan & Main, 1996) is a structured hour-long semi-clinical interview, which inquires about early attachment experiences and their effects. Participants are asked to describe their early relationships with significant attachment figures and to recall specific memories in support of their descriptions. They are also asked if and why they felt closer to one caregiver; what they did if emotionally upset, hurt or ill and how caregivers responded. The protocol goes on to query about significant separations, possible experiences of rejection, threats or abuse. The participant is asked how early experiences affected their adult personality and why caregivers behaved as they did. Major loss and traumatic experiences across lifespan are also enquired about. Lastly, participants are invited to reflect on any changes in their relationship with their attachment figures since childhood and asked to describe the nature of their current relationship with key attachment figures. Its 18 questions are phrased and ordered with the intention to “surprise the unconscious”, that is to provide opportunities for the respondent to contradict or fail to support other statements (George et al., 1996, p.3). The central challenge of the AAI is to reflect on attachment memories whilst simultaneously maintaining a coherent narrative. At present, verbatim transcripts of the AAI can be used to classify attachment styles (Main et al., 2002) and reflective functioning (Fonagy et al., 1998). The AAI has been widely used with clinical and non-clinical populations of both adolescent and adult age. It is considered to provide a highly reliable and valid measure of attachment states of mind (Hesse, 1999).

### **3.7.2 Reflective Functioning Scale**

The Reflective Functioning Scale has been developed to measure an individual's capacity for reflecting on mental states of self and others in the context of early attachment relationships (Fonagy et al., 1998). Whilst Reflective Function (RF) is rated based on the examination of the whole AAI

transcript, the following AAI questions lend themselves particularly well to rating RF because their content structure demands a reflective answer:

- *'Why did your parents behave the way they did during your childhood?'*
- *'Do you think your childhood experiences have an influence on who you are today?'*
- *'Are there any other aspects of your early experiences that you feel were a set-back to your development?'*
- *'Did you ever feel rejected as a young child?'*
- *'In relation to losses, abuse or trauma, how did you feel at the time and how have your feelings changed over time?'*
- *'Have there been changes in your relationship with your parents since childhood?'*

Individual answers are examined for level of reflective function. Indicators of moderate to high reflective function are (1) showing an awareness of nature of mental states; (2) demonstrating an effort to tease out mental states underlying behaviour; (3) recognising developmental aspects of mental states; (4) and showing attunement to the mental states of the interviewer. Indicators of absent or low reflective function are (1) rejection of reflection function; (2) unintegrated, bizarre, or inappropriate reflective function; (3) disavowal of reflective function; (4) Distorting or self-serving bias in consideration of mental states; (5) Naïve or simplistic reflective function or (6) overanalytical reflective function.

Following standardized criteria, individual answers are ranked on a scale of '-1' (negative RF) to '9' (exceptional RF). A rating of '-1' represents absent RF; '1' denotes lacking in RF; '3' corresponds to questionable or low RF, '5' denotes ordinary RF, '7' refers to marked and '9' to exceptional RF. The sum of all individual ratings are aggregated into an overall score and yield one of 6 corresponding RF categories (negative; lacking; questionable or low; ordinary; marked; exceptional). Fonagy et al. (1998) show that the RF scale and rating procedure exhibit a satisfactory inter-rater reliability and provide evidence for a good discriminant validity of the RF scale.

### **3.7.3 Open-ended qualitative interview**

The initial open-ended question asked participants to reflect on how their life has changed since the onset of mental health difficulties:

- *'How have things been for you since you have become involved with psychiatric services?'*

Further open-ended questions were used to encourage the development of a narrative surrounding the emerging topics. Follow-up and probe questions were informed by principles of qualitative interviewing (Willig, 2001; Charmaz, 2006). The broad initial research question allowed for a relatively assumption-free approach to data collection. As the research progressed, the major themes identified in the preceding interviews served to refine the range of topics asked about. An interview guide was used to facilitate the formation of a narrative and to maintain conversational flow. The final interview guide consisted of open-ended questions covering the following broad domains: (1) changes in self, future, relationships, maturation; (2) impact of mental health difficulties; (3) managing mental health difficulties on intra- and interpersonal level, (4) experience of health professionals, services; (5) emotion regulation.

### **3.7.4 Reflexive diary**

Reflexive notes were written throughout the research process to make explicit the researcher's subjective reactions, biases and interpretations of the data and thus to increase transparency of the analysis process. Immediately following interviews, reflections were noted on process and content of interview as well as thoughts about any similarities and differences with the literature and previous interviews. Memos on the coding were written throughout data analysis to integrate new insights. All reflexive material and memos were used to guide analytic theorizing about data. (Charmaz, 2006)

### **3.8 Procedure**

#### **3.8.1 Ethical issues**

The study had been approved by the Lothian Regional Ethics Committee and the local NHS Research & Development Department to include both psychosis and non-psychosis patients attending the adolescent mental health service (Appendix 8.1, 8.2). To narrow the focus of the study, it was decided to limit the sample to individuals with psychosis.

#### **3.8.2 Piloting interviews**

Prior to the commencement of the study, the author needed to learn to conduct the AAI and the unstructured qualitative research interview. The author had experience in conducting semi-structured clinical interviews and unstructured clinical interviews with individuals experiencing psychosis. Firstly, two AAIs were completed with colleagues (Assistant Psychologist, Trainee Clinical Psychologist). Secondly, to ensure the credibility and relevance of the initial interview question to a clinical population, two adolescent patients with non-psychotic psychiatric difficulties were interviewed. Staff had approached pilots, who were made aware that their information would not be used in the study. Audio-recordings of all four interviews were reviewed by the academic supervisor. Comments on interview style were discussed in supervision.

#### **3.8.3 Recruitment**

Following a presentation of the study to the local early psychosis service and the inpatient unit, approval was given to recruit patients from both teams. Keyworkers identified potential participants according to inclusion criteria. Potential participants had to be considered suitable to participate by both the consultant psychiatrist and the keyworker before they could be approached about the study by the keyworker. Keyworkers invited patients to consider participating and passed on information sheets (Appendix 8.3). Those young

people who were interested in participating contacted the author directly. During a pre-interview conversation – either over the phone or face-to-face- the author introduced the study, discussed consent and answered any questions. If the young person verbally agreed to participate, a provisional date for the interview was arranged. Interviews took place at least 24 hours following the pre-interview conversation to give participants sufficient time to re- consider their decision, and if necessary to withdraw consent.

Prior to giving written consent, each participant was fully informed of the purpose of the study, the format, confidentiality and data protection, management of recording and transcription, and was given opportunity to ask questions. The consent emphasized the voluntary nature of their participation and asked for permission to publish anonymised quotes.

Out of 9 identified young people, 8 consented to participate in the study.

### **3.8.4 Interviewing**

#### **3.8.4.1 Adult Attachment Interviews**

Seven participants had completed the AAI as part of routine clinical assessment prior to completing the grounded theory interview. All seven participants gave retrospective consent to their AAI being used in the present research. Six of these AAIs had been conducted by a trained assistant psychologist; one by the academic supervisor. The author interviewed one participant, who gave prospective consent for the AAI to be used both for routine clinical data collection and for the present study. All AAIs were conducted on site between 1 week and 12 months prior to the grounded theory interview. All AAIs were recorded using a digital voice recorder and were transcribed verbatim by the trained assistant psychologist. Duration of AAIs ranged from 22 to 38 min. Because of the structured nature of the AAI, the responses are less dependent on the interviewer than the unstructured grounded theory interviews.

### **3.8.4.2 Grounded Theory interviews**

Five young people, who attended the early psychosis support service regularly, were interviewed on site. The other 3 participants were interviewed in a private and quiet room in their homes either because they did not attend services regularly or because they preferred to be seen at home. All interviews were conducted by the researcher and were recorded using a digital voice recorder and external microphone. Duration of interviews ranged from 43 to 68 minutes.

### **3.8.4.3 Sampling for Grounded Theory interviews**

The research process was iterative in that the researcher selected an initial sample of two participants, coded and analysed the data, and then interviewed a further two participants in order to refine the emerging themes or categories. This sampling process was aimed to be continued until themes were sufficiently rich and dense data to make analytical claims ('theoretical sufficiency', Dey, 1999, p.257).

'Theoretical sufficiency' was preferred over 'theoretical saturation', which refers to reaching the point in analysis where no new themes or insights are forthcoming from the data (Strauss & Corbin, 1998). Dey (1999) and Charmaz (2006) have criticized the concept of theoretical saturation on three grounds. Firstly, the term 'saturation' suggests that data have been coded exhaustively, which is impossible for a researcher to evidence. Secondly, they question the utility of the claim of having saturated a category since it may lead to the premature foreclosing of analytical possibilities. Thirdly, claims to saturation do not protect from constructing superficial analyses.

### **3.8.5 Data management**

To ensure the transferability and dependability of data, high quality stereo audio recordings of interviews were transcribed verbatim and analysed using NVIVO Version 2 software designed for qualitative data analysis (Lincoln &

Guba, 1985). All participants had consented to their interviews being audio-recorded and transcribed verbatim. Audio-recordings of AAls were transcribed by an assistant psychologist. The first two grounded theory interviews were transcribed by a private secretary. The subsequent six audio-recordings were transcribed by the researcher facilitating an immersion into the text as a first step of data analysis. Audio-recordings and transcripts were anonymised. All information that could lead to the identification of the participant was removed from the transcript and replaced with a general descriptive noun. For the purposes of transparency, Participants have been assigned pseudonyms including a number referring to their position in the interview sequence.

## **4. RESULTS**

### **4.1 Process of data analysis**

To enhance transparency, the process of data analysis and integration is outlined below.

#### **4.1.1 Quantitative data**

AAIs were transcribed verbatim. The academic supervisor categorized each transcript as relating to one of the 6 reflective function categories specified by Fonagy et al (1998). The academic supervisor had successfully completed training in the rating of reflective function based on the AAI.

#### **4.1.2 Qualitative data**

##### **4.1.2.1 Grounded theory analysis of adaptation narratives**

Grounded theory prescribes an interactive process of simultaneous data collection and constant comparative analysis. Qualitative data analysis using grounded theory proceeded according to the following steps (Charmaz, 2006, p.11): (1) Transcription, (2) Immersion, (3) Open initial coding, (4) Selective focused and axial coding, (5) Crossvalidation, (6) Theoretical coding, (7) Memo-writing, (8) Writing grounded theory.

Following immersion into the texts during transcription, all verbatim transcripts were analysed using NVIVO Version 2 software designed for qualitative analysis. The first interview transcript was subjected to line-by-line open-coding, which involved identifying significant processes and assigning descriptive codes to the smallest meaningful units of texts (Charmaz, 2006). The purpose of open coding was to remain open to all possible interpretations of the data. The academic supervisor inspected the initial open codes. An excerpt from an interview transcript provides an example of how open codes were assigned to participants' narratives (Appendix 8.4). During the process of focused coding, the most frequent and/or significant

initial codes were used to summarise all data and to condense them into higher-level analytical categories. During axial coding (Strauss & Corbin, 1998) properties and dimensions of core categories were identified by reassembling data into an increasingly coherent structure. Questions about the 'if', 'when', 'how', 'where' and 'why' of categorized processes facilitated axial coding. Throughout open and focused coding, similarities and differences between data, emerging codes and interviews were examined - a technique known as 'constant comparative analysis' (Strauss & Corbin, 1998). Negative cases, which seemed to disconfirm the emerging category, were considered to increase the trustworthiness of the analysis.

To ensure internal validity, the initial coding structure and strategies for coding were inspected by the academic supervisor. The second interview was coded into the first coding structure following the same process, which led to an elaboration of properties and dimensions of existing categories and to the emergence of new categories.

The first two narratives tended to cluster around themes relating to the psychological, interpersonal and practical changes that had occurred in young people's lives following the onset of mental health difficulties. Young people talked about these changes occurring within and out with the context of mental health difficulties, which led to the development of a category focusing on adolescent development. The two main themes of how young people managed mental illness in an interpersonal context and how they felt mental illness had affected their development were subjected to further validation by being carried forward to the next two interviews. A clinical psychologist colleague coded the third interview transcript. Any arising alternative interpretations were incorporated into the evolving coding framework to increase breadth of analysis. As emerging codes were being compared to data and to one another, codes were further organized into hierarchical structures. Theoretical concepts related to adolescent development, adjustment to chronic illness, attachment theory, expressed emotion in psychosis and symbolic interactionism informed the clustering and labelling of categories.

An in-depth analysis of the first four interviews gave rise to the development of several interlinked core categories related to adolescent development, adaptation to mental health difficulties and interpersonal experiences. To further validate and refine the emerging theoretical explanation, new questions were introduced to the subsequent 3 interviews. Following the analysis of interviews 5 to 7, interview questions for Participant 8 were further refined in order to validate and elaborate key themes from preceding interviews.

A second literature review was conducted to crossvalidate themes emerging from the interviews. Ongoing memo-writing facilitated the constant comparison of data, codes and categories, the hypothesizing about relationships between those, their validation through concepts from the literature and the construction of analytical categories. The final model evolved from the researcher's continuous interaction with the data and literature. Theoretical coding involved making hypothetical links between the analytical categories of adapting to mental health difficulties and challenges of adolescent development. Lower-level categories were summarized into two main categories of 'Experiencing mental health difficulties' and 'Developing adolescent self', which were linked through an overarching core category labeled 'Recovering emerging self'.

#### **4.1.2.2 Deductive coding of RF processes in adaptation narratives**

Qualitative data were also examined according to predetermined categories of reflective function (RF; Fonagy et al., 1998) originally developed to be applied to transcripts of the Adult Attachment Interview. The predetermined coding framework distinguished between four indicators of moderate/high reflective function ((1) Awareness of nature of mental states; (2) Effort to tease out mental states underlying behaviour; (3) Recognising developmental aspects of mental states; (4) Mental states in relation to interviewer) and six indicators of negative reflective function ((1) Rejection of reflection function; (2) Unintegrated, bizarre, inappropriate reflective function; (3) Disavowal of reflective function; (4) Distorting or self-serving bias; (5) Naïve or simplistic reflective function ; (6) Overanalytical reflective function). The researcher

applied the classification criteria for the 10 indicators outlined in the RF manual to any statements on reflections on mental states of others or self in the adaptation narratives. The academic supervisor checked the resulting coding of the first two interviews. An example of how reflective function was coded in the context of young people's adaptation narratives is provided in Appendix (Appendix 8.4).

#### **4.1.3 Integration of qualitative and quantitative data**

Subsequently, the main themes in the recovery narratives were linked to coding of reflective function by examining the level of reflective function in relevant passages of text across participants. An excerpt from an interview transcript illustrates how narratives were coded for both content and level of reflective function for each participant (Appendix 8.4). The example demonstrates how the young person mostly tries to evade invitations to reflect on the impact of his illness on his activities, attitude towards the future and friendships. Such evasions were classified as examples of negative and limited reflective function.

Quantitative categorical data were integrated with the qualitative results in order to provide an additional framework for reexamining the inferences made in the qualitative analysis.

#### **4.1.4 Reflections on research process**

Over the course of the research, I used a reflective diary to keep a record of my immediate impressions of individual interviews and any associated ideas that arose from both process and content of interviews.

Most importantly, I observed that the themes young people brought up in a more unstructured setting were in fact more person-centred and normative than I had expected. It made me realize that there was a degree of discrepancy between my clinical work - some of which still had a symptom-focused bias - and my much more developmentally-sensitive and person-centred formulations of young people's difficulties.

I enjoyed adopting an explicitly non-assumptive and curious stance in the unstructured interviews, as I felt it allowed young people to freely develop their narratives and bring up topics, which were meaningful and relevant to their lives and recovery. All participants appeared to be relatively open about talking about their experiences considering none of them had met me prior to recruitment. The fact that many young people openly discussed negative experiences they had with mental health professionals suggested that they viewed me more as an impartial student than as a member of staff. I noticed that qualitative interviewing started to influence my style during clinical sessions in a helpful way by encouraging me to abandon any preexisting assumptions about the person's problems or priorities.

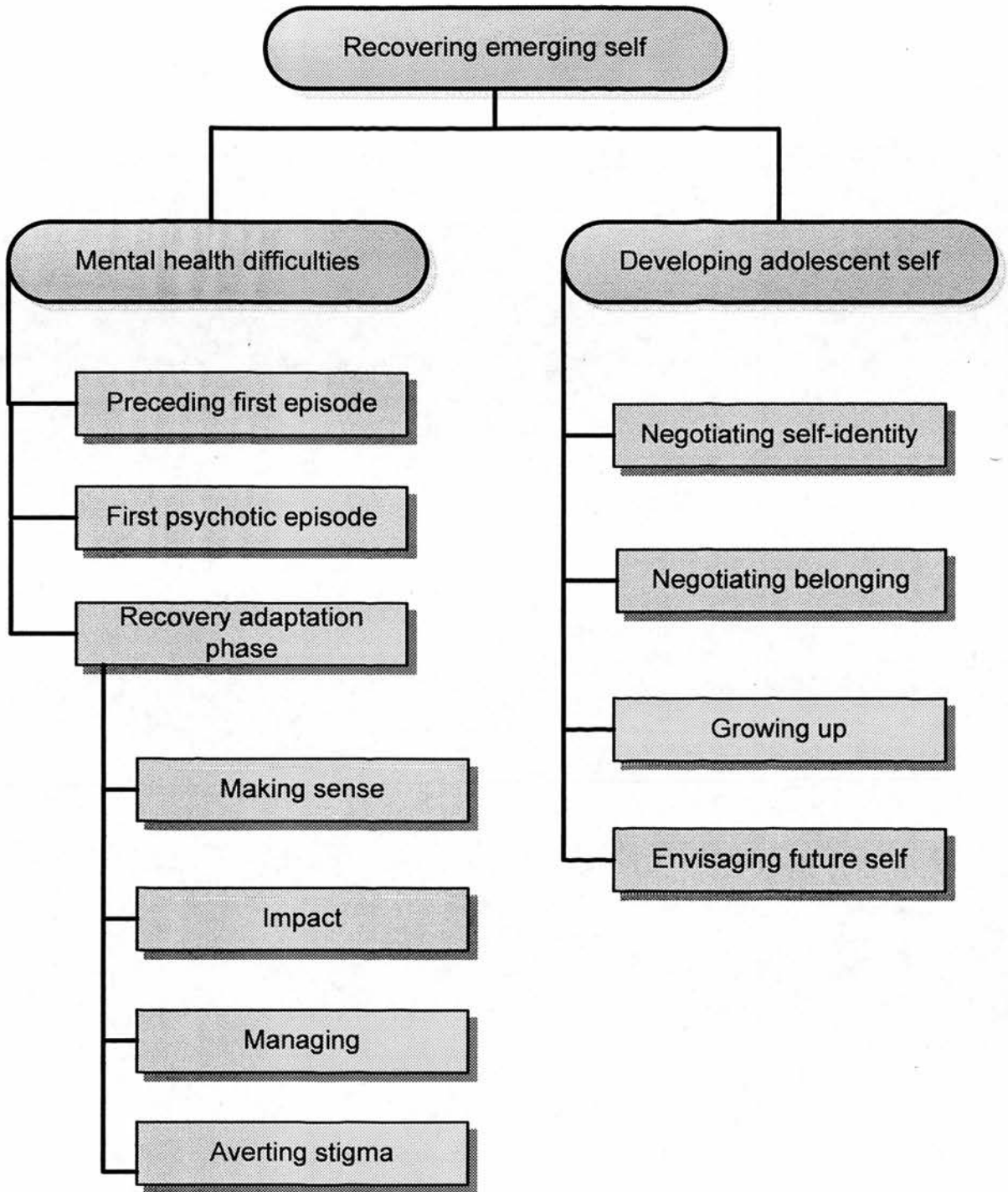
Whilst some young people were easily forthcoming and provided lengthier narratives, others required more prompting and questioning leading to shorter conversational turns, which corresponds to what has been called a 'sealing over' recovery style (McGlashan et al., 1987). Those young people tended to refuse to reflect on their own or others' motives for behaviours, which I experienced as frustrating at times, as I was aiming to gather rich, dense and free-flowing narratives. However, speaking to the latter group of young people and considering the impact of psychosis on their lives over the course of analysis helped me appreciate their motives for adapting an avoidant coping style, which allowed them to deal with the threat and uncertainty that psychosis posed to their future.

