

**The Experience and Meaning of Relationships for People with  
Psychosis in a Rehabilitation Service: An Interpretative  
Phenomenological Approach**

Diane Naomi Agoro

Submitted in accordance with the requirements for the degree of  
Doctor of Clinical Psychology (D. Clin. Psychol.)

The University of Leeds

School of Medicine

Academic Unit of Psychiatry and Behavioural Sciences

May 2015

The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

This copy has been supplied on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.

© 2015 The University of Leeds and Diane Naomi Agoro

The right of Diane Naomi Agoro to be identified as Author of this work has been asserted by her in accordance with the Copyright, Designs and Patents Act 1988.

## **ACKNOWLEDGEMENTS**

First, I would like to thank my supervisors Alastair Cardno, Anjula Gupta and Sylvie Collins for their support throughout this study.

Thank you to the Macmillan Fund for providing extra financial aid for covering the costs of this study.

I am extremely grateful to the staff at the rehabilitation service, despite being busy, they showed a lot of enthusiasm for this research and supported me as I recruited participants for the study.

Thank you to my family who have always believed in me and have told me never to give up.

To my husband Jacob, thank you for your continuous support and encouragement. Your words of wisdom and advice have been a source of great comfort. I could never have got this far without you.

I would like to express my gratitude to the service users who gave up their time to take part in the research. Without them this study would not have been possible and I feel privileged to have spent time with them, hearing about their experiences.

Most importantly, I would like to thank God for his continual blessings and for giving me the strength to persevere through it all.

## **ABSTRACT**

*Introduction:* There has been a wealth of literature that has looked at social functioning in individuals with experiences of psychosis. Most of this has been quantitative research and has tended to suggest that social difficulties may be due to a social cognition deficit such as an impaired Theory of Mind. The present study aimed to give voice to people with experiences of psychosis and explore their own understanding of their relationships with others, including how they make sense of any difficulties they might experience.

*Method:* A qualitative approach was used to explore the experience and meaning of relationships for people with psychosis. Five participants recruited from a local Rehabilitation service were interviewed using a semi-structured format. The data were analysed using Interpretative Phenomenological Analysis. Participants also completed The Hinting Task, a test to measure Theory of Mind ability. Analysis was done on an individual and group level.

*Results:* Three superordinate themes emerged from the group analysis: 1) Feeling connected to important others 2) Having psychosis can get in the way of relationships 3) Being cautious around others.

*Discussion:* The participants seemed to make sense of their relationships in terms of what the relationships provided; this included support and recovery but also a sense of belonging. Negative experiences with important others, for example, experiencing stigma, were blamed on important others' difficulties in understanding experiences of psychosis. In relation to the existing literature, the present study suggests that it may be too simplistic to suggest that difficulties interacting with others are due to a social cognition deficit. Clinical implications for improving service user's experiences and further research are discussed.

## TABLE OF CONTENTS

<b>ACKNOWLEDGEMENTS</b> .....	<b>iii</b>
<b>ABSTRACT</b> .....	<b>iv</b>
<b>TABLE OF CONTENTS</b> .....	<b>v</b>
<b>LIST OF TABLES</b> .....	<b>viii</b>
<b>LIST OF FIGURES</b> .....	<b>ix</b>
<b>ABBREVIATIONS</b> .....	<b>10</b>
<b>INTRODUCTION</b> .....	<b>11</b>
Literature review .....	11
Defining psychosis.....	11
Social functioning in psychosis .....	13
Social cognition training.....	19
Attachment style and psychosis .....	21
Qualitative studies .....	24
Family .....	25
Social relationships.....	26
Service user community .....	28
Research Questions .....	29
<b>METHODOLOGICAL APPROACH</b> .....	<b>31</b>
Interpretative Phenomenological Analysis.....	31
Semi-structured interviews .....	33
Alternative approaches.....	33
<b>METHOD</b> .....	<b>35</b>
Design .....	35
Participants.....	35
Recruitment .....	35
Data collection .....	36
Semi-structured interview .....	36
Measures .....	37
Ethical considerations.....	38
Ethical approval .....	38
Service User involvement.....	38
Managing the potential for participant distress .....	38

Maintaining privacy and confidentiality .....	38
Informed consent.....	39
Analysis .....	39
Quality and reflexive positioning.....	41
Owning one's perspective.....	41
Situating the sample .....	43
Grounding in samples.....	43
Providing credibility checks.....	43
Coherence .....	44
Accomplishing general versus specific research tasks.....	44
Resonating with readers .....	44
<b>RESULTS.....</b>	<b>45</b>
Overview of sample .....	45
Individual analysis .....	46
George.....	46
Robert.....	53
Therese.....	59
Henry .....	64
Philip.....	72
Group analysis.....	78
<b>DISCUSSION .....</b>	<b>90</b>
How do people with experiences of psychosis make sense of their relationships with important others? .....	90
Relationships provide support and aid recovery.....	91
Relationships provide a sense of belonging .....	95
How do they make sense of any difficulties they experience with important others?.....	98
Lack of understanding and stigma.....	98
Relationships are vulnerable to change.....	101
Difficulty establishing new relationships .....	103
Theory of Mind.....	105
Research methodology: strengths and limitations.....	108
Qualitative research and Interpretative Phenomenological Analysis...	108
Interviews.....	110
Sample and recruitment.....	112
<b>CLINICAL IMPLICATIONS AND RECOMMENDATIONS .....</b>	<b>113</b>
Strengthening the staff-service user relationship.....	113