I found conducting qualitative research for the first time a rewarding yet labour-intensive experience as it forced me to deepen my understanding of young people by having to immerse myself into their narratives and do justice to their experience. The research process in general helped develop my thinking on broader relationships between affect regulation and reflective function in severe mental illness.

## **4.2 Descriptive account of inductive qualitative data**

### **Core category: Recovering emerging self**

The resulting core category comprised two interrelated main categories of (1) Experiencing mental health difficulties and (2) Developing adolescent self. Each of these categories and its subcategories are presented below (see Figure 2.1). Anonymised excerpts from interview transcripts are used to represent categories across participants, while being embedded in the context of the individual interview.



**Figure 2.1** Overview of main themes associated with core category

#### **4.2.1 Main theme 1: Experiencing mental health difficulties**

In order to contextualize the changes occurring following their psychotic episode all participants described relevant experiences from before and during their psychosis. Themes relating to the phases preceding and surrounding the first psychotic episode will be described briefly. The richer categories relating to the recovery and adaptation phase will be explained in more detail.

##### **Subcategory 1.1 Preceding first episode**

###### ***Childhood mental health problems***

The onset of psychosis was typically preceded by earlier mental health and behavioural problems. In some cases these dated back as far as early childhood. One participant recalled starting hearing voices at the age of 5, which resulted in neither distress nor treatment. Another young person described always feeling 'weird things (..) inside' (Anna 1) Others reported developing significant dysregulated mood, behavioural and interpersonal problems at primary school. Some of these problems remained undetected whereas others received treatment from child mental health services.

###### ***Adolescent mental health problems***

All four female participants experienced affective disturbance during adolescence. Existing dysregulated mood worsened during puberty. Others described the onset of significant depression and anxiety, which coincided with drinking alcohol and smoking cannabis. Depression resulted in the loss of friends in one young person and in dropping out of school in another. Emerging performance anxiety resulted in the painful loss of a valued activity for another young person. One male participant described longstanding and escalating externalising difficulties such as antisocial behaviour, chaotic polysubstance and alcohol abuse, which created a lack of meaning and purpose.

## **Subcategory 1.2 First psychotic episode**

### ***Distressing voices***

Most young people described the sudden onset of distressing and disabling auditory hallucinations. In one case, previously pleasant voices had changed in content and thus became upsetting. Some experienced the first onset of distressing voices in the context of severe depressive or manic phases.

### ***Personality change***

Another young person recalled his personality changing in that he stopped talking to others and became increasingly obsessed with the television. One participant recalled positive experiences of obtaining sudden exceptional intelligence and mental power.

### ***First admission and contact with services***

As others around them noticed changes in young people's behaviour and personality, parents encouraged them to seek professional help. Some participants recalled initially disbelieving others' concerns but most eventually realized that their mental state was unusually different. Three out of the five young people who had been admitted to hospital recalled their inpatient stays as unsettling and even traumatizing. Witnessing patients' distress, having personal possessions taken away and sleeping in a dormitory on an adult ward were experienced as deeply unsettling and exhausting. The traumatic memory of the hospitalization on an adolescent ward continued to be re-experienced as distressing flashbacks.

### **Excerpt**

Leon 3: (...) but like as we're talking about it now I can get flashbacks and stuff like that so I still remember like pictures of it, of doing stuff, of how things were, and of how I first went to the [adolescent inpatient unit] and how like odd it was and stuff and I didn't know where I was and how, acting strangely and stuff.  
(...)

CB: **Uhuh. How does it feel thinking back to these times now?**

Leon 3: It's quite...{3sec} hurtful, I don't know.

Others recalled initially being hostile and physically aggressive whilst on the ward as they resented being locked up.

### Excerpt

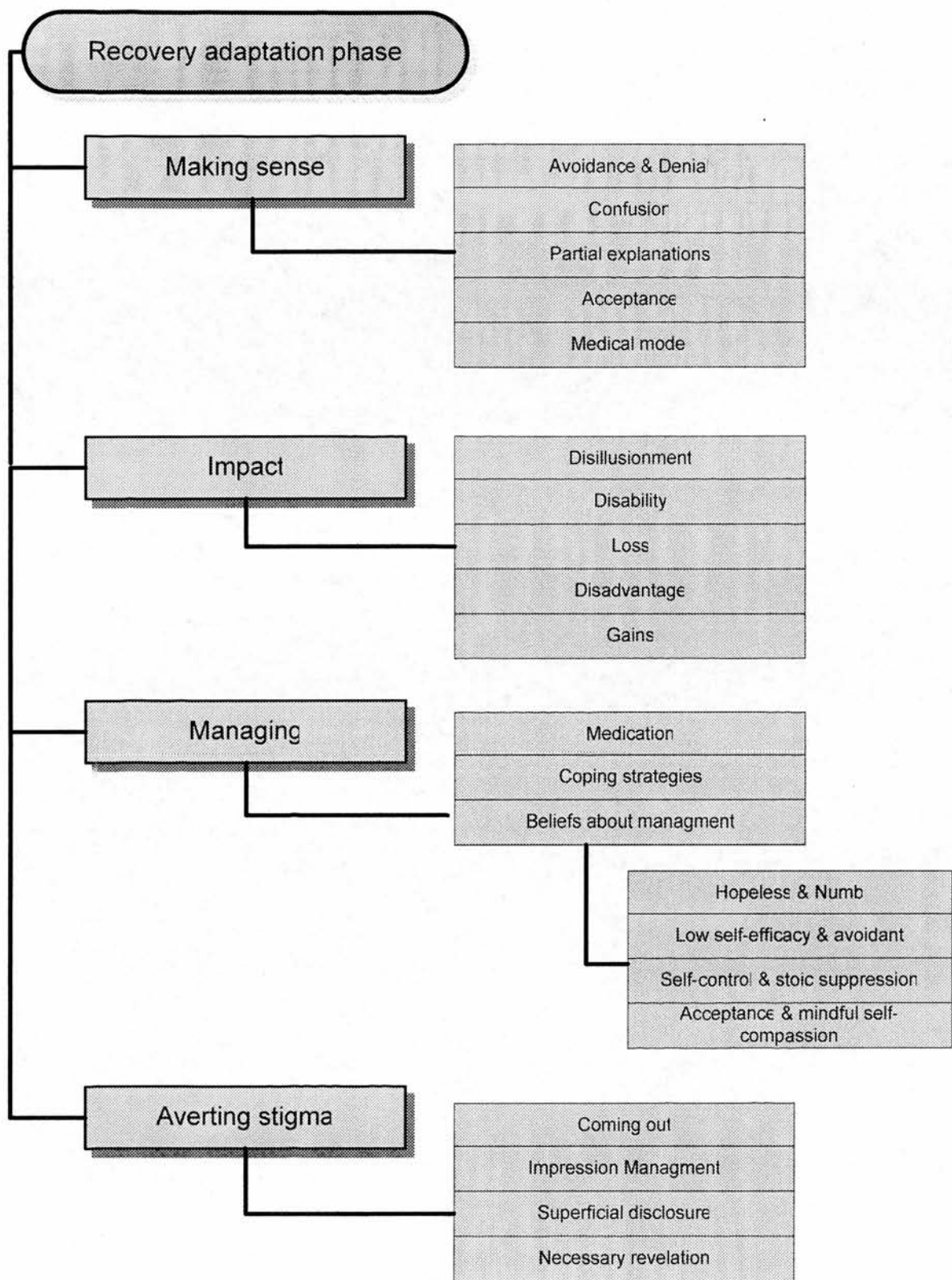
John 8: Yeah, I really hated the hospital when I was in, eh, I just hated it with a passion. I was always smashing things up and that. I actually got out because I was smashing the place up too much, eh. (...) But I feel a lot better for it now, so it was worth it.

Both young men reported retrospectively valuing the hospital stay as a necessary yet painful part of their recovery.

The remaining three participants reported making more neutral first contacts to the early psychosis service through their GP, psychiatric emergency team or other parts of the adolescent service.

### **Subcategory 1.3 Recovery adaptation phase**

Narratives surrounding the recovery and adaptation phase of mental health difficulties were summarized into four main themes and subcategories (see Figure 2.2).



**Figure 2.2** Overview of subcategories related to main theme 1

### **1.3 a Making sense of mental health difficulties**

There was marked diversity in how young people labeled their primary mental health difficulties. Diagnostic terminology such as 'bipolar disorder', 'schizophrenia', 'manic phase', 'depression' and 'psychotic disorder' was employed. These medical terms tended to coexist alongside more personal non-technical labels such as being 'insane', 'having bad thoughts', 'hearing voices', 'having paranoid thoughts', 'random thinking problem', 'being ill', going 'mental', being 'on psychosis' and experiencing a 'brain change'. Young people considered affective and behavioural difficulties as central to their problems. In some cases these took precedence over psychotic experiences. Depressed mood and anxiety about travelling on public transport or about socialising were common. One individual labelled himself as an alcoholic. One young person admitted to not having a label for his experiences and merely associated his psychotic episode with manifesting odd behaviour.

Participants appeared to be at different stages in the process of explaining and understanding their experiences. Avoidance, denial and confusion were characteristic of early stages. Acceptance and integration marked the later stages of meaning-making. There appeared to be a distinction between those who were actively seeking to understand and those who were not engaged in meaning-making either because they avoided thinking about the traumatic and egodystonic memory of psychosis or because they had adopted foreclosed explanations borrowed from others such as parents or health professionals. Despite offering superficially plausible explanations, it became clear that these young people had not gone through a process of reflective meaning-making and thus did not own their understanding. Amongst those who were seeking to understand, some had found partial explanations or had come up with hypotheses representing an intermediate stage of meaning-making.

#### ***Avoidance and denial***

A few young people acknowledged that they avoided thinking about their mental health difficulties and thus did not try to understand them further.

Avoiding the meaning behind their mental health experiences was viewed as a means to evade distressing memories, to enable oneself to move on by engaging with the here and now or it had been abandoned prematurely. Avoidance was viewed as the most convenient coping mechanism.

Excerpt

**CB: Do you have a way of making sense of why you had that low time?**

Julia 7: I don't think about it that much. I tend to find like getting through things like that better if I don't think about it **(mh)**. So I just sort of concentrate on other things. It's a bit problematic when people like 'What do you think about it?' Well, I don't.

Traumatic memories of the first psychotic episode were seemingly successfully suppressed.

Excerpt

Leon 3: I just try not to, I just try and distract myself from thinking about it, as much (...) Cos that's like, I don't really think, I just try not to think about it, I mean this is the first time I think about it in probably this year, I don't know so.

Others claimed that they abandoned thinking about their experiences after thinking about them initially.

Excerpt

**CB: I mean is it something you think about on a daily basis?**

Craig 2: What? Hospital?

**CB: Yeah or hearing voices?**

Craig 2: No. Back then I did but not now.

Amongst those who avoided reflecting on their experiences was one young man who appeared to reject invitations to reflect on the causes of his experiences or behaviours by claiming ignorance about his mental states.

### Excerpt

**CB:** Uhuh, so when did you stop going to school?

David 6: When I became ill. I think it was like March some time. March.

**CB:** And did that happen from one day to the next or/

David 6: /Sorry?

**CB:** How did the becoming ill happen?

David 6: Don't know..{2 sec} mm, I'm not sure.

(...)

**CB:** Aha. Why do you think that was, that you were sitting in your room on your own?

David 6: I don't know.

**CB:** How long before you became unwell were you doing that?

David 6: I don't know. A couple of years.

### ***Confusion***

Amongst those who were seeking to understand their experiences, some continued to struggle to make sense in a coherent way. The following excerpt illustrates how the young woman's inability to understand a profound and overwhelming change in –and even loss of - self, is mirrored in an incoherent and fragmented narrative. She showed a lapse in meta-cognitive monitoring as she switched between past, present and future selves. The deteriorating narrative quality suggests that the change in 'brain' or self-experience had not been sufficiently processed.

### Excerpt

Anna 1: I'm this person that's not actually there any more because I'm not, it's not there, it's nothing like it was before, nothing. And I can't understand how my brain's so changed.

**CB:** Really?

Anna 1: Totally changed.

**CB:**            **When you say you're not like how you used to be before, when did it change? What happened at the time when it changed?**

Anna 1:        Well as I say, it's when, it's come fae about three years ago to get it to do what I'm doing and myself, and there's other things I'd still like to change. It's a miracle because...{3sec} What was the question anyway? I can't actually relate to this.

Frequently changing psychiatric diagnoses, which aimed to capture the complexity of difficulties, also created confusion. Sense-making thus became a process owned by health professionals.

#### Excerpt

Rebecca 5:    Back then it was really different cos back then I, I was just told that I just had depression (**right**) since then I've been told that I have bipolar, and they didn't know and now they've got no clue. So basically I just, I don't, I don't, I don't really know what I've got.

#### ***Partial explanations***

The intermediate stage of meaning-making was characterized by partial and at times contradictory or borrowed hypotheses. One participant described psychosis as a non-sensical bad trip during which he became 'Trapped in my head. Trapped in my imagination.' (John 8) and thus uncomfortably disconnected from reality. The discourse of being 'on psychosis' and using hospitalization to detoxify was partly contradicted by reference to emotional causes without offering a coherent conclusive answer.

#### Excerpt

John 8:        Psychosis to me is just being absolutely drooned off the planet, like floating in space sort of thing, with no idea what's going on or where it's going on or where it's going or stuff like that.(...) but whilst I was on the psychosis, I was just a total zombie, eh.(...) Cos I was put in hospital for taking too many drugs and stuff like that, eh, so getting it all out of my system a wee bit is good.

(...)

**CB:**           **What are your feelings when you have a psychosis?**

John 8:        Cos that's what causes it obviously (...) So therefore psychosis is just a feeling, eh, and you say some stupid crap whilst you're on it, eh.

Borrowed explanations from health professionals or from parents also provided partial accounts, which offered a shared understanding.

Excerpt

Leon 3:        Well, my mum says it's just part of growing up.

**CB:**           **What do you think?**

Leon 3:        Probably I'd say that, I'd say the same.

***Accepting mental health difficulties***

A gradual process of meaning-making was described by a few young people. After initially rejecting the diagnosis it was slowly being accepted whilst still being viewed as a primarily negative abnormality from which one wanted to be cured. In an attempt to understand these experiences, one young woman proactively researched her mental illness. Having the opportunity to discuss concerns with health professionals and friends and learning about the illness allowed young people to reframe their experiences in a positive way. Narratives of reaching acceptance made frequent reference to participants' and others' mental states.

Excerpt

Sarah 4:        I think doing research and just kind of talking to [psychiatrist] about it, and also talking to [boyfriend] about it, as well as having realized that yes, I was insane. Talking to him [boyfriend] about it, he sort of helped me find good things about it that I liked.

Recognizing aspects of one's personality in the description of mental illness helped accept it as an integral non-threatening part of oneself.

Excerpt

Sarah 4:        It's as much part of me, cos it's my brain, as it is my liking of computing. It kind of just made it seem more neutral.

The initial wish to be normal was transformed into a valuing and appreciation of a unique part of one's identity, which made the individual stand out from others. The energy and enthusiasm occurring during hypomania were appreciated the most.

#### Excerpt

Sarah 4: I like being that bit different, and sort of realizing that bipolar disorder is part of that (...) And actually if I could just cure the whole thing, I wouldn't want to.

To emphasize this point, social comparisons were made suggesting that everyone is different and 'insane' to some extent thus normalizing one's mental illness.

Whilst bipolar illness was gradually embraced and accepted as an eccentric personality trait, others had always viewed visual and auditory hallucinations as a normal part of self-experience.

#### Excerpt

Julia 7: Em, I mean I lived with it for most of my life so it's just like part of who I am so I find it a bit weird when someone is like 'oh'. I hadn't heard the term psychosis until I came here so.

#### ***Medical model of illness***

A biological understanding to experiences was common. However, it was employed in different ways across stages of meaning-making.

For some, the medical model offered a ready-made impersonal account and cause of illness, which foreclosed any further need for meaning-making.

#### Excerpt

**CB: Uhuh, so lots of bad thoughts and you didn't want to go out anymore because/**

David 6: Yeah.

**CB: What would you call the difficulties you've had?**

David 6: Em, I don't know. Psychotic disorder or something like that.

On the other end of the continuum, Sarah offered an acceptance of her mental health problems as an integral part of herself, which was nevertheless conceptualized as an underlying biochemical vulnerability.

#### Excerpt

Sarah 4: Yeah, I kind of go with the 'I'm always a bit insane'. It's just kind of. It's me cos the way my brain works. Obviously if I have this bipolar the way my brain works cannot be the normal way. There must be something that changes some of the chemicals and makes them more of one and less of another and stuff like that. So, it's always going to be not quite right whether it manifests itself or not (**uhuh**). And yeah, I am just generally insane, that's just part of me.

### **1.3 b Impact of mental health difficulties**

Psychosis and associated mental health difficulties affected young people's lives on multiple levels. Existential, psychological, developmental, physical, behavioural, interpersonal and social consequences were experienced. With a few exceptions, most of these consequences were perceived to be negative.

#### ***Disillusionment***

On an existential level, experiencing psychosis resulted in disillusionment, which resembled the notion of 'shattered assumptions' outlined by Janoff-Bulman (1992). The psychosis represented a traumatic adverse event, which fundamentally challenged the young person's assumptions about the world, the future and thus potentially undermined a previous sense of invincibility. The following excerpt demonstrates how the psychosis had not yet been fully assimilated into the person's pre-existing belief system. The young man admitted defeat by adopting a fatalistic and pessimistic attitude.

#### Excerpt

**CB: Uhuh. Would you say that the way you experience your feelings, your emotions has changed?**

David 6: Yeah, I don't care what happens to me, you just get used to it. I just got used to bad things happening.



(...)

**CB: What were you like beforehand?**

David 6: With my feelings and stuff? I didn't really think about feelings to be honest (**Uhuh**). Cos nothing really bad happened.

**CB: And now?**

David 6: Nothing really bad happened now but when I was ill (...) don't know.

Disillusionment was related to experiencing low mood as a reaction to psychosis and subsequent self-medication with mood-lifting drugs. Although participants referred to their emotions, they only offered generalized superficial explanations for their disillusionment.

#### Excerpt

John 8: When you've got a psychosis, you're disillusioned so. (...) Because you're feelings, they're just dragging you down.

#### Excerpt

David 6: Na..{2 sec} it's probably things like voices that bring me down I suppose. Just em.

#### ***Disability***

Most young people felt that mental health difficulties had initially restricted and typically continued to restrict their freedom. Both psychiatric complaints and their management were experienced as disabling.

Although most young people had experienced some recovery from the most acute and disabling complaints, voices, compulsions, anxieties, stress and cognitive difficulties continued to interfere with activities. An inability to control voices held one young person back from returning to college for fear of relapsing.

#### Excerpt

David 6: (...) I don't think I'll be able to last. Like going to college this year, I don't think I'll be able to last the whole year (**uhuh**). It's cos I end up relapsing or something like that.

(...)

**CB: Just tell me what do you think would stop you from lasting a year?**

David 6: Cos you constantly have to ignore the voices (...) But when you're out at college, like every day, you're constantly getting them (...)

Behaviourally, a fear of travelling on public transport created a greater dependency on others to get about. To stay well, young people had stopped smoking cannabis and had either stopped or limited their alcohol intake. In an attempt to ensure their child's well-being, some parents reinforced some of these restrictions, which was usually perceived as patronizing. Remembering to take daily medication was perceived by some young people as restricting their freedom and spontaneity. Physical effects resulting from medication side-effects such as increased weight, loss in stamina, energy and motivation were experienced as disabling and challenging to overcome.

#### Excerpt

Leon 3: I set the alarm for half seven and then I find it really really hard to get up.

David 6: Just cos it's harder to do. Just everything is harder to do.

Some young people were acutely aware that they were in some ways more disabled than their peers. Some found it more difficult to interact with others, partly for fear of being stigmatized.

#### **Loss**

Losses of aspects of past self, peers and aspirations were experienced with differing emotional impact. Psychosis appeared to coincide with profound changes in self. Self-experience became increasingly inconsistent and fragmented.

#### Excerpt

Anna 1: And when I look back, I feel I've been taken away in a way (mh) I'm this person that's not actually there any more because I'm not, it's not there, it's nothing like what I was before, nothing.

(...)

One minute I have this opinion in my head and I'm just speaking away or whatever and then two minutes later, phow, I just get this feeling through my body, it's no way, this is not the case and it's different, it's completely different to what I was thinking before. It's not right and then I've changed back again to something completely different. I'm like so confused because I don't actually what the hell.

Self-confidence was undermined by struggling to cope with voices.

### Excerpt

**CB: How would you say has the way that you feel about yourself changed from before you became ill till now?**

David 6: Eh, I probably like myself less, I don't know.

**CB: In what way do you like yourself less?**

David 6: I don't know...{2 sec} not as confident in myself..

**CB: Any ideas why?**

David 6: Na...{3sec} it's probably things like voices that bring me down I suppose. Just em.

Most young people reported losing friends over the course of their mental health problems and having reduced or markedly different social contact since then. A 'network crisis' of this kind is commonly observed following a psychotic episode (McGorry, 1992). Explanations for the initial loss of existing peer relations were the interruption caused by hospital admission, breaks from education, distancing themselves from friends or the gradual rejection by friends, who were not understanding of mental health problems. Responses appeared to vary with regards to level of reflective function. Whilst some clearly considered their own and others' mental states in growing more distant, some young people offered more superficial and at times contradictory explanations, which seemed to minimize the significance of the loss. Interestingly, social withdrawal was not mentioned as a cause for losing friends.

Sarah offered a highly reflective attempt to understand the thoughts and intentions of peers, who were unable to empathize with her mood swings.

#### Excerpt

Sarah 4: Em, I was much more prone to having no friends because they just couldn't cope with the fact that sometimes I was completely different. Fairly understandable from their point of view, cos my friends now struggle to understand it and they're all first year of university most of them. So it's a bit harsh to expect like a 4<sup>th</sup> year to understand it.

(...) my various mood changes force different people away cos they can't cope with them, but other people seem quite fascinated with them.

Some young men provided circumstantial reasons for why they lost touch with friends since the psychosis without referring to their own or others' mental states. They communicated an indifference towards their peers, which could be interpreted as a defense to having to deal with the reality of the loss.

#### Excerpt

David 6: I don't see my friends very much.(...) Em, nothing really changed, apart from I don't see them anymore, as much. Just because I'm not at school, that's one of the reasons. Eh, apart fae that nothing's really changed.

#### Excerpt

Leon 3: When I came back, I left like I had four, I missed like half of my school year and when I came back to school I was in fifth year, an all the people were in fourth year, so all the people in my year had left, so I had to make new friends.

Leon subsequently offered superficial and contradictory explanations for his reduced contact with old friends.

#### Excerpt

Leon 3: Em..{2sec} I've kind of lost touch with most of them, kind of. But I've kept some of them, like I can phone them and meet up in the Centre and stuff. But I've not seen most of them for a while. But other ones I see them around, but I don't like hanging out with them, but some others I do.

(...)

No, I've some of them as well. I'm just saying like, I keep in touch with some of them, like with 3 or 4, but the rest I've not, I don't see that often or I can't remember their faces or something, cos everyone changes, you know what I mean.

Craig initially switched topic after offering a superficial reason for losing touch with friends post-psychosis. He denied any emotional impact of this loss.

### Excerpt

**CB: Like what was it like before, with your friends and stuff and what's it like now? How did it change?**

Craig 2: Well...{3sec} well my mates at school basically stayed near me and the mates now stay in other places and you just can't do the sort of things they do any more because it was triggered off by smoking hash eh, it's proven it can cause illnesses. So I can't do that any more, it makes me worse. Because that's all I used to do was sit around and smoking hash basically. But I feel better for it though.

(...)

Craig 2: Well, I went to hospital for quite a long time as well, just didn't really keep in touch.

**CB: What do you make of that?**

Craig 2: What do you mean?

**CB: What do you make of them not sort of keeping in touch?**

Craig 2: I'm not bothered because I made mates in the unit, only a few like, but that's enough.

Mental health difficulties disrupted education, employment and other valued activities in all young people to differing degrees, which led to some having to suspend or abandon their past professional ambitions. These included wanting to become an athlete, an accountant or an electrician or studying computer sciences.

Whilst some were hoping to return to their premorbid plans, others felt they had to abandon past ambitions. Those who were grieving the loss of their past aspirations varied in the extent to which they had adjusted to and

engaged with a new future. This excerpt highlights the struggle of coming to terms with the loss of a valued activity, which had acted as the sole opportunity for developing a positive sense of self.

### Excerpt

Anna 1: It was just that and then a few years down the line somebody came to the door and my dad was selling my starting blocks, because obviously I wasn't doing it anymore. I mean this was years after but I was crying because I was thinking how good I was at something and I was kind of thinking that I'd made the wrong decision, that just because I was good at it.

### ***Disadvantage***

Educational and vocational setbacks such as missing a school or university year, failing exams, dropping out of school without any qualifications or losing jobs were experienced by the majority of participants. Whilst some were indifferent about receiving benefits or having left school prematurely, others were frustrated by having become socially disadvantaged in pursuing a career due to their mental health problems.

### Excerpt

Rebecca 5: I have no job because I'm finding it hard to find a job that accepts me for my health problems, because all the application forms these days say 'How long have you been in the last year off work?' and I was off for 6 months last year. So, it doesn't help it.

### ***Gains***

Few positive consequences resulting from episodes of mental illness were reported. Within individuals' narratives negative effects typically outweighed minor positive ones. Several young people felt that having been ill had improved their relationships with family members or with friends. Whilst mental illness had imposed restrictions on some young people's lives, it was also experienced as liberating in that it legitimized immature behaviours and helped become more confident in expressing one's feelings. This sense of liberation was associated with acceptance.

### Excerpt

Sarah 4: (...) but on the other hand I feel quite a bit more liberated because I can tell people about it [mental health problems].

## **1.4 b Managing mental health difficulties**

Three main themes emerged relating to how young people managed mental health difficulties and associated emotional distress. Medication was offered to all as a first line of treatment alongside psychosocial interventions and thus occupied an important role in most young people's recovery. In addition to medication, a diverse range of coping strategies was reported. In keeping with theories on coping in severe mental illness (Roe et al., 2006), choice of coping strategy is not only dependent on appraisal of the 'stressor' but also on appraisal of self and of one's ability to control the 'stressor'. The latter aspect emerged in young people's beliefs about self-efficacy and perceived control over emotions and symptoms, which appeared to influence their choice of coping strategy and seemed to be related to their level of meaning-making. The importance of explaining and trying to manage mental health difficulties effectively mirrors two tasks of recovery identified by Spaniol and colleagues (2002).

### ***Medication***

All young people were receiving pharmacological treatment consisting of different combinations of antipsychotic, mood-stabilising and antidepressant medication. Overall, medication was considered to be helpful in managing psychotic and affective complaints despite causing significant side-effects and set-backs.

Most attributed improvements in mental health to medication. This was reflected in statements about faith in their efficacy and recognition of their importance for staying well.

### Excerpt

Leon 3: Yeah, my number one would be medication. Cos I so much trust it like, I just, I've been so well since 2005, I've been. I find

if I didn't have medication, I don't think I'd be where I am (mh).  
That's why I take my medication so seriously.

Faith and compliance was maintained despite experiencing repeated changes and readjustments in their medication, which was described by some as involving additional physical monitoring, worsening of symptoms, unpleasant side-effects and at times distressing and life-threatening medical negligence.

### Excerpt

Rebecca 5: But the overdose thing, I was put on lithium when I was about 14, 15. And the doctor at the time, no, I must have been 14, 15, didn't take my blood before I was put on it (...) I just, I was sick everywhere (...) I was being sick in the taxi and, em, and that we had to phone for the on-call doctor, who told me I had an overdose, and I was like 'I didn't take an overdose!', and yeah, then they worked out it was the lithium and they took me off it straight away (...)

Whilst some believed ongoing medication to be critical to their well-being, others were hoping to stop taking medication eventually. Antidepressant medication was experienced as being counter-therapeutic by blocking emotions, which would normally be expressed through creative writing or composing.

### Excerpt

Julia 7: There was one I just kind of felt I was like...{2 sec} putting a stopper on sort of my emotions and stuff. So it was like I probably seemed better on the outside but I felt just as bad but I just couldn't let any of it out properly.

### ***Coping strategies***

A diverse range of adaptive and maladaptive strategies to cope with mental health difficulties and emotional distress were employed with variable effectiveness. The complexity of coping strategies appeared to reflect the heterogeneous profile of difficulties young people experienced. The choice of coping method appeared to be influenced by beliefs relating to self-efficacy and to meaning and controllability of mental health difficulties and emotions. The range of coping strategies varied within participants. Some were

resourceful and confidently applied a wide range of adaptive strategies whereas others' repertoire consisted of a few maladaptive methods.

Strategies employed included behavioural techniques to lift low mood, such as general activation, exercise, engaging in pleasurable activities or creative writing, singing or composing. Social support was sought out frequently either to provide a secure interpersonal environment to help contain emotional distress or to provide practical material support to overcome disabilities. Others found relief from a depressing reality in mind-expanding experiences such as pondering the spaciousness and infinity of mind, which in some cases occurred with the assistance of hallucinogenic substances. Intense emotions such as irritability, depression or hypomanic feelings were successfully downregulated by means of self-soothing, distress tolerance and self-instructional relaxation. Some participants applied problem-solving whereas others were more emotion-focused and tended to dwell on negative emotions. Avoidant coping strategies such as alcohol abuse, social withdrawal, inactivation and distraction were also used to deal with emotional distress and symptoms.

The only strategy consistently employed across participants was to create a secure interpersonal environment when distressed. Seeking company and emotional support of family, friends or spiritual guides provided a sense of containment, as the following comment illustrates.

#### Excerpt

**CB: So what else has helped you?**

Sarah 4: Talking to people. Makes a big difference (uhuh). Em, so I think a lot of the things I do require other people. Like doing a crossword with my mum. Em, or playing, a videogame with [boyfriend]. Sitting watching TV with my dad. It's all, quite often having other people there that I know very well can be really good.

**CB: What do you think is helpful about having other people there?**

Sarah 4: I'm really not sure cos normally I'm not that big a fan of like other's people's company but if you're really depressed and I'm

in that kind of mood, it just seems to be exactly the kind of what I need. I don't know why it works.

**CB: What does it do, do you think?**

Sarah 4: I'm really not sure but I mean it makes me feel safe, that's one of the things. Em, ...{3sec} but...{3 sec} and it let's me know that I'm cared for that the person is actually willing to sit there and talk to me. Other than that I have no idea, but it seems to work quite well.

### ***Beliefs about managing mental health difficulties***

Young people showed different levels of motivation and confidence in their ability to overcome mental health difficulties. Coping strategies varied according to their assessment of how they felt they were equipped to and willing to deal with their distress. Appraisals of perceived control over emotions and symptoms ranged from hopelessness and low self-efficacy to optimism and successful self-control.

#### *Helplessness & Numbed emotions*

A sense of helplessness and hopelessness to achieve control over mental health difficulties was communicated in the following comment.

#### Excerpt

Anna 1: Not a lot, nothing helps a lot that I try myself and do. It did used to, things work and then as I said I change all the time, every two minutes or whatever, so I keep changing and getting, ah, nothing's working for me. That's what it's like.

Disillusionment with being able to help oneself coincided with a numbed post-psychotic emotional experience and difficulty in self-regulation. Since her psychosis, Anna had felt dissociated from her experience, particularly her emotions, which she therefore found more difficult to regulate.

#### Excerpt

Anna 1: I don't get upset very much now, em, because I don't actually know how to actually get upset a lot of the time and then sometimes...{2 sec} I cry, that's the best relief ever,(...) Em, but nowadays it's rare so I feel like all, I feel awful in fact because of the fact that I don't feel in certain ways now, because it freaks me out. It worries me that I'm a bit numb.

*Low self-efficacy & avoidant coping*

Another adaptation style was characterized by low self-efficacy combined with a belief that emotions were unchangeable. This coping attitude was observed in the context of a general lack of motivation, passing personal responsibility for well-being to others, relying on family for daily living as well as passive avoidant coping. Young people talked in dismissive or naïve ways about how health professionals could help them, which was indicative of poor reflective functioning.

Excerpt

**CB:**           **What do you do when you get down and depressed?**

Craig 2:       Nothing basically.

(...)

**CB:**           **Who do you think would be more likely to be able to help you?**

Craig 2:       Nobody.

**CB:**           **Really, how come?**

Craig 2:       I don't know. You're depressed, you're depressed and you cannae just cheer up on command and just because somebody talks to you it doesn't mean it's going to improve your mood that much.

(...)

Craig 2:       I cannae see a psychiatrist all the time just repeating myself.

Passive coping such as doing nothing and withdrawing from others were employed although young people were aware that these strategies maintained distress. Responsibility to manage one's distress was passed to health professionals despite often feeling ambivalent towards staff.

## Excerpt

**CB:** Do you know what makes the difference between sort of staying in bed and not doing anything about it and dealing with it?

Rebecca 5: Em, suppose it depends on my mood and how badly I've been affected by it. Em, occasionally, no, sorry I can't be..{2sec}, in fact if it's like happened when it gets to the time that I have a meeting during the week. Say it's happened over the weekend and I've got a meeting say in the first half of the week. So, I've not got really much of a chance to think about what I'm going to do before I speak to somebody here. I usually like end up getting, I usually end up working it out here than deal with it through that than deal with it that way.

(...)

**CB:** What does it do to the upset feeling, staying in bed?

Rebecca 5: (Laughs) probably makes it worse. No, when I'm down I don't eat, I don't leave my bed, I don't drink much, I don't, I turn my phone off. My phone is always on. I refuse to go check my emails, I, I lose contact with anybody. I cancel my meetings with people here [psychiatric service] but I do it in a sly way, like em, cos you can tell by my voice if I'm down most of the time, so I'll text (laughs) and I won't say something like 'I'm not able to make it cos I'm ill or down', I'll just put 'Sorry, will not be able to make it'. I just make it, you know, simple. They think I've got something else on, sort of thing, and then my dad phones in (laughs), so yeah I don't know.

### *Self-control & stoic suppression*

Determination, self-discipline and self-belief were the hallmarks of successful recovery. Pushing oneself to reengage with normal activities shortly after discharge helped overcome many of the secondary disabilities such as anergia, weight gain, disruption to schooling and peer relationships. Setbacks experienced from the psychotic episode even increased resilience in some.

## Excerpt

Leon 3: Just being more, just being confident in myself and believing in myself, that if I can get through this day, I can get through any other day. That's what I always say to myself. Like in the morning when I feel really down, or from the last day or I had a terrible night (...) Just keep my head up and try.

Primary affective difficulties were successfully addressed by self-instructional relaxation. Learning to control arising irritable or elevated mood by mindfully observing oneself and calming oneself down provided a means to gain mastery.