Facilitating family members' understanding of individual experiences of psychosis .....	114
Encouraging peer support from current and previous service users ...	115
Individual interventions tailored towards the social needs of the service user.....	116
<b>FUTURE RESEARCH.....</b>	<b>117</b>
<b>CLOSING REFLECTIONS.....</b>	<b>118</b>
<b>CONCLUSIONS.....</b>	<b>120</b>
<b>REFERENCES.....</b>	<b>122</b>
<b>APPENDIX.....</b>	<b>138</b>
Appendix I: Staff information sheet.....	138
Appendix II: Participant information sheet.....	141
Appendix III: Recruitment procedure .....	144
Appendix IV: Interview guide .....	145
Appendix V: The Hinting Task.....	147
Appendix VI: Ethics approval.....	151
Appendix VII: R&D approval.....	153
Appendix VIII: Protocol to minimize and manage the risk of distress.....	155
Appendix IX: Consent form.....	156
Appendix X: Reflections .....	158

## LIST OF TABLES

<b>Table 1: Common tasks used to measure ToM .....</b>	<b>15</b>
<b>Table 2: Participant details.....</b>	<b>45</b>
<b>Table 3: The types of relationships discussed by each participant.....</b>	<b>46</b>
<b>Table 4: Superordinate themes and themes for George .....</b>	<b>47</b>
<b>Table 5: Superordinate themes and themes for Robert .....</b>	<b>53</b>
<b>Table 6: Superordinate themes and themes for Therese .....</b>	<b>60</b>
<b>Table 7: Superordinate themes and themes for Henry.....</b>	<b>65</b>
<b>Table 8: Superordinate themes and themes for Philip .....</b>	<b>72</b>



## LIST OF FIGURES

<b>Figure 1: Superordinate themes and themes for the group analysis.....</b>	<b>78</b>
--	-----------

## **ABBREVIATIONS**

DSM: The Diagnostic and Statistical Manual of Mental Disorders

FEP: First Episode of Psychosis

IPA: Interpretative Phenomenological Analysis

MDT: Multidisciplinary Team

R&D: Research & Development

SCIT: Social Cognition and Interaction Training

ToM: Theory of Mind

## **INTRODUCTION**

In this study I have chosen to explore the personal experience and meaning of relationships with others among people with experiences of psychosis. During my previous work on inpatient units I noticed that many, although not all, of the service users had few, if any, visitors. I was interested in why this was the case, but also concerned that it was something that was rarely spoken about. Instead, from my experience the focus tended to be on reducing risk and managing the symptoms of psychosis. Although I can appreciate that the inpatient units I worked on are perhaps not representative of all inpatient units, I was curious to find out more about the service users' relationships. It was this curiosity that led me to read the literature regarding relationships among people with experiences of psychosis.

The following literature review includes an overview of the current literature relevant to the present study. I will begin by reviewing cognitive theories of psychosis and why they may be relevant to an understanding of relationships among people with psychosis. I will then discuss the importance of early attachment and how this may impact on current relationships. Following this, I will argue that although there is much literature looking at relationships among people with psychosis, the personal experience for these individuals is missing. This will lead to a discussion about the value of qualitative research and its relevance for the present study.

### **Literature review**

#### **Defining psychosis**

Before moving on to the main topic of social relationships in people with experiences of psychosis, it is important to define the term. However, the term psychosis, and schizophrenia, which is also commonly used, is the subject of much controversy and debate (Henderson & Malhi, 2014; Lasalvia, Penta, Sartorius & Henderson, 2015). The National Institute of Health (NIH, 2012) defines psychosis as a broad term for a range of symptoms that result in a loss of contact with reality. According to DSM-5 (American Psychiatric Association, 2013) psychosis includes disorders such as schizophrenia,

schizoaffective disorder and delusional disorder. Individuals with psychosis may experience positive symptoms such as hallucinations and delusions, negative symptoms such as social withdrawal, disorganised symptoms and manic symptoms.

However, the continuum model suggests that psychosis may consist of a range of experiences that lie on a continuum of what is considered subclinical to those which may lead to a clinical diagnosis (DeRosse & Karlsgodt, 2015). Thus individuals may experience some of the 'symptoms' defined by DSM-5 (American Psychiatric Association, 2013) but would not necessarily be considered as having psychosis. Romme & Escher (1997), argue that voice hearing is not a symptom of an 'illness' and the presence of it should not be used to determine whether someone is 'ill'. What seems to be important is how someone copes with the experience. For example, not everyone who experiences voice hearing requires input from mental health services (Johns & van Os, 2001). Despite this, Nuevo et al. (2012) suggest that even the presence of one "symptom of psychosis" can have a significant impact on someone's health.

Viewing psychosis as being on a continuum is plausible as it means that cultural and social norms can be considered. It emphasises that unusual beliefs and wariness of people's motives is part of human experience and capacity. The only difference is the frequency of the experiences and the distress it may cause. For example, there may be cultural differences in how people perceive and manage human experiences, such as voice hearing (e.g. Luhrmann, Padmavati, Tharoor & Osei, 2015; Wahass & Kent, 1997). However, this also means that psychosis may be difficult to define in a multicultural society that is constantly changing over time.

A range of factors have been explored and suggested as possible risk factors for the development of psychosis. Some of the factors include poor social functioning (Cornblatt et al. 2011), childhood social adversity (Varese et al. 2012; Wicks et al. 2014), having a parent with psychosis (Sorensen et al. 2014), neurobehavioural deficits (Erlenmeyer-Kimling et al. 2000), substance misuse (Moore et al. 2007), lower socio economic status (Werner, Malaspina & Rabinowitz, 2007), trauma (Freeman & Fowler, 2009), urbanisation (Sundquist, Frank & Sundquist, 2004) and genetic factors (Sullivan, Daly & O'Donovan, 2012). In most, and possibly all cases, psychosis is likely

to have a multifactorial aetiology, with many risk factors, each insufficient to cause psychosis on their own, thus acting cumulatively to increase risk (Dean & Murray, 2005).

### **Social functioning in psychosis**

One particular feature of psychosis is the gradual deterioration of social functioning, which may often precede a first episode of psychosis (Bratlien et al. 2013; Jang et al. 2011; Sullivan, Lewis, Wiles, Thompson & Evans, 2013a) and may predict long term outcome (Harrison et al. 2001). Up to two-thirds of individuals with experiences of psychosis have difficulties with social roles, even after recovery (Bellack et al. 2007). Many become socially isolated and have significant difficulties with social relationships (Stain et al. 2012) and are more likely to have experienced social disadvantages during childhood and adulthood (Stilo et al. 2013). In addition, some experiences of psychosis, such as unusual experiences like voice hearing and persecutory ideation, are associated with poorer interpersonal functioning (Collip et al. 2011).