#### Excerpt

**CB: Is there something about not getting too high?**

Leon 3: Yeah, so I can like, you know what I mean, go too high so I can't control myself again, you know what I mean, so I just try and watch what I'm doing. (...) Just take deep breaths and, or like not go too high. Like to relax, like just calm down. Say if someone is moaning at me, I go and like, instead of having a big argument, or if I do, I have a wee..{2sec} or if it's getting a bit out of hand, I just stop, just calm down.

Losing control of emotions was perceived as threatening as it had been the defining feature of psychosis. Maintaining strict self-control was thus a way of protecting self from relapse. The internalized expectation to cope and function normally seemed to be partly imposed by familial expectations to be a mature role model to younger brothers. Emotional restraint – due to fear of stigma and a gendered expectation that 'boys don't cry' – fostered suppression of unpleasant emotions, particularly traumatic memories related to the first episode. A sense of underlying but suppressed depression and even suicidal intent was communicated in this hypothetical scenario.

#### Excerpt

**CB: Do you cry sometimes?**

Leon 3: Sometimes I feel like crying but I don't cry.

**CB: How come? Why do you not cry even though you feel like it?**

Leon 3: At home, I'm like the bigger brother and should set an example, like if they see me crying it's ok for them to be crying, you know what I mean (**uhuh**). They're quite old now, well not old but, I'm old. You don't see my dad crying. If I see my dad crying, well then, it must be serious. Well, I think about crying, I like I think like, I go and take my medication 'Oh, I'm taking my medication', then think like of taking an overdose and start crying and everything you know.

**CB: Has that happened?**

Leon 3: No, I'm just thinking of an example.

### *Acceptance & mindful self-compassion*

An equally high degree of self-efficacy was associated with the adoption of a self-compassionate and accepting stance towards dealing with uncontrollable emotions. Emotional distress and self-harming impulses were successfully managed through self-soothing, distress tolerance and seeking others' company in a preventative manner. Such coping appeared to involve a high degree of awareness of changes in one's mental states.

### Excerpt

Sarah 4: Ideally, I'd notice it as I start to just drop my mood. If it was lunchtime, which it is nearly now, I would phone [boyfriend], because he won't be in class. Em, I try just going and doing something that I always enjoy like putting a film on, playing a videogame or just trying and doing something that I enjoy before it gets too bad so I don't enjoy anything **(yes)**. Em, if it does get that bit worse, generally I opt for a sort of curling up and just kind of embracing the fact that at the moment I don't feel good **(uhuh)** but I'll just keep myself safe and fairly contented as much as possible **(ok)** and like I'll go before I do it I'll make a drink and get some food and put it on the table, just like crisps and chocolate, junk food but kind of comforting food **(yeah)** and I'll just have it there so that as soon as I get a vague passing 'Oh, I could do with some food' it's there and I can eat it. Cos if I have to go to the kitchen for it, I won't do it **(yeah)** so I just try and ride out the storm either until my mum gets home or it just passes by itself.

### **1.4 c Averting stigma**

In addition to trying to make sense of their mental health problems for themselves, young people also faced the challenge of managing their experiences in interpersonal contexts. Most young people found themselves having to account to friends for odd behaviours, increased withdrawal, mood changes or periods of absence. Most participants described strategies of disclosure which served to avert negative social stigmatization. Most cases intended to appear 'normal' to others whereas one participant wanted others to accept her unique 'insane' personality aspects.

### ***'Coming out'***

Negotiating insanity with oneself anticipated 'coming out' to others. By accepting and integrating mental illness as part of self, both self-stigma and social stigma were thought to be averted. Making social comparisons and valuing the positive aspects of mental illness fostered self-acceptance. The use of sarcastic self-defense preempted potential negative stigma in social interactions. Being officially 'insane' also attracted positive interest of peers and thus provided opportunity to educate others and promote social acceptance.

#### Excerpt

Sarah 4:       And if I embrace the whole 'being insane thing', it means I don't tend to get offended when like people try and use it as an insult, cos I go 'Yeah, I know. Yes, I'm insane, I already knew that. Thanks.' (laughs). It's a self-defense thing as well.

### ***Impression Management***

This strategy was preceded by the realization that psychotic experiences constituted a socially unacceptable reality, which was not shared by others and would be likely to result in negative reactions. Young people had quickly learned to hide their internal experiences when interacting with others.

#### Excerpt

Anna 1:       So now I know that when I seen things that are unrealistic I just keep them to myself. I know what I see and I don't explain it to people or try to because it would make me angry because they wouldn't understand and I wouldn't have anybody to speak to ever because they would just be running away again like they used to.

Whilst some continued to believe in the authenticity of their internal reality, others had split off their psychotic experience from their normal self and were profoundly ashamed by it as it threatened their social identity. In anticipation of being marginalized and humiliated, the hospital admission was kept 'my little secret' (Leon 3) and a non-stigmatizing story was fabricated to account for absence from school and any other observable changes related to psychosis.

### Excerpt

Leon 3: You know it's a lie but I just, I don't want anyone, I don't want anyone to know about like I've been to hospital and they'd say like, I'd be like the outcast and nobody would wanna talk to me or they'd like make fun of me or something like that.

A socially acceptable façade was maintained despite facing intense questioning by peers about being absent from school.

### Excerpt

Leon 3: Like say, at PE, like I got PE, I had PE today, I was changing and somebody goes 'You got well bigger' and they'd say 'How did you get bigger?' and stuff and like I go 'Oh, I just ate a lot and didn't do any exercise' and they'd go like 'And where were you like?' and I'd say like 'I was like in London with my mum'. And I says 'right'. 'And why would you not come to school?' I says like 'I've had a fall out with my dad.' 'Ah, what a shame'. So just think it's normal.

### Excerpt

Anna 1: But now I can speak to people sociably without freaking them out because I know what to say and what not to say.

Whilst some appeared to be satisfied with the success of creating the desired impression and thus protecting and strengthening their premorbid social identity, others expressed a sense of frustration about not being able to show and share their authentic self, which was unacceptable to society.

### Excerpt

Anna 1: Sometimes I really want them to see me for the person I am inside rather than the person I come across outside.

### ***Superficial mediated disclosure***

This strategy was also strongly associated with efforts to keep up appearances for fear of stigmatization. Irreversible disclosure had occurred when parents had informed friends of the young person's mental health difficulties to account for their absence. In an attempt to disguise any psychotic experiences and to reverse the disclosure, young people subsequently avoided revealing any details about their illness to friends.

### Excerpt

David 6: I don't tell them that much about it. I just, I just get on with it. I just keep it to myself really (**uhuh**). So they don't really, apart from me going quiet and stuff like that they don't really notice.

(...)

I just said I was, I've got a mental health illness thing. And my mum told them, I didn't tell them. And that's about it really. I told them I was hearing voices and, I've not told them what my thoughts were or anything like that.

Unlike participants who gave reflective and insightful accounts of their motives behind and feelings about their stigma-averting strategies, David denied being concerned about stigmatization by his friends and claimed ignorance about his motives for not wanting to tell his friends.

### Excerpt

David 6: I just didn't want to tell them when I was ill. I don't know why I didn't want to tell them.

**CB: Why? Here comes another daft question. Why did you not want to tell them when you were ill?**

David 6: I'm not sure.

**CB: Looking back now, what do you think, why did you not want to tell them?**

David 6: Em...{3sec} I don't know..{2sec} probably was a reason but I just forgot.

(...)

**CB: What did they say? How did they react to you telling them?**

David 6: I mean they were shocked to be honest. Like I spoke to them about it and they were shocked and.

**CB: What else did they do or say?**

David 6: Eh, nothing really. Just spoke to me the same and..{2sec} I don't know.

**CB: Uhuh. Do you remember how you were feeling before you told them?**

David 6: Eh...{3sec} not really. Probably just nervous or something like that.

**CB:**            **Why would you have been nervous do you think?**

David 6:        Just how they'd react, I don't know.

### ***Necessary revelation***

Hiding inner experiences from others was common amongst young people. Other participants felt they had to tell their family and friends once their difficulties became visible to others and impossible to conceal. Despite initial misunderstandings such a disclosure was received in an empathic and caring manner.

### **Excerpt**

Julia 7:        Yeah, em, most people are ok They'll ask sort of what, how I am doing, what is happening and who have I got to see this week and anything, but it's good, kind of nice sort of. I mean noone is like weirded out by anything.

### ***Negative cases***

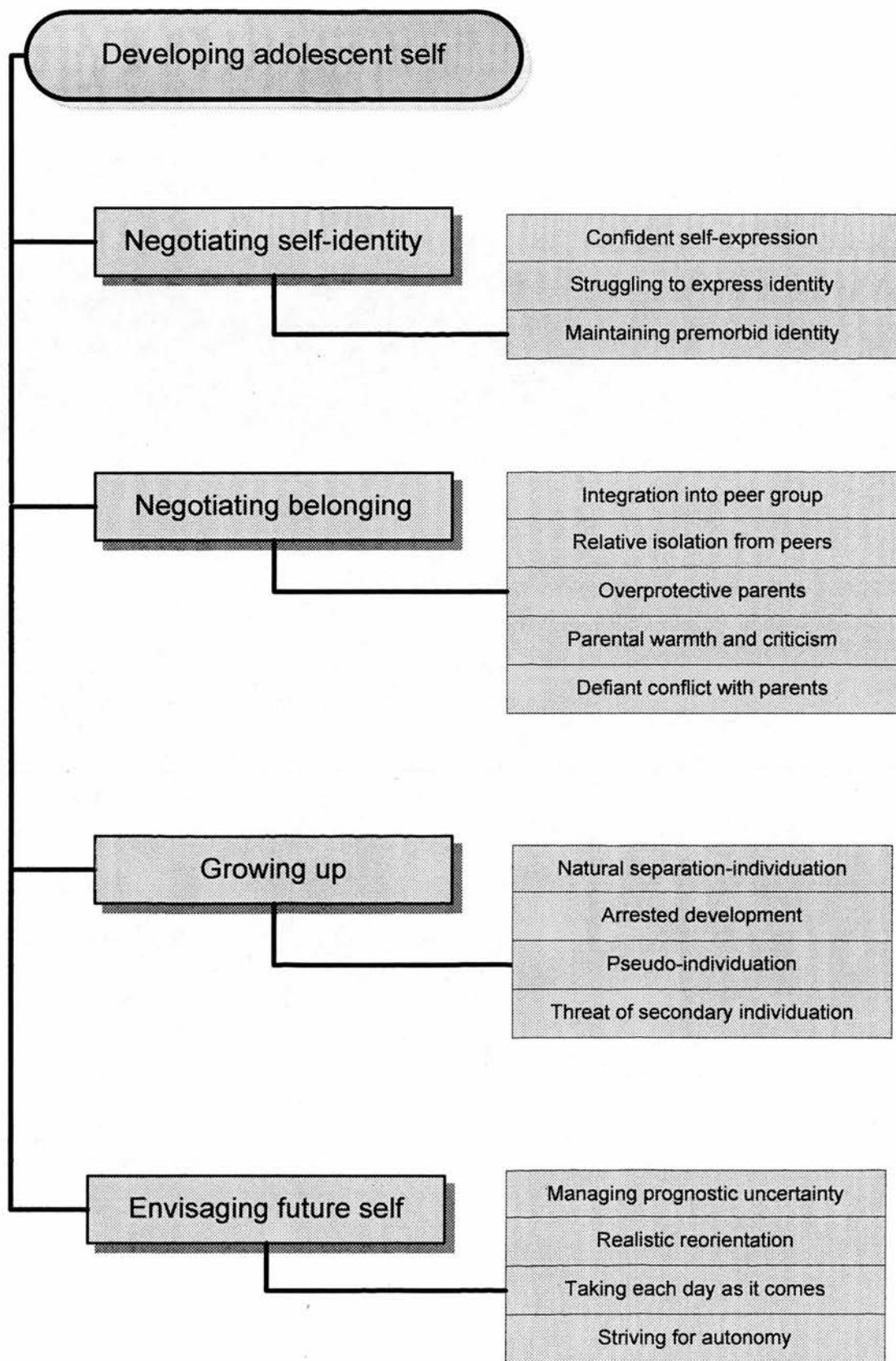
The exception to the outlined stigma-averting strategies was a young man who embraced a positive identity of being a substance user. His psychosis was not perceived as a threat to his social identity as it readily involved altered states of consciousness. Psychosis was therefore merely viewed as a 'bad trip', which was a common experience amongst his peer group.

The remaining two participants both tended to identify with their mental health problems. Their opportunity to be stigmatized was however reduced since they either only socialized with close family and friends or because their peer group consisted of young people with mental health difficulties or other marginalized identities.

### **Main theme 2:        Developing adolescent self**

Mental health difficulties occurred in the context of a developing adolescent self around the ages of 11 to 18. Psychosis tended to develop around middle to late adolescence between the ages 15 and 19. The negotiation of normative developmental tasks such as forming an identity outside of the family, achieving a sense of belonging with peers, separating from parents

and dealing with challenges of growing up and looking into the future were talked about with and without relation to mental health difficulties. Narratives clustered around four themes related to adolescent development (see Figure 2.3).



**Figure 2.3** Overview of subcategories related to main theme 2

## **Subcategory 2.1 Negotiating self identity**

The interaction between mental health difficulties and a developing identity was managed differently by young people. Some split off their experiences from their 'normal' premorbid selves. Others struggled to integrate their experiences into their partially developed identity since actual or perceived stigma precluded them from gaining validation from others. A few participants integrated their mental health experiences either as part of or as the whole of their identity.

### ***Confident self expression***

Most participants recalled lacking confidence when younger, being shy, feeling different from others, and being relatively unaware of self or emotions until early adolescence or even the onset of mental health difficulties. Some young people described having developed increasing self awareness over the course of adolescence. Being confronted with intense emotions and unusual internal experiences during mental illness led some to learn more about themselves. Most had an awareness of themselves as having always been different from others. Some young people had learned to accept their sense of being different by realizing that 'everyone's different' (Anna 1). Although mental health difficulties had posed a challenge to identity formation, these young people had continued to develop a sense of self, which to a greater or lesser extent incorporated mental health difficulties.

Identity formation had been partly achieved by some young people. Affiliation with youth subcultures provided a source of pre-established identities. Outer appearance and lifestyle choices helped to find 'self' by way of communicating the newly acquired identity to others.

### **Excerpt**

Rebecca 5: (...) But I'm more confident in who I really am.

**CB:**           **How come? What made that happen do you think?**

Rebecca 5: I suppose I am finding myself more these days (laughs). Like most people, most people find themselves when they sort of, I don't know, I find myself through different clothing, piercings, tattoos, all sort of stuff I go, I am in the weird and wonderful world of everything and yeah.

This self-concept was however inseparable from experiences of longstanding mental health difficulties.

#### Excerpt

Rebecca 5: So I've not really been off medication for long enough to know what I'm like without it and I've changed so much over the last 5 years that I don't know what I would be like, so I could be totally different, so yeah.

Some young people had come to recognize multiple aspects of themselves. Their sense of self and autonomy had continued to develop in the context of mental health difficulties. Illness-related traits were integrated and accepted as an integral part of self, which allowed some participants to freely express themselves whilst embracing the risk of possible rejection from others. An ability to reflect on one's own and others' mental states appeared to be a prerequisite for arriving at these insights about self, as can be seen in the following excerpts.

#### Excerpt

Sarah 4: There's me when I'm manic, there's me when I'm depressed, there's me when I'm paranoid, which is fairly similar to the depressed one but only slightly different so. There's normal me and there's the grown up bit of me, and there's the completely amazingly childish bit of me (**uhuh**) (...) And there's these bits of me that to a lot of people appear to be quite autistic for some reason (...) But they're all me and they're just my way of looking at myself that they're all separate whereas in fact they're all just slightly different sides of me but I view them as slightly different bits of me.

#### Excerpt

Julia 7: It's much the same, but I've always had quite weird self-confidence cos like, I'm quite self-confident in that I make friends really easily, I chat to complete strangers and I can be quite loud and I'm always running off to other countries and stuff to see concerts and stuff so I guess, I can't use telephones because they frighten me (laughs). So, it's things like that I'm really not confident with at all, so it's quite warped.

### ***Struggling to express identity***

Ego identity or self-image comes into being by being recognized and validated by others, and is therefore inherently social. Recognition from

others confirms one's existence (Sartre, 1943/1957). A dilemma arises when identity formation is blocked by social prejudice. Despite having become more confident socially and more self aware, some participants struggled to express their identity because their perception of reality was socially unacceptable and was anticipated to lead to social rejection. Whilst having developed a stronger sense of self internally, it was left invalidated by others, which hindered identity development. Fear of stigmatization also prevented some young people from building new authentic relationships.

#### Excerpt

Anna 1: Em, I feel like it's a bit annoying at times. It can be really annoying in fact still because I'm like ...{3 sec} because I'm not exactly being who I am because of the way other people are. That annoys me.

#### Excerpt

**CB: (...)** say you meet somebody you don't know (uhuh), em, how would you manage your experience?

David 6: That would be harder to tell cos I don't know..{2 sec} I've not really tried that. I was gonna try that at college when I was gonna go back but. And I tried to do it with [Psychologist] and stuff but.

**CB: Oh, did you/**

David 6: /Yeah, but I didn't do it, cos I didn't go back, so didn't have to do it. Probably part of why I didn't go back.

Lack of validation and understanding from others, unintegrated loss of past self and ambitions and psychotic experiences themselves led to self-criticism, self-doubt and generally undermined self-confidence.

#### Excerpt

Anna 1: No, sometimes I think I was a nutter, I'm an asshole.

(...)

And then sometimes though if it's a bad day I'll think, oh my God, am I really that stupid? Because I can't even get my sister to tell me that I'm not.

According to attachment theorists (Fonagy, 2002), the absence of any kind of recognition communicates a negative message about the loveability and worth of self, which the infant typically internalizes. When older, the individual then projects out his or her own negative self-image on to others. The following quote illustrated angry preoccupation with an environment that was perceived to be invalidating and humiliating. Resultant habitual pattern of acting out how one was expected to be treated by others perpetuated reluctance to express any authentic feelings and exacerbated fears of stigmatization. Real and anticipated invalidation from others posed a barrier to connecting with others.

#### Excerpt

Anna 1: But these folks are thinking that I'm stupid and I don't know what they're doing or saying, whatever they're at, they don't understand that I know because they really do believe that I'm stupid and I'll act it, I'll just act the goat because I don't see the point of causing aggravation for nothing. That's basically what I meant by don't treat me like I'm a doormat.

#### ***Maintaining premorbid identity***

Some young people managed to preserve their premorbid social identities. Re-engaging with 'normal' activities with peers enabled young people to realign themselves with their premorbid selves and to reconnect with others. Valued pre-psychosis activities involved heavy substance use, going out to gigs with friends, playing sports with friends or attending school. A strong identification with drug use provided a positive sense of self associated with a cohesive peer group, recognition from peers and high self-esteem despite contributing to the development of psychosis. The benefits of a positive social identity appeared to outweigh the costs of continuing to engage in risk-taking behaviour.

#### Excerpt

John 8: And everybody knew me as the guy that could take bongs (...) and every time I took a bong and no matter how much you filled in the bong, no matter what, how much you put in it, I had to clear it in a onner, eh. I was well known for that.

(...)

cos I was put in hospital for taking too many drugs and stuff like that, eh, so getting that all out of my system a wee bit is good cos now I can just take my drugs now and just sit back and relax, eh, and no problems with anything, eh.

Overwhelming and undignifying psychosis memories continued to threaten the normal social self. To protect one's social integrity, the illness experience was split off from the core self. The following excerpt provides a present tense trauma narrative of hospitalization followed by a borrowed explanation for psychosis suggesting that the ill self had not been sufficiently integrated into the core self.

### Excerpt

Leon 3: I've been made to like move and then shouting and being knocked down and waking up again (**mh**). It's like behaving strange. And then my parents come and they see me. And my little brother crying.

**CB: Mh. How do you make sense of all that now? You say you don't think about it but I am just wondering, you know.**

Leon 3: It's quite a sad time. Not really a good time.

**CB: How does it fit in with the rest of your life, do you think?**

Leon 3: Well...{3 sec} my mum says it's just part of growing up.

**CB: What do you think?**

Leon 3: Probably I'd say that, I'd say the same.

### **Subcategory 2.2 Negotiating belonging**

Most young people recall having some positive peer relationships during childhood. However, reports of being bullied, feeling different from others, feeling underestimated and misunderstood pointed to significant invalidating experiences with peers, teachers and parents. Negative sexual experiences further undermined the developing sense of self. Resulting mental health problems led to further peer rejection, social isolation, and loss of meaningful goals. Three participants clearly describe socially withdrawing prior to and around the time of emergence of psychotic experiences.

Most young people, especially those who spent weeks to months in hospital, experienced a disruption to their peer relationships, which in some cases had already been weakened due to preceding social withdrawal. With the exception of one participant, who felt supported by her boyfriend throughout her illness, romantic partners were rarely mentioned. Some mothers informed friends of participants' mental health problems and hospitalization to account for their sudden absence. Overall, the psychotic episode represented a challenge to young people's social network, which was affected to different degrees.

Most young people experienced a change in their peer relations following the onset of their difficulties. During acute phases of illness, most experienced a reduction in their peer interactions whilst relationships with immediate family intensified. Following these critical periods, a few young people remained relatively isolated with family and health professionals as their main social contact, whilst most young people managed to either re-establish contact with old friends or sought out new peer groups.

### ***Integration with peer group***

Contact with old friends was reestablished in some. Whilst some were content with remaining in their old social circle, others maintained reduced contact and sought out new peers.

In some cases, losing older friends was followed by making new friends during the adaptation period. The loosening of old networks led to a reorientation and search for new and different peers in some. Leaving school to attend day services, changing class, going to college or to university often created natural opportunities where young people could make new friends. Identification with particular youth subcultures and even with psychiatric services facilitated the process of making new friends and thus provided a social platform for forming an identity.

### **Excerpt**

Rebecca 5: (...) and it's weird cos I'll go into [nightclub] and there's usually someone that's been here [adolescent psychiatric services] in

there, that's seen me in there. I've had people come up to me in the toilet going, 'You used to go to the, em, [adolescent psychiatric service]?' And I'm going 'Excuse me?' (laughs). 'I've seen you in the waiting room.' 'Em, heya (laughs), I'm [name].' It's just how you make, you know what I mean, it's helped me make friends, it's quite funny, it's like, aye, just like.

Some sought out a more eclectic and diverse range of friends, which was more reflective of participants' developing interests. Others flourished amongst somewhat younger peers, who positively valued participants for their mental health difficulties and by virtue of being older.

#### Excerpt

Sarah 4: Em, but they see me as being kind of different to them but in a good way (**uhuh**) which is very different from my friends at uni, which see me as different to them in a bad way. So my 5<sup>th</sup> year friends, there's kind of a lot of respect from them and we got on really well, em, (...) but it's just like I feel like I'm being accepted for who I am because they all knew that I was completely insane really before I joined their little group (**uhuh**) whereas my friends from like school they didn't.

An overly idealized projection of the cohesiveness and solidarity existing amongst the new peer group at school may have served to reduce fears of being 'found out', humiliated and marginalized for having experienced psychosis.

#### Excerpt

Leon 3: But in like 6<sup>th</sup> Year we have a common room and everyone goes there, so everyone like hangs about together, so..{2 sec} so everyone is everyone's friend.

(...)

Well, everyone looks after each other cos we're all 6<sup>th</sup> years. (...) There's a small group of us, so, it's just, it's not like two people going away and crabbing in the corner, everybody stays together and we just chat and stuff, and help each other out with things like homework and stuff.

### ***Relative isolation from peers***

Other young people remained relatively isolated post-psychosis despite in some cases having become less egocentric, more confident and wanting to build new improved relationships.

#### Excerpt

Anna 1: I've had time on my own to realize who I am as a person and my own needs and that the world does not revolve around myself so much now and that you do need other people as well in life. That's the stage I would say I was at.

Mistrust of others was the primary barrier to relating. Interactions with others seemed to threaten the integrity of self and were therefore avoided.

Protective self-aggrandizing beliefs about self, which could only be maintained in isolation, threatened to conflict with dehumanizing other-self evaluations. Fear of further invalidation from others and lasting frustration contributed to ambivalence to engaging socially.

#### Excerpt

Anna 1: But then other times I'm quite happy with it because I think, well fine then if you think that, like more fools you lot, but ...{3 sec} I mean it's a kind of angry feeling both ways but the other way I try and think that I know things that they obviously don't know I know and it makes me feel better.

(...)

But I think they've got small minds quite a lot of the people in my own head because they're thinking she's stupid and I'm thinking I'm not really that stupid as you think.

(...)

and they treat me as a walkover, like somebody that will, it's like they almost don't realize that I know things in my brain that click to things they are saying or doing to me because I've got a, if they think I'm thick-skinned and some things don't get to me, are not getting to me, but I know exactly what they folk are saying or doing but seen it's not actually hurting my heart or getting to me in the brain and I'm thinking ah, that's their fault and downfall.

A paranoid internal working model of others was maintaining isolation from others. It was felt that talking to others about internal experiences was pointless as others were intending to manipulate one's personal beliefs.

Excerpt

**CB: Would you say they [mental health professionals] are helping you to do what you want to do?**

Craig 2: No.

**CB: How come, why is that, why is it not happening?**

Craig 2: Because they try and change my mind and my beliefs and my condition.

**CB: Who could do that?**

Craig 2: Nobody, I'll always believe what's happened, to me it's real and nobody can change that.

(...)

**CB: Who gets you the most? Who really understands?**

Craig 2: Craig.

Mistrust of opening up to others was communicated when Craig refused to explore the reason of why he was unable to travel on buses.

Excerpt

Craig 2: Yeah, I mean I rely on my dad a lot.

**CB: Why is that? Why do you have less freedom in that way?**

Craig 2: I'd rather not say.

Although admitting to the fact that his main contacts were family and health professionals, Craig made a somewhat generalized statement about him getting on with many people.

## Excerpt

Craig 2: (...) And I see [friend] once a week and I see [CPN] once a week and we go along to the funpark. So I'm getting along with a lot of people, my favourite sport, eh, that's how.

Pre-psychosis relationships with parents were marked by conflict related to arguments around defiant or rebellious acts - such as drug use, antisocial behaviour - emerging mental health problems or other intrafamilial tensions in most young people. Conflicts were typically focused on mothers.

All help-seeking was initiated and supported by parents. Parents were supportive during hospital stays and provided welcome distraction and entertainment. Some young people mentioned parents' reactions to their mental distress. One mother took a break from work seemingly to deal with her own distress and to support her son. Parents also struggled to come to terms with the psychiatric diagnoses given to their child.

### ***Overprotective parents***

All parents continued to support their children during their adaptation. Parents' concern for their children's mental health led some of them to become overprotective. However, support from parents was perceived differently: whilst some enjoyed being cared for and not having to take responsibility for their own lives, others felt held back and suffocated by their parents' concern, which interfered with the natural process of separation during late adolescence.

Those young people who felt their parents' caring behaviour to be partly counterproductive for their well-being and development were able to provide a reflective account taking into account their own and their parents' motivations and emotions. Parents' well-intended actions were at times perceived to be insensitive to participants' needs. Furthermore, young people felt under pressure to alleviate parents' worry by proving to them that they were doing well.

### Excerpt

Anna 1: It's quite a difficulty because they act in a way, they're concerned about me more than I am, right.

(...) but whereas they are seeing it differently, they've never been in my head so they worry more and it worries me more when they worry and it's like a weight on my shoulders constantly because you feel you've got to keep proving yourself to your mum and dad to keep them happy because you don't want to make them worry (...)

Kind of like they make me iller in some ways, and it's horrible to say, but because it's your mum and dad and they love you so much, but it doesn't mean they really know you as much or understand you.

Other young people accepted responsibility for eliciting at times overbearing caring behaviour.

### Excerpt

Sarah 4: And just like people generally trying to take care of me, occasionally more forcefully than I'd like (**alright**) but it's usually for my own good and it's usually my own fault so I can't usually complain.

Some parents imposed restrictions on young people in an attempt to help them stay well. Most participants readily accepted limit-setting and monitoring, which was perceived as caring.

### Excerpt

Leon 3: Like on my birthday my dad like saying, you know like, well, when I had two beers, like saying 'Don't have another one because you're not meant to because of your medication.' Sometimes my dad says 'Don't go out', cos...{3 sec} even though you're not feeling that, like, 'You've been in hospital and stuff so take care what you're doing.' Just watching out for me.

### ***Parental warmth and criticism***

Many young people felt that their relationships with their family members had improved during the recovery period.

Some young people noticed being less critical and argumentative with their parents. Previously irritating maternal criticism had been reframed as a welcome motivation to overcome disabling avolition post-onset. David 6 repeatedly claimed to be ignorant about his mother's or his own mental states, which might have been underlying any criticism.

Excerpt

**CB: How would you say things have changed with your mum, if at all?**

David 6: I probably don't, I probably don't moan at her as much.

**CB: Did you use to moan at your mum?**

David 6: Eh, I used to like, I don't know.

**CB: When did you use to moan at your mum?**

David 6: I don't know it's just like all the time really.

**CB: Before you became unwell?**

David 6: Yeah.

**CB: Can you tell me a bit more about why you would moan at her and stuff?**

David 6: I don't know.

**CB: Lots of young people do, that's normal.**

David 6: I don't know.

**CB: What might she do for you to moan at her?**

David 6: I think, I don't know, tell me to do something or, I'm not sure.

(...)

David 6: I don't know. My mum always asks me to do things that I don't want to do. That helps, somebody pushing you to do it.

In another case, parents no longer criticized their daughter for having erratic moods as they now attributed them to her mental illness, which improved understanding, communication and allowed them to show more warmth towards each other.

### Excerpt

Sarah 4: Em, grew up, mood changes for me got worse, eh, far more arguments with my parents, most commonly with my mum **(uhuh)**. Em, but sort of, with the whole bipolar thing, it made my mum realize that a lot of it is not my fault. It's just me. And that with her being able to understand it bit better, she's become more understanding of my way of thinking **(uhuh)**, which she doesn't always approve of what I'm doing, means she doesn't just get very cross. She usually finds a more constructive way of like telling me to stop it **(aha)**...But with my mum it's changed a huge amount. Em, and certainly with having come back from [university city] em, she's so incredibly supportive and it's just made me really realize that I might not always see how much she cares for me but she really does **(uhuh)** and when I have a crisis she will be there **(uhuh)**, which is really reassuring to know actually.

### ***Defiant conflict with parents***

Others reported deteriorating relationships with parents post-onset. Conflicts arose due to spending too much time together at home and a perceived lack of empathy for the young person's mental health problems. The following account lacked coherence in that Rebecca failed to fully describe her mental state or that of her mother but merely alluded to possible emotions underlying their conflict.

### Excerpt

Rebecca 5: Me and my mum used to get on ok (...) We just see each other far too often. You know how you can get these people who you just can't live with or you spend too much time together? That's me and my mum. We just get on each other's nerves like that, and, if like (laughs) sorry, I shouldn't say that. I was gonna say, if I was a normal child, eh, then I'd be like, eh, you know what I mean, I wouldn't be like..{2 sec} she doesn't, she gets all angry with me when I like get depressed because like em 'Why you all ...{3 sec}?', you know what I mean, it's just like for fff.

Conflict-laden relationships were marked by an egocentric lack of trust and openness between young person and parents typical of adolescent defiance. In keeping with this non-reflective defiant stance, Rebecca did not offer a motive for her uncooperative behaviour.

### Excerpt

**CB: Has that changed like what you tell them about yourself?**

Rebecca 5: No (laughs). Dad wishes it would. Dad gets really pissed off cos like something will happen and I won't tell them about it. And then like, it'll all suddenly come out somehow and he'll go mmmmental that I haven't told them anything about it. And I'll just be like 'Aye, whatever.' (laughs).

#### **Subcategory 2.4 Growing up**

Young people were faced with the challenge of negotiating separation-individuation (Blos, 1967). The primary task of adolescence involves the renegotiating of a more autonomous and egalitarian role within the family whilst maintaining supportive interdependent relationships with parents. Separating from parents is thought to allow the young person to leave behind the parents' childhood image and to develop an increasingly crystallized identity based primarily within peer relationships.

As family contact intensified post-onset, young people's tendencies towards separation and individuation were affected in different ways. Following a temporary set-back, some young people re-embarked on a process of gradual separation and identity formation. Despite striving for more autonomy, a few young people continued to be held back in their development. Others projected a false individuated self which stood in contrast to them having given up trying to establish an identity with peers and remaining dependent on parents. A few young people were threatened by the idea of separation-individuation due to a lack of confidence and preferred to remain dependent on parents.

#### ***Natural separation-individuation***

Many young people described a normative and organic process of developing the wish to move out from parents. An increasing sense of suffocation and alienation in the family's home led young people to consider living independently. The prospect of living independently was viewed as exciting. Most young people were able to tease out their feelings and motives for wanting to move out and to reflect on how they felt about their level of maturation.

### Excerpt

Julia 7: Oh, I just feel really suffocated like I don't know, it's hard to explain (laughs). I don't know, I just feel a bit alienated in my own house, well not my house, cos like ...{3 sec} em, just getting this feeling that I don't belong here anymore and it's time that I did something else and move on, that's pretty much all I can say.

There was a clear striving for increasing autonomy and will to build one's confidence and abilities for looking after oneself. Some could already fall back on experiences of having managed responsibilities independently, which helped boost their confidence.

### Excerpt

Julia 7: I don't have any uncertainties about being able to manage.

Some had a sense of already or nearly being an adult. Having taken on adult responsibilities gave young people the right to claim to be treated like an adult.

### Excerpt

Leon 3: I try and behave like an adult, so I should be treated like an adult.

Others felt comfortable with having partly grown up and still enjoyed an interdependent relationship with their parents, which provided a secure base to return to in times of difficulties.

### Excerpt

Sarah 4: But I kind of feel a big mixture of whether or not I am an adult yet (**aha**). Yes, I am 18, so technically I should be, but I don't want to be (**uhuh**). I like being looked after by people. I like being like, having my needs pandered to (**uhuh**). It's em, I don't know if I am like sensible enough to cope with the whole actually paying for things, and remembering to cook food and remembering to go and stuff like that (**yeah**). I'm, I'm not scatter-brained but if I start playing videogames or something I don't remember the fact that I need to eat (laughs). I need people to remind me (**yeah**). So (**yeah**) I didn't do too badly for my 6 weeks at university though, so hopefully I will actually be fine when I leave home.

Experiencing mental health problems over the course of adolescence both hindered and promoted the maturation process in some young people.

#### Excerpt

Sarah 4: It makes me do growing up in little spurts, like, at the beginning of a mood change I do a lot of growing up to help me cope with it and help me accept the fact that it is happening. I do a lot of growing down at the end of it where I forget all this maturity that I have developed.(...) Oh, it's a mixed bag of fun! But no, I find growing up probably about as difficult as everybody else just that I had some extra fun with mood.

Facing the challenge of coping with mental health problems led to the internalization of a mature parent self, which helped to regulate affect and to look after oneself when mentally unwell.

#### Excerpt

Sarah 4: But with the mood changes, it's, it's made me able to tap into a different bit of myself that's obviously done quite a bit of growing up while I haven't noticed (**aha?**). And it's obviously just sort of there waiting for it being needed, and when something does go badly wrong it sort of kicks in, and is a bit more like my mum and does the sensible thing.

This stage was resolved in other young people somewhat less successfully by rebelling, experimenting with subculture identities and possibly alienating parents. Whilst still being largely dependent on parents for support and relatively immature in their behaviour, there was a clear intent to separate from family and to live with and invest in peer relationships in the near future.

#### Excerpt

Rebecca 5: Apart from that, we're currently waiting to hear back from a letting agency about a flat: me, her and a couple of other mates (...) But it's the first flat above the [Nightclub] – we'd never leave! (laughs)...{3 sec} we already spend 4, 5 nights a week in there and we'd live in there!

#### ***Arrested development***

Despite a determination to individuate, to separate from parents and to reinvest in relationships with peers, others' concern about the young person's abilities and well-being held back development by inducing self-doubt.

### Excerpt

Anna 1: (...) and even this concernedness is holding me down because obviously if somebody's concerned for you, you're going to think why, eh? What is it that they can see or what am I doing that I don't know about. That's what it is. That holds you back a lot like.

Ongoing perceived humiliation and invalidation contributed to feeling inferior and child-like. Abandoning one's childhood image was hindered by other's lack of validation and lack of opportunity to explore and consolidate a more adult-like egalitarian self.

### Excerpt

Anna 1: in turn that made me feel like I wasn't an adult and I wasn't equal to them, everybody in thinking-wise because they were making it out like that but it was like I knew that I was an adult but I didn't feel like it. I was like I don't feel it in front of these people because they make you feel like a child so I'll act like one, naturally, without even thinking. And then like when you are on your own and you recall things you think, for God's sake man, why can't folk get rid of that because if they got rid of that I'd feel better, for some reason.