Social cognition seems to be an important aspect of social functioning (Couture, Penn & Roberts, 2006) and therefore may have implications for social difficulties in people with psychosis. Social cognition refers to the range of mental processes and operations involved in social interactions, for example, interpreting others' behaviour and generating responses (Green et al. 2008). Social cognition is adaptive as it facilitates the exchange of signals and communication with others, which is vital for survival (Frith & Frith, 2007). Any cognitive process used for interpersonal functioning is a form of social cognition (Wykes & Reeder, 2005). Therefore, social cognition may be seen as an umbrella term for a range of processes used in a social context; for example, being able to judge emotions from facial expressions (Kennedy & Adolphs, 2012) and being able to recognise social cues (Corrigan, Buican & Toomey, 1996).

One particular form of social cognition, which has gained a lot of interest is Theory of Mind (ToM), and whether deficits in this ability may affect social functioning in people with psychosis. ToM refers to the ability to make inferences about the mental states, beliefs and intentions of self and others (Premack & Woodruff, 1978). ToM is important for social interactions since, in order to understand and predict others' behaviour,

individuals need to be able to predict their mental state (Philpot, Rinehart, Gray, Howlin & Cornish, 2013).

Generally, a typically developing child will develop a ToM around the time they reach five years old (Wimmer & Perner, 1983). ToM delay or impairments have been found in a range of disorders and disabilities among children with specific language impairments (Andres-Roqueta, Adrian, Clemente & Katsos, 2013) and autism (Colle, Baron-Cohen & Hill, 2007) and, in later life, individuals with Alzheimer's Disease (Moreau, Viallet & Champagne-Lavau, 2013). There are a range of tasks that have been developed and used to measure ToM ability. Some of the common ones are described in Table 1.

Various studies have suggested that psychosis may also be associated with ToM impairments (Bosco et al. 2009; Drury, Robinson & Birchwood, 1998; Janssen, Krabbendam, Jolles & van Os, 2003; Langdon, Davies & Coltheart 2002; Sarfati & Hardy-Bayle 1999; Scherzer, Leveille, Achini, Boisseau & Stip, 2012). All individuals, at some point, experience difficulties relating to others, thus, it is possible that a deficit in ToM ability has a significant impact on how people with psychosis manage interactions with others.

Bentall (2003), for example, suggests that it is a ToM deficit in people with psychosis that prevents them from considering all the circumstances of a situation. For example, a particular bias associated with people who have psychosis is the tendency to jump to conclusions (Rubio et al. 2011); approximately 40-70% of people may arrive at strong conclusions without sufficiently weighing up the evidence for and against this conclusion (Moritz & Woodward, 2007).

The model offers an explanation as to why individuals with psychosis might experience more difficulties than those without psychosis. However, it does not explain why people with psychosis have this deficit or why they may be more prone to jump to one conclusion over another. The model seems to ignore the context of individual experiences. For example, an individual who has experienced trauma may understandably jump to conclusions about other individuals and be suspicious of their intentions.

Table 1: Common tasks used to measure ToM

<i>Task</i>	<i>Description</i>
<b><i>Sally-Anne (Baron-Cohen, Leslie &amp; Frith, 1985)</i></b>	A test designed to assess children’s ability to attribute false belief to others. Two puppets are used to represent ‘Sally’ and ‘Anne’ in a story. Sally hides a marble in a basket. She then leaves, and whilst she is away, Anne takes the marble and puts it in her own box. Sally returns and the child is asked: “Where will Sally look for her marble?” The child will pass the test if they are able to recognise that Sally will look for the marble in the place where she believes it is.
<b><i>Reading the Mind in the Eyes test (Baron-Cohen, Jolliffe, Mortimore &amp; Roberston, 1997)</i></b>	This tests an individual’s ability to recognise emotions by looking at pictures of eyes. The individual is presented with sets of eyes and asked to choose which one of four words most accurately describes the thoughts or feelings of the person in the picture.
<b><i>Visual Cartoons (Brune, 2005a)</i></b>	The task involves six cartoon pictures depicting stories. The cards are placed face-down in a random order and the participant has to turn them over and sort them into a logical sequence of events.
<b><i>Strange Stories (Happe, 1994)</i></b>	The task was developed for the level of a normal 8-9 year old child. It consists of a series of stories where a child is questioned about the intent or meaning behind a character’s remark.

Couture et al. (2006) suggest a model that considers how early experiences may impact on the biases an individual might hold. For example, it is proposed that an individual with psychosis may hold biases in how they perceive a situation and another individual’s emotions. This bias may be due to early experiences of trauma or adversity, resulting in the individual making biased conclusions and attributions about others’ behaviour. ToM deficits may then prevent individuals from considering and looking at alternative explanations. Thus many people may hold biases about people’s emotions and various situations and make biased attributions, but an intact ToM may enable them to hold and reflect on alternative views due to their understanding that others’ mental states may differ from their own.

This model offers a further explanation as to how and why individuals with psychosis might hold biases about others. However, it still suggests that it is the ToM deficit that prevents them from looking for alternatives. Similar to the model by Bentall (2003) it offers little explanation as to why an individual with psychosis might have a ToM deficit.

In addition, it is unlikely that difficulties in social relationships can be explained entirely as a result of a cognitive deficit. As such, although some studies have suggested an association between ToM and social functioning (e.g., Kosmidis, Giannakou, Garyfallos, Kiosseoglou & Bozikas, 2011; Pinkham & Penn, 2006; Sullivan et al. 2013b) research looking at the association between the two is limited (Couture et al. 2006). Brune (2005b) found that performance on a ToM questionnaire was the strongest predictor of significant social behaviour difficulties. In addition, Roncone et al. (2002) found that competence in making social inferences was associated with better community functioning and that being able to understand other people's mental states was one of the strongest predictors of global social functioning.