### ***Pseudo-individuation***

This category was characterized by young people positioning themselves as mature and grown-up despite remaining largely dependent on parents for practical, emotional and social support in daily living.

Participants made a claim to being an adult by virtue of having made superficial behavioural changes. Living alone, stopping to take drugs and alcohol, spending time with family instead of hanging in the streets were considered to be indicators of successful maturation. Craig claimed ignorance regarding his motives for changing his behaviour and drew on generalized clichéd explanations.

### Excerpt

Craig 2: Not really, I dinnae really drink any more. As a child you can get all the alcohol, eh, but then you turn 18 and I don't really go out that often now. It just doesn't appeal to me as much.

**CB: Yeah, how come?**

Craig 2: I'm not sure, eh, you just get fed up with it. Some people dinnae but some people just aren't drinkers. My dad always saying come out with him, eh, but my mate, [name], wants me to go out with him as well but I just stopped it, I just dinnae want to drink.

The position of being a bona-fide adult was strengthened by giving advice about growing-up to a younger relative.

#### Excerpt

Craig 2: Yeah, because when you get older you dinnae really want to hang about the street all the time, you kind of grow out of that. You'd rather go to someone's house or whatever, just meet somewhere instead of, I've done it myself, walking about the streets or whatever when you're younger. I says that to my wee cousin, you'll grow out of it, you'll no be bothered, you'd rather be in the pubs or doing something, eh.

Living alone was viewed as a sign of successful separation although it primarily provided freedom to engage in immature substance-abuse behaviour away from parental supervision.

#### Excerpt

**CB: When did you move out?**

John 8: When I was 17 or 16 even.

(...)

**CB: What got you to move out?**

John 8: My parents called the police cos I went rag. I said I had too many ibuprofens that day, eh. I just felt like getting high, eh.

(...)

I had just got myself my own house, eh I wanted to live in it, eh, get drunk so, and then you're in hospital that really pissed me off.

Unlike most of other participants, these young people appeared accepting of remaining dependent on parental support in the long-term and did not indicate any intention or desire to become more autonomous. Remaining in parental care appeared to offer a welcome escape from the challenges and responsibilities of adult life. The level of support they received appeared to

exceed their needs for self-care. Young people rarely referred to parents with regard to providing support. If they mentioned parents, virtually no reference was made to each other's mental states. Generalized superficial explanations were offered as to why participants believed the relationship with parents had improved post-psychosis. Avoiding referring to underlying emotions could be interpreted as a way of glossing over premorbid fall-outs with parents.

#### Excerpt

**CB:**           **So how has it become better with your parents?**

Craig 2:       Well basically smoking hash and drinking, mum and dad didn't approve of and I still done it so that's probably why. That's the main fact I think, just me getting older I suppose.

**CB:**           **What does that mean, you getting older?**

Craig 2:       I don't know, I just do more for mum and dad, more conversation I suppose.

#### Excerpt

John 8:       And as [name] say, this guy [name] in the joinery, his son moved out, eh, and he found he got on much better once he had left, and I feel that as well cos now we're not arguing at all, eh. We have a few arguments with my mum but nothing major, eh, and em just getting on with life now eh, just like it was before.

#### ***Threat of secondary individuation***

The onset of psychosis thwarted premorbid plans of moving out. In fact, the threat of separation-individuation appeared to predate the onset and possibly contributed to the development of the psychosis as suggested by Harrop & Trower (2003). Psychosis undermined already weakened self-confidence even further. Exploration of underlying mental states seemed difficult and only occurred minimally.

#### Excerpt

David 6:       I'm not looking forward to it that much. I'd rather stay at home all the time. That will probably change.

**CB:**           **Would you say that having become ill has affected your growing up in any way do you think?**

David 6: Yeah, I think so. I probably would want to move. Well, I did want to move out.

**CB: Did you? When was that?**

David 6: Just last year, before I got ill.

**CB: Mh, so that's changed?**

David 6: I wasn't bothering to move out.

**CB: What do you think happened then between you wanting to move out and becoming ill?**

David 6: I don't know, I just think it became more scary to move out.

**CB: Can you say a bit more what was scary about it?**

David 6: Just cos you would be on your own all the time, not all the time but..{2sec} I don't know what changed actually.

Resulting loss in self-esteem further undermined confidence in young people's abilities to take on responsibilities necessary to live independently. Lack of self-confidence and fear of loneliness turned moving out into a threatening prospect.

#### Excerpt

**CB: What are your thoughts about moving out?**

David 6: I don't want to do it yet...{3 sec} it's too hard the now.

**CB: What would make it hard do you think?**

David 6: You'll be on your own quite a lot. If you know what I mean, looking after yourself, I can't even look after myself. Paying bills and stuff like that.

**CB: What do you think about these things being on your own and having to pay bills?**

David 6: Yeah...{3 sec} I don't know. I think it'll be hard to look after just cos to organize everyone to, I don't know.

#### **Subcategory 2.5 Envisaging future self**

The extent to which young people were able to contemplate their future selves appeared to depend on their readiness to adapt to mental health

difficulties. Some were able to quickly accommodate the impact of psychosis and reoriented their goals adequately. Others adopted a more passive stance by taking each day as it comes and not committing to any future plans. Most young people were striving to gain autonomy in their lives, to engage in meaningful activities and to reconnect with others. Prognostic uncertainty represented an added challenge to envisaging one's future.

### ***Managing prognostic uncertainty***

The current lack of scientific understanding and the idiosyncratic nature of young people's difficulties made it impossible to provide them with long-term prognoses. Participants managed this uncertainty in different ways. The degree to which young people understood and felt they could control their difficulties appeared to influence their prognostic outlook. Nevertheless, confusion and contradictions were common amongst responses.

Some were confused about where they were at in their recovery and worried about stagnating. Being on medication was a safeguard against relapsing, which a few participants were reluctant to let go off. Minimal personal control was experienced and young people felt to be at the mercy of an unfathomable entity. Prognostic guesses were made without reference to underlying mental states.

### Excerpt

**CB:** (...) where would you say you're at in terms of your mental health problems, how do you think they are going to change?

David 6: Probably, don't know...{3 sec} probably just in the middle of it or something like that. Just not quite at the end but getting there I suppose.

(...)

**CB:** What do you think about kind of, what would need to happen for you to get better from now on until you get even better?

David 6: I don't know...{3 sec} I suppose you could say I'm better now, I don't know. I don't know if I'm getting any better or not. Hard to tell.

**CB:**           **Hard to tell? (uhuh) How do you know?**

David 6:        Because I could stay the same.

Excerpt

Rebecca 5:    (...) so I don't know, I'd probably be different of, like, you know what I mean, the voices would get so bad if I went off it that I wouldn't be able to cope or if my depression would come back.

There was confusion about whether young people felt they would require treatment from psychiatric services in the long-term. Whilst some had resigned themselves to the fact that they would need ongoing treatment, others hoped they would not need to. Few rationales for either reasoning were offered.

Excerpt

Sarah 4:        I really don't know. I think I probably need some sort of medication for a lot of my life....{3 sec} but I would imagine I will still need something for most of my life (**uhuh**), which I don't necessarily see as a bad thing. Could be worse, could be on dialysis for the rest of my life.

Excerpt

David 6:        I think I'll get off it completely. Hopefully I won't. I can't be bothered taking tablets for the rest of my life. I'm bored of it already.

Some young people had adapted to living with the threat of potential relapse by being in denial of the impact that mental health difficulties may have on their future. For instance, some participants were surprisingly convinced that their complaints would not return and that they would eventually cope without requiring services.

Excerpt

John 8:         I don't think it'll come back again. I think that's it gone for good, because I'm not gonna take that many drugs again, eh.

Some young people recognized that they had partial control over their recovery. Learning how to control affective difficulties was seen as a way to improve their interpersonal functioning and to move towards autonomy.

### Excerpt

Rebecca 5: If I was moving into a flat shared with friends and to be snapping or going really depressed on them all the time, it just wouldn't work and I can't put pressure on them, so I need to be able to control it to move on with my life.

### ***Realistic reorientation***

Resilience in the face of the setback caused by mental illness helped to grieve the loss of past aspirations and to adjust goals to suit the current level of ability and opportunity. An optimistic and proactive attitude paired with realistic expectations helped make contingency plans for one's vocational future.

### Excerpt

Leon 3: So, I hope I get the job or community college or a year doing a, an engineering course and then try again next year.

### Excerpt

Sarah 4: (...) and I'll be going back [to university] at the end of this year.

Hope, optimism and self-belief seemed to facilitate this process of adjustment. Young people also demonstrated flexibility to adjust to and to reframe resulting setbacks and limitations in a positive way.

### Excerpt

Leon 3: While I was in first and second year, my dad would always say 'you have to be a doctor like my mum'. So, I'd take like chemistry and biology, but...{3 sec} since I missed out a year I had to use my prelim results cos I missed my final exams. So well, I had to just do what I can. Electrician sounds like a good job anyway, cos you get paid a lot of money for it as well, if you're good at what you're doing.

(...)

At the end of the day you have to do something that you like doing so.

### Excerpt

Sarah 4: But I think it'll be good. Em..{2 sec} I don't see my future as being do different to anyone else's (**uhuh**) (...) Judging by the fact that I'm wanting to do computer sciences it looks like I'm

doing the latter (**uhuh**). Em, I think it'll be successful (**yeah**). Yeah, I'll probably still need services for a lot of my life, not all of it, but it doesn't mean that it can't be successful (**uhuh**). I think I'll get a lot of things done.

### ***Taking each day as it comes***

Some young people merely contemplated possibilities for their future but were reluctant to commit to any specific path at this stage.

#### Excerpt

Craig 2: Well before I became ill I quite fancied doing plumbing.

(...)

Craig 2: Maybe plumbing but I doubt it at the moment.

**CB: How come?**

Craig 2: I don't know.

**CB: What do you think might happen in the future?**

Craig 2: I'm not sure. Take each day as it comes.

**CB: Do you have any wishes, how you'd like things to be?**

Craig 2: Yeah, be a plumber but not just now.

#### Excerpt

David 6: Eh, don't know. Don't know whether to do it or not. Just see what happens.

#### Excerpt

**CB: (...) How do you see your future right now?**

Julia 7: Ah, I don't know, I don't want to think about it (**uhuh**) I'm happier concentrating on what I'm doing now. So, em, I don't know, em, I've just started applying for jobs.

As most refused to provide motives for their disengagement, it could be speculated that it was an adaptive response to managing the uncertainty of living with a mental illness. It appeared that young people avoided readjusting their goals following the psychosis. Living day by day could be

viewed as a safe strategy to protect themselves from potential failures, particularly if self-confidence had been undermined by psychosis.

### ***Striving for autonomy***

Level of self-confidence varied and affected the degree to which young people committed themselves to vocational or educational possibilities. Most young people however expressed their dreams and hopes for the future even though they were currently lacking the clarity, confidence or motivation to pursue these plans. College courses, part-time jobs or volunteering were viewed as stepping stones towards long-term goals. Some of these plans were made partly contingent on whether they felt they had recovered from their primary mental health difficulties.

#### Excerpt

David 6: Just now I wanna get a job just now, a part-time job and em, that's about it, that's all that's planned really.

(...)

What to be a fireman or a policeman you have to get better first, I checked that out. You need to be more, be better, I don't know. There must be a way (laughs).

#### Excerpt

Julia 7: Just...{3 sec} doing what I want to do, not what everyone else wants me to do.

#### Excerpt

Anna 1: I see it as great. I won't have it any other way. I know that I'm going to do something and I'm definitely going to do it, I'm just not sure what it is at the moment exactly, but I'll be independent and do things for myself that I want to do and be much happier. I really, really, really know for a fact that I'm not going to sit about for the rest of my life.

### 4.3 Integration of inductive and deductive qualitative components

Processes of reflective functioning provided an added layer of interpretation to the descriptive account of emerging themes across participants. Table 2 below summarizes the relationships between the content of the main themes in the adaptation interview and the concurrent processes of reflective functioning across participants. Although examples of both negative/limited and moderate reflective function could be found in a single adaptation narrative, there was a trend for individuals to demonstrate either primarily negative/limited or moderate reflective function within their adaptation narrative. However, for the purposes of the present analysis, associations between content and corresponding level of reflective function were only examined across participants (Table 2).

<b>Table 2. Relationships between main recovery themes and level of reflective function</b>		
<b>RECOVERY THEMES</b>	<b>LEVEL OF REFLECTIVE FUNCTION</b>	
	<b>Moderate to high RF</b>	<b>Negative or limited RF</b>
<b>Recovery adaptation phase</b>		
Making sense	Acceptance	Avoidance/Denial Confusion
Impact	Loss of peers (empathy)	Loss of peers (indifference) Disillusionment
Managing	Acceptance & mindful self-compassion	Low self-efficacy & passive coping
Averting stigma	Coming out Impression management	Superficial disclosure
<b>Developing adolescent self</b>		
Self-identity	Confident self-expression (integrating mhd* as part of self)	Struggling to express identity
Peers	Integration with peers (valuing)	Integration with peers (idealisation) Isolation from peers (mistrust, alienation)
Parents	Parental overprotection Warmth	Parental criticism Defiant conflict with parents
Growing up	Process of natural separation	Pseudo-individuation Threat of secondary individuation
Future self	Realistic reorientation	Taking each day as it comes
RF - Reflective Function; *mhd - mental health difficulties		

Moderate to high reflective function was considered as being evident when young people were able to (1) show an awareness of the nature of mental states, (2) attempt to tease out their own or others' mental states underlying behaviour, (3) recognize developmental changes in their own or others' mental states or (4) show evidence of emotional attunement to the interviewer. As is illustrated in the top middle column of Table 2, moderate to high reflective function in the context of mental health difficulties was associated with acceptance of mental illness; an empathic and accepting

account of loss of peers over the course of difficulties; mature coping strategies marked by self-soothing and distress tolerance and stigma-averting strategies of direct disclosure and impression management. As can be seen in the bottom middle column of Table 2, moderate to high reflective function in the context of adolescent development, was linked to increased self-confidence, an integration of mental health difficulties as part of overall self-structure; valuing of and reconnecting with peers; parental warmth and overprotection, a natural process of separation-individuation and realistic reorientation of one's future following mental illness.

The most common types of negative or limited reflective function were naive, disavowing or rejecting (Fonagy et al., 1998). Invitations or opportunities to reflect on one's own or others' mental states underlying behaviour during the adaptation interview were either more or less directly evaded or answered with superficial, generalized statements about mental states. As is illustrated in the top right hand column of Table 2, Impaired reflective function was associated with avoidance, denial or confusion about mental illness; subsequent disillusionment; indifference towards loss of peers; low self-efficacy; passive coping and superficial disclosure. As shown in the bottom right hand column of Table 2, impaired reflective function in the context of adolescent development was related to difficulties with expressing self-identity; reintegration with peers marked by idealization of peers; relative isolation from peers related to fear of stigmatization, alienation and mistrust of others; tense and critical relationships with parents; failed separation-individuation and reluctance to commit to future plans.

#### **4.4 Descriptive account of quantitative data**

In addition to examining the relationships between content and level of reflective function across adaptation narratives (Table 2), individuals' level of reflective function with regards to attachment states of mind was rated based on the Adult Attachment Interview (Table 3). Table 3 below lists the categories of reflective function into which the eight transcripts of Adult Attachment Interviews fell. Overall, participants' ability to reflect on their own and their caregivers' mental states ranged from being ordinary to be lacking.

Nobody demonstrated absent, marked or exceptional reflective function with regards to attachment states of minds. This suggests that participants' psychological models of the mind and reactions to mental states in the context of early attachment relationships were either poorly or moderately developed.

**Table 3.** Level of Reflective Function (RF) based on Adult Attachment Interviews

Participant	Overall RF rating	RF subtype	Overall attachment RF
Leon 3	Lacking in RF	Disavowal	Impaired attachment RF
David 6	Lacking in RF	Disavowal	Impaired attachment RF
John 8	Lacking in RF	Disavowal	Impaired attachment RF
Anna 1	Questionable or low RF	Naïve simplistic	Impaired attachment RF
Craig 2	Questionable or low RF	Naïve simplistic	Impaired attachment RF
Rebecca 5	Ordinary RF	Ordinary understanding	Moderate attachment RF
Julia 7	Ordinary RF	Inconsistent understanding	Moderate attachment RF
Sarah 4	Ordinary RF	Inconsistent understanding	Moderate attachment RF

#### 4.5 Integration of quantitative and qualitative data

Inductive and deductive qualitative and deductive categorical data were integrated by examining relationships between processes within and across participants. Information summarized in Table 2 and Table 3 was combined by noting an individual's attachment reflective function (Table 3) and their individual profile of associations between content and level of reflective function in the adaptation narrative. Combining information on the level of attachment reflective function, the level of adaptation reflective function and the concurrent thematic content of adaptation narratives within participants revealed two trajectories of adaptation and individuation processes across participants.

The young people who had shown moderate to high reflective function in the context of primarily positive adaptation and successful individuation following psychosis demonstrated moderately developed (ordinary RF) reflective function with regard to attachment states of mind. Those young people who had shown negative to low reflective function in the context of unresolved adaptation and failed individuation to psychosis were lacking or low in attachment reflective function (lacking RF, questionable or low RF).

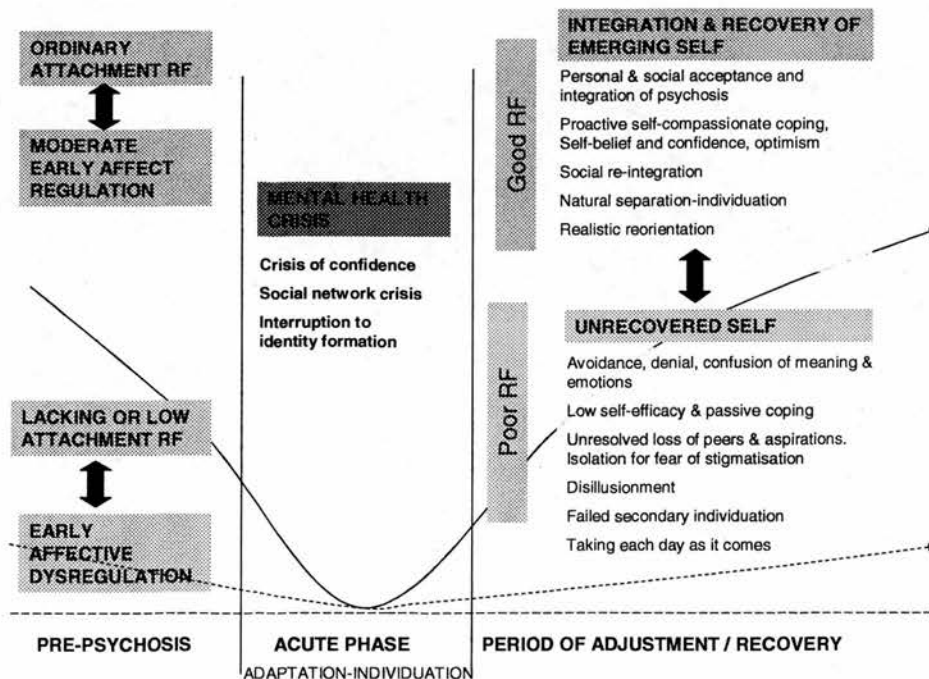
One participant formed an exception to this trend. Although Leon 3 was lacking reflective function with regards to attachment, he showed a somewhat better ability to reflect on themes relating to his adaptation and individuation and had generally adjusted remarkably well.

However, due to the general correspondence between attachment reflective function and adaptation reflective function, both processes referred to as reflective function in the discussion.

## 5. DISCUSSION

### 5.1 Presentation and validation of integrated model

The integration of all data resulted in the construction of a theoretical model (see Figure 3). Processes of reflective functioning appeared to moderate individuation and adaptation processes following psychosis. All young people experienced a mental health crisis, which was associated with significant disruptions to peer relations, education, work and identity formation. As can be seen in the upper trajectory (turquoise) in Figure 3 below, positive adaptation and successful separation-individuation post-psychosis were related to moderate attachment reflective function and moderate to high reflective function in adaptation narratives. Conversely, unsuccessful adaptation and arrested individuation post-psychosis were related to impaired attachment reflective function and to equally impaired reflective function in adaptation narratives, as is illustrated in the lower trajectory (yellow).



**Figure 3.** Proposed model of adaptation processes in adolescent psychosis

The associations between the main themes extrapolated from young people's accounts and processes of reflective functioning were subsequently validated in the research literature to derive hypotheses about the processes involved in adaptation to psychosis. A synthesis of the present findings and existing theoretical concepts gave rise to two core hypotheses about adaptation and individuation. Each hypothesis is discussed in turn with reference to the present findings and relevant literature.

➤ **Hypothesis 1: Adaptation process**

Adaptation to psychosis during adolescence involves grieving losses related to psychosis and/or defending against egodystonic aspects of psychosis, which threaten the integrity of self.

The concept of loss applied to the present sample of young people in that they experienced psychosis, which in itself represented a loss of psychological integrity, and which resulted in secondary losses of self-confidence, motivation, hope, emotional well-being, autonomy, relationships and future aspirations. In a review of qualitative research on recovery from schizophrenia, Sells and colleagues (2004) concluded that the processes involved in the recovery of self are not specific to schizophrenia but resemble those occurring in non-psychiatric populations in response to other stressful life events such as loss. Recent stage models of recovery from schizophrenia and severe mental illness (Spaniol et al., 2002; Andresen et al., 2003) strongly resemble models for coping with loss, bereavement or terminal illness (Bowlby, 1969; Kuebler-Ross, 1973; Parkes, 1988). Akin to the early phases of mourning, young people with impaired reflective function and poorer affect regulation avoided the process of integration of the psychotic episode and consequently avoided fully recognizing the losses that had occurred. Disillusionment, helplessness, numbness, confusion and angry preoccupation were also observed as a way of coping with psychosis. These young people often remained detached and withdrawn from the social world. Those with moderately developed reflective function managed to positively reappraise distressing episodes of mental illness, which allowed them to reach acceptance, integrate the losses and ongoing threat of loss into their lives and reinvest in their future similar to later stages in the grieving process.

More specifically, it appears that there are some parallels between the processes of emotion regulation involved in complex grief and poor adaptation to psychosis. The Dual Process Model of bereavement (Stroebe & Schut, 1999; Stroebe et al., 2005) proposes that insecure or disorganized attachment leads to complicated grief via ineffective affect regulation. Stroebe and colleagues argued that insecure attachment manifests as ineffective oscillation between loss-orientation (internal confrontation with the loss and associated thoughts and feelings) and restoration-orientation (external focus on adjusting to life without the deceased). Excessive emotion-focused rumination on loss is thought to result in protracted chronic grief, which was evident in young people with impaired reflective function who remained preoccupied and emotionally distressed by the impact of psychosis. The opposite complication of inhibited or delayed grief is thought to result from prolonged avoidance of the emotional aspect of loss and exclusive problem-focus on restoration. The only person with impaired reflective function who was excessively restoration-focused suppressed traumatic and distressing memories of psychosis but appeared to have adjusted well. Other participants with impaired reflective function denied the emotional impact of psychosis but were largely passive and dependent.

In addition to adaptation being hindered by impaired reflective function and ineffective affect regulation, young people with psychosis may also be more prone to developing an unresolved adaptation akin to complex grief due to the nature of the loss. Research suggests that the grieving process can be protracted if the loss is less tangible or definite. Mental illness could thus be viewed as an "ambiguous loss" (Rando, 1992), in which the implications are difficult to assess. The question arises what young people are adapting to. What have they lost? Which losses are temporary, what can be retrieved and what is irretrievable? What is yet to be lost? Most young people with impaired reflective function and affect regulation were reluctant to assess the impact of their difficulties and avoided reinvesting in life or envisaging their future. Psychotic and affective disturbances were experienced by most as having threatened and in some cases continued to threaten the integrity of their

selves and social identities. Such intrapsychic experiences are more difficult to isolate from the self and are difficult to delineate in concrete terms.

It could be hypothesized that individuals with lower reflective function, poorer affect regulation, and weaker self-organisation perceived psychosis and its possible consequences as a greater threat to their more fragile selves than young people with better reflective function. 'Sealing over' tendencies such as denial, avoidance of meaning-making and rejection of own mental states could be viewed as a defense mechanism against intrusions of traumatic memories of psychosis, potentially uncontrollable emotional distress and further fragmentation of self. Since such individuals are less well equipped to deal effectively with emotional distress, they are more likely to adopt avoidant strategies. A few individuals with lower mentalizing capacity remained confused by their experiences. Instead of avoiding unpleasant emotions, they were angrily preoccupied by losses, which held them back from moving on.

In contrast to participants with lower mentalizing capacity, young people with good attachment and adaptation reflective function were able to integrate and accept their mental health difficulties and showed successful adaptation and individuation. Their moderate ability to reflect on their own and others' mind states and more developed sense of self enabled them not only to examine, reappraise and integrate psychosis and its impact but also to tolerate and cope with the associated affect. After going through a stage of initial avoidance and angry protest, gradual reappraisal, acceptance and reinvestment occurred. Meaning-making and cognitive reappraisal of events has been shown to promote adjustment to both bereavement (Davis et al., 1998) and to schizophrenia (Roe et al., 2006). From a grief perspective, young people showed adaptive oscillation between loss and restoration-orientation. Functional mentalized affectivity allowed these young people to reinvest into relationships and educational goals whilst gently confronting and constructively dealing with negative consequences of psychosis. They successfully embraced their vulnerabilities and prognostic uncertainty, which they accommodated into their sense of self. This process is in keeping with Curtis's (2001) description of recovery as a movement from being engulfed by illness to accepting illness as but a small part of the whole self. It also

echoes Bartlett & Lapsley's (2006) category of 'living well'. Reflective ability enabled these young people to face up to a difficult and painful adjustment process, which in some cases represented an opportunity for personal growth and maturation.

➤ **Hypothesis 2: Individuation process**

Adaptation to psychosis during adolescence involves negotiating separation-individuation in the context of experiencing a challenge to the construction of self identity and social identity.

Adaptation to psychosis occurred to the background of normative adolescent development. Adaptation and individuation emerged as two separate yet critically related processes, which resonates with recent literature that has highlighted the relevance of adolescent development in the onset of psychosis (Harrop & Trower, 2003; Hirschfeld et al., 2005; Holland et al., 2006). Re-establishing a sense of an enduring and stable self is considered to be at the heart of recovery (Davidson & Strauss, 1992). However unlike individuals with an onset in adulthood, young people faced the challenge of preserving partly individuated self-structures and continuing to develop a sense of self in the face of primarily negative consequences of mental illness. Whilst developmental trajectories were relatively unaffected in young people with good reflective function, most trajectories of young people with impaired reflective function were either arrested, had plateaued or had regressed to a below-premorbid level of functioning.

Young people with well-developed attachment and adaptation reflective function were able to re-embark on a process of natural separation-individuation following temporarily increased dependence on their parents during the mental health crisis, whereas young adults with impaired attachment and reflective function demonstrated different types of dysfunctional separation-individuation (Blos, 1967). Whilst some partly acknowledged the threat of individuating and worried about lacking the necessary confidence and resources, others pretended to have individuated whilst still being largely dependent on their parents without any intention to become more independent. All types of unsuccessful separation-individuation

were associated with difficulties expressing self-identity, which corresponds to Harrop & Trower's notion of psychosis arising as a result of blocked self-construction in late adolescence (Harrop & Trower, 2003). A further indicator of inadequate separation was the observation that previously conflict-laden relationships with parents had seemingly improved post-onset. What was premorbidly perceived as irritating criticism was now viewed as helpful motivation to overcome anergia. The lack of mentalization evident in this context strongly suggested that young people were unable to de-idealise parents. The same process of blocked adolescence that may have contributed to the onset remained unresolved and thus continued to hinder recovery.

Psychosis and the resulting losses and uncertainties appeared to have interfered with secondary individuation by undermining confidence to explore the world and by creating insecurity about one's future in those with poor reflective function. Such 'ontological insecurity' (Laing, 1960) may in fact have lain dormant in young people with impaired mentalized affectivity. Failed secondary individuation produced compliant teenagers and relatively conflict-free relationships with parents. Creating such a secure base at the cost of individuation could be viewed as an adaptive strategy in response to threat. The apparent absence of an adolescent conflict in pseudo-individuated young people corresponds to what Blos (1979) termed 'prolonged adolescence'. The hesitation to reinvest into their future and the indifference towards becoming independent evident in those with impaired reflective function and dismissive tendencies might be the result of having successfully detached themselves from their own overwhelming emotional experience. A passive and helpless attitude towards managing their mental health problems perpetuated dependence on parents and professionals.

In their revision of Erikson's developmental dilemmas, Newman & Newman (2003) placed particular emphasis on the need to establish both a group identity and an ego identity during late adolescence. If neither of those tasks is achieved, alienation and role confusion ensue. In the present sample all young people faced the challenge of renegotiating belonging to peers after experiencing a social network crisis. Young people with good reflective

function showed a positive reintegration with old or new peers, which was marked by empathy. Their mentalizing capacity appeared to have enabled these young people to reflect on the emotions and motives of peers and their own mental states in relation to losing friends, having to make new ones and considering the possible effects of stigma. The opposite development was observed in young people with impoverished reflective function. Alienation from and mistrust of peers maintained social isolation, which young people either glossed over or claimed to be indifferent about. Whilst it remains possible that these young people may have also been lacking the social and interpersonal skills necessary to maintain peer relationships, it is also likely that negative internal working models of others may have prevented them from fully re-engaging with peers for fear of being harmed or humiliated. This observation corresponds to Harrop & Trower's (2003) notion of alien self, which refers to young people who are unable to attach to peers pre-morbidly for fear of being engulfed by others. Mackrell and colleagues' (2004) grounded theory study on peer relationships in psychosis describes a process of increasing social isolation stretching from childhood to the recovery period. They conclude that early family adversity and insecure internal working models for peer relationships perpetuated the sense of rejection by peers post-psychosis and thus maintained isolation and dependence on family.

Actual and anticipated stigmatization posed another obstacle to the construction of self and social identities. The literature distinguishes between self-stigma and public stigma. Self-stigmatization occurs once the public devaluation and marginalization of people with mental illness has been internalized regardless of the level of actual discrimination experienced. Avoidant coping strategies of secrecy and withdrawal - as employed by young people with impaired reflective function - have been associated with shame, depression, low self-esteem and low self-efficacy (Vauth et al., 2007). Participants with impaired reflective function showed fear of stigma and humiliation, which are linked to hopelessness and entrapment (Karatzias et al., 2007). Fear of stigmatization by peers also hindered full re-engagement. In contrast, young people with good reflective function freely acknowledged the potentially detrimental effect that their diagnosis may have on their social

identities. Unlike those with impaired reflective function, they had accepted their mental health problems as part of themselves, which reduced self-stigma and thus decreased the threat of social stigmatization.

Evolutionary-based social ranking theory (Gilbert, 1992) provides a framework for understanding some young people's efforts to escape from a socially subordinate and marginalized role as a mentally ill person. Their perceived lowered attractiveness to others resulted in different strategies to increase attractiveness. Presenting one's 'insanity' as an eccentric and interesting personality trait appeared to make it appealing to peers. Seeking out a peer group that highly valued marginalized identities was another strategy to increase perceived social rank. Creating a socially acceptable and desirable façade to peers whilst keeping mental illness a secret was another effective strategy. The later strategy of impression management (Goffman, 1959) may however be harder to maintain in the long-term as the threat of eventually being devalued by others continued. Young people who were lacking in reflective function used withdrawal and secrecy without adopting any particular impression management strategy thus resigning to a subordinate role. Those young people with minimally better but still impaired reflective function with regards to attachment states of mind employed secrecy and conscious impression management strategies, which required reflective abilities to anticipate others' reactions. Young adults with moderate reflective function employed direct disclosure, in which they showed moderate to high reflective ability in anticipating and assessing others' reactions. Taken together, participants with reflective ability actively tried to avert stigma whereas those with impaired reflective function adopted passive strategies of secrecy and withdrawal.

Based on the current findings, Tait and colleagues' (2004) conclusions can be amended by suggesting that 'sealing over' tendencies are adopted by individuals who lack affect regulation capacities to deal with the threat of psychosis as a result of impaired reflective function. Unlike more static categorical outcomes of attachment security or recovery styles used in previous studies, reflective function provides an insight into the underlying processes. If the concept of impaired reflective function is applied to

understand maladaptive recovery styles, then 'sealing over' could be defined more broadly as the failure to integrate and accommodate psychotic experiences and its impact into the self-concept. Such failure to reflect on one's own emotions, beliefs and intentions was evident in young people who either avoided reflecting or excessively reflected on their experiences without reaching a resolution. Those who avoided thinking about psychosis and denied experiencing any emotional distress may have indeed been protecting themselves from confronting seemingly uncontainable distress, which they may feel in relation to psychosis. The unresolved preoccupation with psychosis and related losses in other young people with impaired reflective function may constitute an unhelpful investment in or identification with mental illness, which is difficult to abandon.

### **5.3 Evaluation of study**

#### **5.3.1 Strengths**

The present findings are amongst the first to contribute to the validation of the hypothesised links between early development, attachment and recovery (Tait et al., 2004; Gumley & Schwannauer, 2006) by applying the concept of mentalization (Fonagy et al., 2002). Unlike the majority of basic research, which focuses on risk factors of psychosis, the current study demonstrated how a psychological capacity formed in early life influences adaptation to psychosis. The concept of mentalization allowed us to generate more specific hypotheses about why some young people who have experienced psychosis struggle to adjust.

A further strength of the present design was that it used the robust theoretical and development construct of mentalization to investigate the processes involved in adaptation instead of solely drawing on thematic content of qualitative interviews. Attachment reflective function therefore served to validate the level of reflective function evident in the adaptation narratives.

#### **5.3.2 Limitations**

Due to time and resource constraints the current design and analysis suffered from several methodological and conceptual shortcomings.

Firstly, the scope of the research did not allow for a full implementation of theoretical sampling and sufficiency. Further data collection with young people with psychosis may well have unearthed new categories or novel properties of existing categories. The theoretical model therefore does not represent a fully developed theory in terms of density and variation of categories but offers initial hypotheses contributing towards the construction of a grounded theory.

Secondly, sampling was non-probabilistic and criterion-based, so it was not intended to be random. However, one potential bias may have been at play in selection. Keyworkers approached those clients first who had already completed the Adult Attachment Interview as a clinical assessment. Other clients had either refused or were too unwell to complete the Adult Attachment Interview. Hence, clients who had refused were not approached with the current study. It may well be that refusing to talk about early childhood experiences is related to a 'sealing over' recovery style, experiences of childhood adversities and impaired mentalized affectivity.

Thirdly, the study lacked in cross-validation and triangulation. Ideally, coding of transcripts should have been checked or multiply coded more consistently by different colleagues to allow for greater breadth of analysis. Validation of arising themes by participants would have also been beneficial in enhancing the validity of study by contributing to triangulation. Whilst acknowledging a need for increased methodological rigour, qualitative researchers have also emphasized that rigour within qualitative methods is relative and certain ideal notions are impossible to attain (Barbour, 2001).

Fourthly, the categorical measure of reflective function based on the Adult Attachment Interview was considered to be an indicator of quality of early mirroring without taking into account the content of young people's early experiences. To gain a more detailed understanding of how processes of reflective function and early experiences might influence individuation and recovery, both the content and format of the Adult Attachment Interview could have been coded. A subsequent comparison to the content and format of the

adaptation interview may have given insights into the potentially differential activation of reflective function across themes.

Fifthly, since moving forward through the recovery process is a personal journey with no set timeframe, it remains possible that some of the young people in our sample may have simply been moving at a slower pace than other service users and have yet to reach a higher level of adaptation and individuation.

#### **5.4 Implications of findings**

The present findings have important clinical implications for adjusting psychological therapies for young people with psychosis by taking into account their level of mentalized affectivity.

Young people with a 'sealing over' style in particular are known to be difficult to engage in services and have in some studies shown to have worse outcome than 'integrators' (Startup, 2006). Such interpersonal avoidance may be related to early interpersonal rejection, neglectful parenting and insecure attachment (Tait et al., 2004). Their impaired capacity to reflect and to self-regulate appears to make it more threatening to confront psychotic experiences and to individuate. Recent research supports the suggestion that psychosis in adolescence brings with it age-specific challenges. Haddock and colleagues (2006) noted that psychosis patients under 21 were not only more difficult to engage in psychological therapies than older recent-onset cases but also responded differently. Modifications in psychological interventions for psychosis may want to target this group of young people in particular.