Furthermore, research into the association between ToM and psychosis suggests that there are various factors involved. For example, the age at onset of psychosis may be important. Smeets-Janssen et al. (2013) looked at ToM impairments in older adults with either early-onset psychosis or late-onset psychosis. Those with early-onset psychosis performed significantly worse on ToM tests than those with late-onset psychosis. Adolescence and young adulthood is an important period for the development of peer relationships (Field, Diego & Sanders, 2002; Harrop & Trower, 2001). It is possible that this period is significantly disrupted in people who develop early-onset psychosis, depriving them of the opportunity to develop and maintain relationships. However, people who develop late-onset psychosis have already had the opportunity to develop important peer relationships.

There may also be methodological issues with measuring ToM ability. Chan and Chen (2011) reviewed the literature on ToM and psychosis. They suggest that the type of ToM task used may be a confounding variable as to whether conclusions can be drawn about ToM ability and social functioning. Many of the tasks focus on the third person perspective and fail to capture the demands placed on an individual when they are actively engaging in social interactions.



In addition, there are a wide range of ToM tasks that measure a variety of abilities such as false belief (Wimmer & Perner, 1983), understanding irony (Baron-Cohen, 1997) and perspective taking (Korver-Nieberg et al. 2013). Many of these ToM tasks were developed for children with autism; therefore it can be argued that these tasks may not be valid for adults with psychosis. In addition, many of these tasks are rather abstract; they do not represent everyday functioning (Philpot et al., 2013) and may not be ecologically valid.

A common ToM task used in psychosis research (Couture et al. 2006) is The Hinting Task (Corcoran, Mercer & Frith, 1995). This task was developed specifically for people with psychosis in order to measure the relationship between ToM ability and social competence. The task includes ten short stories about an interaction between two individuals. One of the stories involves one character that has run out of money complaining to another character that they have no money and cannot go out with them. The participant is then asked questions about the intent behind what a character says in each of the stories.

As with many tasks, it lacks the emotional and realistic aspect of everyday situations, however, it is likely to be more ecologically valid than the more abstract and traditional tasks such as the Sally-Anne task (Baron-Cohen et al. 1985). It also requires fewer demands on cognitive abilities such as working memory and it includes real world speech and social communication (Fish, 2009).

In addition, individuals with psychosis perform poorly on The Hinting Task compared to healthy controls (Corcoran et al. 1995; Scherzer et al. 2012). Corcoran et al. (1995) found that people with psychosis scored on average 15.6 compared to controls that scored 18.3 out of twenty. The significant difference between the groups remained, even when IQ was considered, suggesting that performance was not due to an overall level of functioning. In addition, scores varied depending on presentation; for example participants with a more negative presentation tended to perform worse (Corcoran et al. 1995).

Scherzer et al. (2012) found that people who were highly suspicious were impaired on ToM tasks such as The Hinting Task and 'strange stories' (Happe et al. 1999) but did well on the 'reading the mind in the eyes' test (Baron-Cohen et al. 1997). Sullivan et al. (2013b) looked at the association between negative symptoms, ToM and social functioning in people with first episode psychosis. They used The Hinting Task and the Visual Cartoon Test (Brune, 2005a) to measure ToM ability. ToM as measured using The Hinting Task was associated with social functioning, however, it was not associated with social functioning when ToM was measured using the Visual Cartoon Test.

Whilst some studies look specifically at ToM and social functioning, others draw conclusions from studies looking at social cognition in general. For example, Mazza et al. (2012) found that social cognition was strongly associated with negative symptoms and social functioning in people with chronic and first episode psychosis. However, Maat, Fett and Derks (2012) found that ToM was the only form of social cognition that was associated with quality of life.

Some studies have found no evidence of a ToM impairment (Korver-Nieberg et al. 2013) or have found small differences between participants and controls (Fizdon, Fanning, Johannesen & Bell, 2013). In addition, some studies have found no evidence of an association between ToM ability and social functioning outcome. Sullivan et al. (2014) did a longitudinal study looking at the association between ToM (measured using The Hinting Task), unusual experiences and social functioning in people with first episode psychosis. Although ToM ability was found to be stable over time it was not associated with social functioning outcome. However, the longest follow-up was at 12 months. Thus it is possible that after periods of greater than 12 months, ToM ability may be associated with social functioning.

Overall, meta-analyses have found that there are ToM impairments in people experiencing psychosis (Bora, Yucel & Pantelis, 2009; Brune, 2005b; Harrington, Siegert & McClure, 2005; Sprong, Schothorst, Vos & Hox, 2007). However, it is important to acknowledge that experiences of psychosis can vary considerably from one individual to another and this may explain why ToM impairments may not be consistent. Research varies, with some studies suggesting that ToM deficits are most

common in those with disorganised symptoms (Sprong et al. 2007), persecutory delusions (Langdon, Siegert, McClure, Harrington, 2005) and negative symptoms (Corcoran et al. 1995, Garety & Freeman, 2013). In addition, some studies suggest that general cognitive ability (Janssen, Krabbendam, Jolles & van Os, 2003) and other neuropsychological factors such as verbal memory (Greig, Bryson, & Bell, 2004) may mediate the association between ToM impairments and psychosis.

Frith (1992) suggests that ToM abilities may differ depending on which symptoms are most dominant. An individual with more dominant negative symptoms may have ToM impairments because they are unable to represent mental states. However, an individual presenting predominantly with suspiciousness may be able to acknowledge that others have mental states but is unable to use contextual information when making inferences about these mental states.

It is also important to acknowledge the various risk factors that may contribute to the development of psychosis. If an individual has had a traumatic upbringing and has experienced childhood adversity then this is likely to affect not only their ability to make sense of other people's intentions but it may also have an impact on how they perceive society.

### **Social cognition training**

Interventions for psychosis have started to incorporate aspects of social cognition training. One particular group intervention is Social Cognition and Interaction Training (SCIT, Roberts & Penn, 2009), which involves emotion recognition training, recognising attribution style and transferring these skills into real life situations. Combs et al. (2007) compared the efficacy of SCIT to a coping skills control group. Participants improved in their ToM ability and reported that they noticed improvements in their social functioning, particularly in their ability to understand others. However, participants were not randomly assigned to each group of the study. Participants volunteered to do SCIT and the researchers had no control over the coping skills control group. Therefore, it is possible that self-reported improvements in social skills may be influenced by demand characteristics and motivations to improve in social functioning (Combs et al. 2007).

However, there was modest support for a generalisable and stable improvement at six-month follow-up (Combs et al. 2009).

Research findings on the efficacy of SCIT on ToM vary. Bartholomeusz et al. (2013) found that although a group of people with FEP reported that they found SCIT useful they did not show any significant improvements in ToM ability as measured using The Hinting Task. Roberts and Penn (2009) also found that SCIT did not improve performance on ToM ability as measured using The Hinting Task, but ToM did improve when measured using The Awareness of Social Inference Test (TASIT, MacDonald, Flanagan, Rollins & Kinch, 2008). Finally, Tas, Danaci, Cubukuoglu and Brune (2012) found that when evaluating the efficacy of F-SCIT (Family assisted Social Cognition and Interaction Training) individuals showed improvement in ToM when it was measured using The Hinting Task but not when it was measured using the Reading-the-Mind-in-the-Eyes-Test-Revised (Baron-Cohen, Wheelwright, Hill, Raste, Plumb, 2001). This suggests that again the type of test or task used to measure ToM ability may be a confounding variable.

Horan et al. (2009) compared the efficacy of social cognition training in comparison to a control group. The social cognitive training involved skill-building strategies particularly around emotion and social perception and social attribution and ToM. They found no significant improvements in ToM in either group. Instead the authors suggest that ToM covers a range of concepts such as sarcasm, deception and humour and therefore it can be hard to define and hard to translate into a measurable task. Despite this, it appears that at least some aspect of ToM may be amenable to change and this may have important implications for improving social functioning outcomes for people with psychosis.

Other social cognition training interventions have also been found to improve ToM. Mazza et al. (2010) developed Emotion and ToM Imitation Training (ETIT) a group intervention designed specifically for people with psychosis. It consists of four phases that aid learning through observation and imitation. For example, one of the phases involves observing and imitating facial expressions. Compared to a problem-solving group, participants in the ETIT intervention showed more improvements in social cognition, including ToM and also showed general improvements in social functioning.

Roncone et al. (2004) looked at the efficacy of Instrumental Enrichment Programme (IEP, Feuerstein, 1980) that involves completing various exercises aimed at improving social skills compared to a control group. The IEP group showed significant improvement in ToM ability compared to the control group and showed better social functioning. However, this programme was developed for slow learners and was aimed at helping low achieving adolescents become better learners (Burden, 1987) rather than being specific for people with psychosis.

In summary, difficulties with social functioning may be explained at least partly in terms of difficulties with social cognition, particularly ToM. Some studies have found an association between psychosis and ToM impairments (e.g. Drury et al. 1998) and a few have found an association between ToM deficits and social functioning (e.g. Brune, 2005b). However, findings have been mixed and some studies have not found an association between ToM deficits and psychosis (e.g. Korver-Nieberg et al. 2013). It is possible that various factors such as the age of onset of psychosis, the type of ToM task being used and the type of symptoms may all have an effect on the association between ToM and psychosis. Despite this, the fact that interventions have been developed which seem to improve ToM is promising as it suggests that ToM may be amenable to change. This may therefore have important implications for improving social functioning, particularly if it may precede an episode of psychosis.

### **Attachment style and psychosis**

A limitation of much of the literature looking at the possible association between ToM and social difficulties in people with psychosis is that it has neglected to consider how past events and an individual's upbringing may affect their ability to interact with others. Attachment style research can offer an explanation as to how an individual's early attachments may influence how they understand others and also how they learn to relate to others in the future.

A secure attachment develops when a child has a caregiver who is emotionally available and responsive to their behaviour and emotional needs (Ainsworth, Bleharm Waters & Wall, 1978). Various studies have looked at how infant attachment styles

may develop into adulthood (Brennan, Clark & Shaver, 1998; Main, Kaplan & Cassidy, 1985). If an individual does not have a caregiver who meets these needs, then they may develop insecure attachments which are either avoidant or ambivalent or a disorganised attachment style. Adult avoidant attachment style is associated with being dismissive of attachment related experiences (Main et al. 1985) and characterised by a preference for being alone (Brennan et al. 1998). Ambivalent attachment style is associated with the need to be with others but being fearful of rejection (Brennan et al. 1998). A disorganised attachment is characterised by incoherent and conflicting behaviour that is not orientated to the present situation (Hesse & Main, 2000).

Secure attachment style has been found to be important in establishing self-esteem (Feeney & Noller, 1990), marital satisfaction (Feeney, 1994) and reducing depressive symptoms (Murphy & Bates, 1997). Insecure and disorganised attachment styles have been associated with psychopathology (Fossatti, 2012; Harder, 2014; Muela, Torres & Ballverka, 2012). Gumley, Taylor, Schwannauer and MacBeth (2014) carried out a systematic review of the literature looking at the association between attachment and psychosis. They found that there was a small to moderate association between greater attachment insecurity and more interpersonal problems. Couture, Lecomte and Leclerc (2007) found that individuals with FEP are more likely to have attachment difficulties with their peers than non-clinical controls. In addition, Berry, Barrowclough & Wearden (2008) suggest that adult attachment style may be an important predictor of interpersonal difficulties in people with psychosis.