In addition to replacing a solely symptom-focused perspective with a person-centred and developmentally-sensitive approach, therapeutic style and focus need to be attuned to the young person's level of mentalized affectivity. Attachment and mentalization-based interventions (Bateman & Fonagy, 2004), through which young people can learn to regulate their affect

effectively, form a positive identity and safely negotiate interdependent relationships with peers, offer an exciting new avenue of treatment yet to be applied to young people with psychosis. The first step may be to help young people construct a stable sense of self and group identity by overcoming interpersonal obstacles (Harrop & Trower, 2003). This work can serve as a base from which young people can build reflective ability. Narrative approaches may also be useful in promoting integration and recovery in a playful and less threatening manner. Notions of promoting the internalization of a compassionate internal object may help counteract negative self-evaluations (Gilbert & Irons, 2005). Although any skilled psychotherapy is thought to foster the reflective self (Power, 2007), psychological interventions for psychosis are relatively new and still evolving with an increasing focus on developmental and interpersonal constructs (Gumley & Schwannauer, 2006).

Furthermore, applying a grief model to emotional recovery from psychosis and its secondary losses clinically would help young people normalize and understand their emotional and cognitive reactions as has been suggested by Gumley & Schwannauer (2006). Carefully-paced exploration of the appraisals and affect related to events that may have resulted in feelings of loss, humiliation, shame or entrapment may create an inroad to allow a dismissive and 'sealed over' young person to safely reflect on their inner experiences.

## **5.5 Future research**

The present study did not explore the potential causes of impaired mentalized affectivity. In the adaptation interview, most young people reported experiencing some degree of early invalidation. Childhood adversities such as abuse, neglect, parental loss, maternal separation or other traumatic events are common amongst individuals with psychosis (Janssen et al., 2004). Childhood trauma has been linked to insecure and disorganized attachment styles (Styron & Janoff-Bulman, 1997), which in turn have both been independently associated with development of psychopathology (Bowlby, 1988; Rosenstein & Horowitz, 1996) and complicated grief reactions (Stroebe et al., 2005). It has been suggested that

early adverse experiences contribute to the development of impaired reflective function by affecting the availability of effective mirroring and subsequent confirmation of resulting false selves. Reflective function appears to moderate adaptation to losses associated with psychosis. Future studies may want to include measures of objective and subjective experiences of childhood adversities, as had been intended in the original design of the study.

Future studies should aim to saturate and refine categories further by interviewing more young people about their experience of adaptation to psychosis. More specific hypotheses about the developmental processes that influence adaptation could be generated by assessing young people's attachment style, childhood adversities as well as caregivers' reflective function and attachment style. The hypotheses generated could then be tested in a deductive manner as part of a circular research process (Huberman & Miles, 1994). Whilst future research should be committed to ensuring methodological rigour, research proposals should be evaluated primarily on their contribution to the advancement of knowledge as opposed to adherence to methodological paradigms. Unnecessary 'paradigm wars' (Kelle, 2006; p.293) between qualitative and quantitative researchers hold back progression in the field whilst 'composite analysis' research has much to offer (Yardley, 2007).

## **6. CONCLUSIONS**

The present findings suggest that adaptation to psychosis in adolescence involves the double challenge of adjusting to a mental health crisis in the context of developing self-identity, building relationships with peers, separating from parents and striving for autonomy. Ability to mentalize with regards to attachment and to adaptation tended to moderate adaptation and individuation processes following psychosis. Moderate capacity to reflect on one's own and others' mental states was related to positive adaptation and successful separation-individuation post-psychosis whereas unsuccessful adaptation and arrested individuation following psychosis was related to

impaired reflective function. Examining developmental constructs such as reflective function and affect regulation helps elucidate the clinical phenomenon of clients' failure to integrate psychotic experiences. The limited efficacy of symptom-focused interventions for psychosis (Jones et al., 2004) suggests that psychological therapies for such complex difficulties of disturbed self-experience, dysregulated affect and interpersonal problems could benefit from interventions that take into account clients' level of mentalizing capacity to help this most disabled group recover.

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## **8. APPENDICES**

- 8.1 NHS Ethics Committee - Letter of approval**
- 8.2 NHS Research & Development Department – Letter of approval**
- 8.3 Participant Information Sheet**
- 8.4 Sample of coded interview transcript**

03 October 2006

Telephone:  
Facsimile:Miss Christine Braehler  
(Trainee Clinical Psychologist)

Dear Miss Braehler

**Full title of study:** A qualitative exploration of the influence of childhood trauma and reflective function on adaptation to adolescent-onset psychosis

**REC reference number:** 06/S1104/38

The Chair on behalf of Local Research Ethics Committee 4 reviewed the above application at a meeting held on 25 October 2006.

**Ethical opinion**

The Committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation.

**Conditions of approval**

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

**Approved documents**

The documents reviewed and approved at the meeting were

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application	1	06 September 2006
Investigator CV	1	23 August 2006
Protocol	1	23 August 2006
Covering Letter		05 September 2006
Interview Schedules/Topic Guides	1	23 August 2006
Participant Information Sheet	Revised	20 October 2006
Participant Consent Form	1	23 August 2006
Response to Request for Further Information		20 October 2006

Research governance approval



## Local Research Ethics Committee 04

## LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

*For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors.  
For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.*

**REC reference number:** 06/S1104/38                      **Issue number:** 1                      **Date of issue:** 25/10/2006

**Chief Investigator:** Miss Christine Braehler

**Full title of study:** A qualitative exploration of the influence of childhood trauma and reflective function on adaption to adolescent-onset psychosis

*This study was given a favourable ethical opinion by Local Research Ethics Committee 04 on 25 October 2006. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.*

<i>Principal Investigator</i>	<i>Post</i>	<i>Research site</i>	<i>Site assessor</i>	<i>Date opin</i>
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Approved by the Chair on behalf of the REC:

..... (delete as applicable)                      (Signature of Chair/Co-ordinator)

..... (Name)

- (1) *The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension or termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.*

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**06/S1104/38**

**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Chair

Email:

Enclosures:

*List of names and professions of members who were present at the meeting and those who submitted written comments  
Standard approval conditions [SL-AC1 for CTIMPs, SL-AC2 for other studies]  
Site approval form (SF1)*

Copy to:

*[R&D Department for NHS care organisation at lead site]*

## NHS

Research & Development Office,

Project ID: 2006/P/PSY/21

Project Title: A qualitative exploration of the influence of childhood trauma and reflective function on adaptation to adolescent-onset psychosis

REC Ref: 06/S1104/38

Principal Investigator: Miss Christine Braehler

### RESEARCH GOVERNANCE FRAMEWORK (RGF) FOR HEALTH & COMMUNITY CARE

The framework is of direct relevance to all those who host, conduct, participate in, fund and manage health and community care research. The framework applies to all managers and staff, in all professional groups, irrespective of seniority.

#### Research Governance

- Sets standards
- Defines mechanisms to deliver standards
- Requires monitoring and assessment
- Improves research quality & safeguards the public

#### Responsibilities and Accountabilities of Principal Investigator (PI)

The PI must take responsibility for the conduct of the research and is accountable for this to their employer, and, through them, to the sponsor of the research and to the care organisation(s) within which the research takes place or through which participants, their organs, tissue or data are accessed. The PI must have adequate qualifications and experience to take on these responsibilities.

#### In brief, they must ensure that:

- The dignity, rights, safety and well being of participants are given priority at all times by the research team.
- Ethical and management approval is obtained **BEFORE** study commences.
- Care professionals involved with patients are informed of study and its protocols.
- Study complies with all legal and ethical requirements e.g. data protection, informed consent & with RGF.
- Each member of the research team is qualified to discharge their role in study and that students are adequately supervised.
- When a study involves participants under the care of a doctor, nurse or other worker for the condition in which the study relates, those care professionals are informed that their patients or users are being invited to participate and agree to retain overall responsibility for their care.
- If any information relevant to the care of a patient arises through research, the patient's care professional must be notified. Unless, the patient or the relevant research ethics committee request otherwise.
- Reporting all adverse events, including adverse drug reactions through the appropriate systems.
- Controlled trials are registered.
- Research follows an approved protocol - any proposed changes or amendments to protocol are notified to the appropriate research ethics committee, sponsor and research host.
- Findings open to critical review through accepted scientific and professional channels and disseminated promptly.
- Key role in detecting and preventing scientific misconduct, by adopting role of guarantor on published outputs.
- Arrangements in place for financial management of the study and any Intellectual Property arising from it
- All data are stored appropriately at end of study and are available for audit.
- Procedures are in place to ensure quality data are collected, processed, analysed, stored and archived
- Progress reports are sent to sponsors promptly and are of an acceptable standard

For further information and access to the complete Research Governance document visit: -  
<http://www.show.scot.nhs.uk/cso>

Date: 19/01/2007 1

Contact Person: Miss Christine Braehler

Phone:

Address:

Fax:

EMail:

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Project ID:	REC Ref:	MREC Ref:	Start Date:	End Date:
2006/P/PSY/21	06/S1104/38	Not known	01/10/2006	27/09/2007

**Research Title:**

A qualitative exploration of the influence of childhood trauma and reflective function on adaptation to adolescent-onset psychosis

**Multi Centre:** No**Lead Centre:** NHS**Research Question:**

Young people with severe mental illness, such as psychosis, depression or eating disorders, are often found to have experienced abuse or neglect as children. Such early trauma, if experienced with the caregiver, can disrupt both childhood and adult attach

**Outcome Measure:**

To investigate the hypothesized effects of trauma processing on adaptation to psychosis.

**Sample Group:**

12-14 participants (two groups of either 6 or 7)

**Study Type:**

Questionnaire

Interviews

**Funder:**

no funding identified

**Reference:****Amount:**

£0

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**Authorisation:**

I authorise/have made changes and authorise/do not authorise that the above details can be supplied for inclusion in the National Research Register.

**Signature**Date: 26/01/07**NB: Please**

Research and Development Office, NHS

[Logo of Health Board]

## PARTICIPANT INFORMATION SHEET

### **A QUALITATIVE STUDY OF YOUNG PEOPLE AND ADAPTATION TO MENTAL HEALTH PROBLEMS**

\*\*\*\*\*

You have been invited to take part in a study exploring young people's thoughts and feelings. Please read the information below before deciding whether you would like to take part. There is no hurry for you to decide. If you have any questions, please ask your keyworker. You can contact me at the [adolescent psychiatric services]:

**Christine Braehler**

Trainee Clinical Psychologist

Ph:

WHAT IS THE STUDY ABOUT?

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

I am interested in finding out what you think about your experience. I am especially interested in how your life may have changed since you have been attending [adolescent psychiatric services] and how this might have changed over time.

WHY HAVE I BEEN ASKED TO TAKE PART?

You have been asked to take part because you're aged between 16-21, and have become involved with [adolescent psychiatric services] because of mental health problems.

WHAT WILL I BE ASKED TO DO?

This project involves a series of interviews. In the interviews you will be asked about how the way you make sense of your experiences and how you deal with them may have changed over time. We will also ask about your relationship with the person who brought you up and how things were when you were little. The aim is to find out what you think about your early experiences and how you have adapted to your difficulties.

One interview will ask you a series of open questions. In the other interview you will be able to lead the interview by talking about what is important to you. It is an opportunity for you to explore your own experiences and to describe it in your words. When you feel you have explored enough, the interview will end.

Interviews will be held at [adolescent psychiatric services]. We will meet for 2 to 3 interview sessions over a period of 1 to 3 weeks. To help remember

what you have said, sessions will be tape-recorded. The tapes will be stored securely at [adolescent psychiatric services], and will be destroyed after a maximum period of 3 years.

### DO I HAVE TO TAKE PART?

No. It is up to you. The interview is not part of the care you receive at [adolescent psychiatric services]. Your decision about taking part will have no effect on the treatment you receive. If you decide to take part, you are asked to sign a consent form. You will still be able to change your mind at any time, without giving any reason.

### ARE THERE ANY RISKS OR BENEFITS?

We hope that the interviews are interesting and helpful to you, and it could help us to develop better services for young people. If, at any time, you are asked questions you don't want to answer or find the discussion upsetting, you can ignore the question or stop the interview. Remember you're free to withdraw from the study at any time without giving an explanation.

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

The staff at the [adolescent psychiatric services], will know so they can help with arrangements. You can discuss the interviews with them if you wish, but we will not share anything you have said unless you say something that causes concern about your safety or that of other people.

As this research is conducted within the NHS, I am obliged to inform your GP about your participation. However, your GP will still not have access to any information you give me during the study. All information is confidential.

### WHAT IF SOMETHING GOES WRONG?

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

### WHO HAS REVIEWED THIS RESEARCH?

[Name of Health Board] Local Research Ethics Committee has responsibility for all research conducted within [Name of Health Board]. It has examined the proposed research and raised no objections from a medical ethics point of view.

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

Reflective Function Coding	<u>Excerpt from adaptation interview</u> (from Participant 'David 6')	Open coding
<p>Claiming ignorance what helped recovery (Lacking in RF – Disavowal)</p>	<p><b>What would you call the difficulties you've had?</b></p> <p>Em, I don't know. Psychotic disorder or something like that.</p> <p><b>Ok. Em, and what would you say helped? Cos you said you got a lot better, what was it that helped?</b></p> <p>I don't know the tablets or something like that, I don't know.. {2 sec} I don't know what it was. Obviously the tablets cos nothing else, I don't know.</p> <p><b>So you think it's been the tablets?</b></p> <p>Yeah.</p> <p><b>Ok. Em, and how else has your life changed since you got better?</b></p> <p>I've been doing more...em, I'm, I suppose, eh... {3 sec} that's about it really.</p> <p><b>Uhuh. Em, so would you say that, you know we've talked about how you feel about yourself. Would you say that anything else has changed in your life?</b></p> <p>Em/</p>	<p>Guessing psychosis Unsure how label experiences Having psychotic disorder</p> <p>Guessing recovery due meds Nothing but meds helped Unsure what helped recovery</p> <p>Doing more than when ill</p>
<p>Contradicting statements about change in activity (Negative RF – unintegrated)</p>	<p><b>/any other aspects of your life have changed for better or worse since you've become involved with/</b></p> <p>/I'm probably doing less cos I used to go swimming and had school to go to. Now I just sit in the house. So I'm probably doing less. Eh... {3 sec} apart from that I don't know what's really changed. I don't see my friends very much.</p> <p><b>Really?... {3 sec} How are you finding, say for instance the first thing you said, not going to school/</b></p> <p>Yeah</p> <p><b>/anymore, how are you finding that?</b></p> <p>I've got used to it now. I'd rather, I'd rather be back at school for some reason as well. I didn't like</p>	<p>Being less active than before Sitting in house Having go to school before ill Going swimming before ill Not seeing friends much since ill</p> <p>Getting used to no school Wanting to be back</p>

<p>Contradicting feelings loss of school (Negative RF – unintegrated) Claiming to not care about loss school (Lacking in RF – Disavowal)</p>	<p>school. Just cos you see your friends more.</p> <p><b>And how are you feeling about not going to school?</b></p> <p>That’s fine. I’m not bothered now.</p> <p><b>Have you’ve got any plans about that? School?</b></p> <p>Oh, I might be going to college next year. I don’t know.</p> <p><b>What are your thoughts?</b></p> <p>What?</p> <p><b>What are your thoughts about/</b></p> <p>College?</p> <p><b>That plan?</b></p> <p>Eh, don’t know. Don’t know whether to do it or not. Just see what happens.</p> <p><b>Ok. And you talked about friends. That was something I was going to ask you actually. How have things changed with your friends maybe even before you became ill and involved with services up to now? What has happened?</b></p>	<p>at school Not liking school past Seeing friends more at school</p> <p>Not bothered not going school</p> <p>Considering college next year</p> <p>Taking each day as it comes Uncertain going to college</p>
<p>Denying change in friendships since illness (Lacking in RF – Disavowal)</p>	<p>Em, nothing really changed, apart from I don’t see them anymore, as much. Just because I’m not at school, that’s one of the reasons. Eh...{3sec}apart fae that nothing’s really changed.</p> <p><b>Uhuh. So when did you stop going to school?</b></p> <p>When I became ill. I think it was like March some time. March.</p> <p><b>And did that happen from one day to the next or/</b></p>	<p>Not seeing friends not school</p> <p>Stopping school when ill</p>
<p>Claiming ignorance how became ill (Lacking in RF – Disavowal)</p>	<p>Sorry?</p> <p><b>How did the becoming ill happen?</b></p> <p>Don’t know..{2sec} mh, I’m not sure.</p> <p><b>Does the time with regards to going to school I’m thinking. Did it happen from one day to the next or was it more of a gradual change?</b></p>	<p>Not understanding question</p> <p>Uncertain about how became ill</p>

<p>Recognizing change enjoying friends (Moderate RF-Recognizing developmental aspects of mental states)</p>	<p>It was pretty, it was kind of a gradual one. Like, the first voices I ever had, they were like good voices for like, for like quite a long while and then it changed like in like a day... {3 sec} so.</p> <p><b>Em, and with regards to your friends. What kind of contact do you have just now?</b></p> <p>I see them at the weekends and occasionally during the week. We go out to gigs and stuff like that.</p> <p><b>And what is it like being with your friends these days?</b></p> <p>Good... {3 sec} I didn't use to like it cos I used to have bad voices and stuff like that as well like. But now, it's fine.</p> <p><b>Uhuh. How do you, like a few of the young people I've spoken to have said that since they've had difficulties, the way they relate, the way the sort of manage these experiences like say the voices and stuff like that, with others has changed.</b></p> <p>What do you mean like?</p> <p><b>I'm wondering how you, like, when they're with other people and some of them might know, might not know that they've had difficulties, they kind of find different ways of talking about them or not talking about these experiences. So I am wondering how do you, when you're with your friends say on the weekend (yeah), how do you manage your illness or the difficulties you've had with them?</b></p> <p>I don't tell them that much about it. I just, I just get on with it. I just keep it to myself really.</p> <p><b>Uhuh.</b></p> <p>So they don't really, apart from me going quiet and stuff like that they don't really notice. They kind of notice when we were.</p> <p><b>What have you told them if anything?</b></p> <p>Yeah, I've told them about illness and stuff like that, or most of them anyway.</p> <p><b>Can you tell me what you told them?</b></p>	<p>Recalling gradual onset voices Hearing good voices before ill Good voices suddenly turning bad</p> <p>Going out gigs with friends</p> <p>Disliking friends' company due to voices Enjoying friends' company</p> <p>Not understanding question</p> <p>Not telling friends illness Getting on with it Keeping things to self</p> <p>Thinking friends noticing nothing</p> <p>Having told most friends illness</p>
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