Main (1991) linked the concept of a secure attachment with the ability to draw upon metacognitive knowledge. Metacognitive knowledge includes having the ability to reflect on one's own thoughts and have an awareness of its validity and source. Without this ability individuals are unable to understand that they and others may have false beliefs. This lack of ability to reflect on one's own thoughts is likely to have an impact on how a person interacts with others. For example, being able to identify and challenge cognitive biases, which discourage them from engaging with other people.

Memories and expectations from the internal working model, which develops as the result of an infant's relationship with their primary caregiver, guides the person's interactions with others (Bowlby, 1983). It is therefore plausible that an insecure

attachment may affect an individual's ability to interact with others because they lack an adaptive internal working model that enables them to reflect on their thoughts and form positive relationships with others. If individuals with psychosis are at higher risk of jumping to conclusions and neglect to appreciate alternative views then this suggests that they are less able to engage in metacognition (Wykes & Reeder, 2005), which may be explained by their upbringing and early attachment style.

However, it is likely that, in addition to lacking the ability to understand others, an insecure attachment may mean that individuals have had less opportunity to develop appropriate and adaptive social skills. As previously discussed, research suggests that difficulties with social functioning may precede the onset of psychosis (Bratlien et al. 2013; Jang et al. 2011; Sullivan et al. 2013a). Pos et al. (2014) found that an anxious attachment style was associated with poorer ToM. It is possible that this lack of secure attachment prevents people not only from having the social skills to interact with others but also the metacognitive knowledge to appraise their own thoughts, which may make them more vulnerable to experiencing psychosis.

However, experiences of psychosis can vary considerably from one individual to another, thus the association between psychosis and attachment style is likely to be confounded by other variables. For example, Pickering, Simpson and Bentall (2008) found that insecure attachment style was specifically related to suspiciousness but not voice hearing. van Dam Korver-Nieberg, Velthorst, Meijer, and de Haan (2014) suggest that adult attachment style may mediate the relationship between childhood maltreatment and unusual experiences.

Attachment style may also be important in terms of recovery. Florian, Mikulincer and Bucholtz, (1994) found that individuals with an insecure attachment style are less likely to seek emotional and social support than those with a secure attachment style. During recovery there are two main types of recovery styles that individuals with psychosis tend to adopt (Berry, Barrowclough & Wearden, 2007). A 'sealing over' recovery style is associated with refusing to acknowledge or understand experiences of psychosis. Alternatively, a more integrative recovery style is associated with recognising and understanding the psychosis experience (Tait, Birchwood & Trower, 2004).

Drayton, Birchwood and Trower (1998) suggest that individuals with psychosis may develop different styles of recovering depending on their attachment style. Those who adopted a 'sealing over' recovery style were more likely to be severely depressed than the integrative group, had more negative self-evaluations and were more likely to perceive their parents as less caring. It is possible that their depressed mood may have affected their perceptions of their parents. However, Tait et al. (2004) replicated the findings, this time controlling for mood, and found that those with a 'sealing over' recovery style reported lower levels of parental care during childhood, more childhood abuse and higher anxiety about relationships in terms of rejection, dependence and closeness.

In summary, attachment style appears to be important in terms of enabling an individual to develop the metacognitive abilities to reflect on their own thoughts. This would seem important in understanding why someone may hold strange beliefs or ideas despite there being evidence to the contrary. In addition, attachment style seems to be important in terms of facilitating interpersonal relationships and also aiding recovery. However, due to the wide range of psychosis experiences it is possible that attachment style may be more associated with certain experiences of psychosis, for example a tendency to be suspicious.

### **Qualitative studies**

The attachment literature is useful in understanding how early experiences may have an impact on current relationships. The implications are that attachment style affects an individual's template for current relationships and how they understand other mental states. However, it is not clear how this translates to the real world and how the individual experiences these relationships. Qualitative literature might provide a more detailed understanding of relationships for people with psychosis.

The use of qualitative methodology in psychology has increased rapidly over the last few years (Smith, 2004). Qualitative methodology involves collecting data and answering questions about phenomena that cannot be easily quantified (Camic, Rhodes & Yardley, 2003), for example, life experiences. Such data can be collected through observations, interviews and focus groups and analysed for various themes,



events and experiences. This differs from quantitative methodology which is based on raw numerical data and is often interested in covariation and comparison (Barker, Pistrang & Elliot, 2002).

Both qualitative and quantitative methodology have their strengths and weaknesses though ultimately the most appropriate method is dependent on the research question. In psychosis, research has tended to focus on the commonality of certain difficulties with relationships in people with psychosis and has thus adopted quantitative methods (e.g. Jang et al. 2011; Sullivan et al. 2013a and Bratlien et al. 2013).

Qualitative studies exploring the experience of psychosis are limited and have tended to focus on individuals with First Episode psychosis (FEP) (Andersen, Fuhrer & Malla, 2013; Redmond, Larkin & Harrop, 2010; Mackrell & Lavender, 2004; Windell & Norman, 2012). In many of the studies, themes around social contacts and relationships have emerged. Generally, the studies suggest that social contacts and relationships are important in aiding recovery and maintaining normality. However, there is also an indication that these relationships can be difficult to maintain and may at times be a source of conflict. In these studies the main relationships that tend to be discussed are those with family members, friends and other service users. In addition, as most of the qualitative research has been on FEP there is perhaps a need for research looking at other stages in psychosis.

## **Family**

Family members can be an important source of support for people with psychosis. Andersen et al. (2013) interviewed people with FEP about factors that helped or prevented them from seeking help in relation to their psychosis. Data were analysed using content analysis. Participants emphasised the impact that significant others had on helping them initiate their first contact with services. Importantly some suggested that without this significant other, this contact might never have been initiated. This supports the importance of a secure attachment in aiding recovery as suggested by Florian et al. (1994).

Andersen et al. (2013) and Brown (2011) found that several participants described how the supportive nature of their family brought them closer together and strengthened their ties. However, other studies have suggested that experiences of psychosis place a heavy strain on families (Windell and Norman, 2012).

Evenson, Rhodes, Feigenbaum, & Solly (2008) did an Interpretative Phenomenological Analysis (IPA) study exploring the experiences of fathers with psychosis. The participants spoke about how the experiences and events around having psychosis disrupted the parent-child relationship. The role of being a father changed; some interviewees said this occurred because of their unusual experiences, for example, feeling suspicious and not wanting to be around their children. Others described how being hospitalised meant that they missed out on important milestones and events. The relationships were disrupted further, for some, as they refused to allow their children to visit and see them in a distressed state. However, some fathers mentioned that their children were very understanding and accepting of their psychosis and offered them a lot of support.

Mackrell and Lavender (2004) interviewed adolescents experiencing FEP; they also described having a difficult relationship with their family. Adolescence tends to be a challenging time and strained relationships with parents is not uncommon (Montemayor, 1983, Harrop & Trower, 2001), therefore it may be understandable that experiences of psychosis may put additional pressure on the relationship. The pressure may have not been so evident in the studies by Andersen et al. (2013) and Brown (2011) because the participants were older and perhaps had a different relationship with their parents. Instead, as evidenced in the Evenson et al. (2008) study, the parent-child relationship may be particularly vulnerable to the impact of psychosis.

### **Social relationships**

Social relationships, in addition to providing support, may also aid recovery. Windell and Norman (2012) did a thematic analysis of factors that affect recovery in people with FEP and social support was identified as the most important factor. Perry, Taylor and Shaw (2007) interviewed male participants about their experiences of hope after

their first episode of psychosis. A theme around developing a sense of belonging emerged; participants stressed the importance of being part of a social or work group. Friends were identified as an important source of support, to share experiences with and to maintain a sense of hope.

Social relationships may play an important function in managing voice hearing. In an IPA study looking at voice hearing in people with psychosis, Mawson, Berry, Murray and Hayward (2011) found that participants reported that social relationships enabled them to maintain a sense of normality and to argue against the content of the voices. Despite this need for relationships, however, participants complained of a difficulty in maintaining these relationships. For example, at times the voices made them suspicious and distrusting of others. Some described not wanting to depend on others or to be seen as a burden, whilst others felt that they needed to protect themselves from others who may not understand their voice hearing. Finally, for those who were socially isolated, voice hearing was adaptive as it provided a replacement for social relationships.

Brown (2011) interviewed five people about life before, during and after psychosis. Data was analysed using thematic analysis. Similar to other research that suggests that individuals may have difficulties with social functioning prior to the onset of psychosis, many of the participants recalled having difficulties making friends and having relationships with their family before the onset of psychosis. Whilst they had psychosis they described finding it difficult to maintain friendships and to continue socialising. Although they felt able to tell their friends about the psychosis, they were reluctant to disclose their experiences to new friends. Mackrell and Lavender (2004) found that adolescents experiencing a FEP had more negative than positive experiences of peer relationships. They felt increasingly isolated, paranoid and experienced bullying at school.

There may also be difficulties in forming and having intimate relationships. Brown (2011) found that none of the participants had intimate relationships at the time of the interviews and some of them were concerned that they might never have one because of the psychosis. Redmond et al. (2010) used IPA to explore perceptions of romantic relationships in young people with psychosis. They found that there was some conflict

in their perceptions; they viewed romantic relationships as incompatible with psychosis and felt that they lacked the skills to have romantic relationships though also stressed the importance of them in maintaining “normality” and improving recovery.

### **Service user community**

Views of the benefits of engaging with and interacting with other people with experiences of psychosis vary. Some people appear to value being around other people who have been through similar circumstances as it gives them a sense of community (Andersen et al. 2013). Other service users can also be a source of information and share advice about useful coping strategies (Windell & Norman, 2012).

However, some people feel it is important to separate themselves from the negative identity of being a service user. Perry et al. (2007) found that participants described wanting to distance themselves from other individuals with ‘mental health issues’. Instead they highlighted the importance of maintaining normality by doing activities that ‘normal’ people do such as going out with friends. Similarly, Knight, Wykes and Hayward (2003) found that there appeared to be a conflict between the value of being with other people who shared their experiences and wanting to distance themselves from a group of people who are not viewed favourably by society.

In summary, friends and family appear to be of particular importance for people with psychosis as they can provide support and aid recovery. However, people also may feel the need to protect themselves from those who may not understand their experiences of psychosis. These relationships can be difficult to maintain and manage due to the potential stress of having psychosis and at times individuals with psychosis may avoid others, as they do not want to be seen as a burden. The challenges of having psychosis may have a particularly negative effect on parent child relationships, suggesting that the age of onset of psychosis may be an important factor in determining the quality of future relationships. Other service users can be of particular value as it can be validating to speak to someone who is going through similar experiences and can offer useful advice. However, it appears that stigma may prevent some people from wanting to associate with other service users and believe that distancing themselves is necessary to maintain normality.

Overall, the current literature suggests that individuals with psychosis may have an impaired ToM; this impairment may be more or less pronounced depending on the age of onset of psychosis and type of experiences. It is possible that this ToM impairment may affect social functioning and thus explain some of the difficulties individuals with psychosis may have with other people. Attachment seems to be important in two ways. First, a secure attachment facilitates the development of metacognitive knowledge; the ability to reflect on one's own internal state. Second, a secure attachment leads to the development of future secure relationships which can be important for social and emotional support in the event of psychosis. Qualitative studies have provided some more context and personal accounts which demonstrate that various factors may determine the importance of relationships particularly with friends and family and whether they are maintained.

## **Research Questions**

Although there has been a wealth of literature exploring social relationships and difficulties in people with psychosis (e.g. Bellack et al. 2007; Jang et al. 2011), few studies have looked at the personal meaning of these experiences for the individual. Many qualitative studies (e.g. Knight et al. 2003; Perry et al., 2007; Windell & Norman, 2012) have found themes which relate to the importance of relationships, however exploring the personal meaning of them has not been the aim or focus of these studies. In addition, other studies which have looked more directly at relationships have tended to focus on specific types of relationships in young people or those with FEP (e.g. Mackrell & Lavender, 2004; Redmond et al. 2010).

The present study is interested in people with psychosis and their understanding of their social world, particularly in relation to personal accounts of their interactions with the important people in their life. The research questions are:

1. How do people with experiences of psychosis make sense of their relationships with important others?
2. How do they make sense of any difficulties they experience with important others?

It is apparent that there may be some difficulties with social relationships and interactions in people with psychosis. There is a wide range of literature to support this. However, the quantitative data is narrow in its stance as the individual and personal accounts and in depth experiences of people with psychosis appears to be largely missing. ToM studies focus on, and imply that, there is a problem with the individual, and neglect the impact of the wider social context and environment. Similarly, although research suggests that attachment difficulties may explain difficulties in understanding others and in forming new relationships, again the personal experience appears to be missing.

Qualitative studies suggest that psychosis may have an impact on social functioning and relationships, however there is no indication that being able to understand others is a factor in determining the quality of relationships. It seems important to explore what aspects of the experience of psychosis, whether ToM impairments or other factors, impact on everyday functioning and social interactions. It would be particularly interesting to explore how people make sense of any changes in their relationships and/or in social functioning and whether there is any indication that this may be a result of difficulties in understanding others.

The first research question therefore aims to explore how people make sense of their relationships with important others. This includes who they identify as important and why. In addition, the study is interested in finding out about their experiences with these important others and what it means to the participant. The literature overwhelmingly seems to suggest that impairments within the individual are to blame for any difficulties with social functioning. The second research question therefore aims to explore participant's own perspective of why they believe they may experience any difficulties in their relationships with others to see whether they make personal or external attributions.

## **METHODOLOGICAL APPROACH**

### **Interpretative Phenomenological Analysis**

A qualitative approach was chosen as the most suitable methodology to answer the research questions. Interpretative Phenomenological Analysis (IPA) is a qualitative approach used to explore individuals' experiences and how they make sense of them (Smith, Flowers & Larkin, 2009). When an individual has an experience they often reflect on the significance of that event and derive some sort of meaning from it. The purpose of IPA is to engage with these reflections and to ascertain how an individual might make sense of such events (Smith et al. 2009).

The use of IPA has increased over the years, with the majority of publications in health psychology (Smith, 2011). However, IPA has also been used to explore a range of experiences, including religious identity (Sinclair & Milner, 2005), motherhood (Smith, 1999), same-sex parenting (Touroni & Coyle, 2002) and workplace coaching (Gyllensten & Palmer, 2007). In addition, IPA has been employed to explore various experiences of psychosis including voice hearing (Mawson et al. 2011), delusions (Rhodes & Jakes, 2000), suspiciousness (Campbell & Morrison, 2007), stigma (Knight et al. 2003) and hope (Perry et al. 2007).

The foundation of IPA is based on three theoretical and philosophical positions: phenomenology, hermeneutics and idiography. Husserl (1927) introduced the concept of phenomenology within psychology when he emphasised the notion of reflecting on one's own experiences of events beyond the basic values and goals. Of relevance to IPA, Husserl's work emphasised the importance of disengaging from activities and being conscious of the perception of experiences (Smith et al. 2009). The phenomenological philosophy is therefore important as it provides ideas about how we as psychologists may examine and understand people's experiences (Smith, 1996).

The philosophical movement of phenomenology is concerned with the study of lived experiences (Smith et al. 2009) with particular focus on the detailed examination of experience (Smith et al. 2011). Emphasis is placed on an individual's account or

perception of an event or object rather than an objective statement of the event (Smith, 1996). It is a dynamic process complicated by the researcher's own conceptions (Smith, 1996). In this context, IPA requires engagement and also interpretations from the researcher (Smith, 2011).

Smith et al. (2009) suggest the hermeneutic circle, which concerns itself with the methods and purpose of interpretation, as an appropriate method for IPA research. The method focuses on the dynamic relationship between various parts and the whole at a range of levels. How one looks at the meaning of text can be made at various related levels with a range of perspectives (Smith et al. 2009).

In addition, Smith (2011) describes the process of IPA as engaging in a double hermeneutic, which involves the researcher attempting to make sense of the participant trying to make sense of their experiences. In a sense the researcher has a dual role, being like a participant who is making sense of their world but also listening to the participant's reports of their own experiences (Smith et al. 2009). IPA therefore operates at more than one level: from a level that is grounded in the text to a level that is more interpretative and psychological (Smith, 2004).

The third important foundation of IPA, idiography, involves highly intensive and detailed analysis of each case individually (Larkin, Watts & Clifton, 2006). Once all the cases have been analysed in this way, cross-case analysis may take place (Smith, 2004). Good IPA studies look at the differences and similarities between cases and how these themes emerge for different individuals (Smith, 2011).

In IPA, researchers should be flexible and not constrained by existing literature and hypotheses. Thus research questions should be broad in order to allow for a range of data (Smith, 2004). IPA aims to contribute to psychology by interrogating existing research thus, the results of in-depth case analysis are discussed in relation to existing research (Smith, 2004).



## **Semi-structured interviews**

The use of semi-structured interviews is common in IPA studies. They allow the researcher to follow-up points of interest that emerge during the interview in real-time (Smith, 2004). In addition, individual interviews allow for rapport building and give the interviewee the opportunity to fully express themselves (Smith et al. 2009). However, a disadvantage is that the researcher has less control, interviews can be longer, making analysis more difficult than a more structured interview (Smith & Osborn, 2007).

Collecting data via a focus group was considered as an alternative and perhaps quicker approach for the current study. However, the data collected would not be as rich in individual experiences and participants would most likely not be able to give their personal accounts in sufficient detail (Smith, 2004). Importantly, as participants are being asked to talk about their personal experiences of relationships, they might be hesitant to discuss this subject within a group. Thus it was decided that individual semi-structured interviews would be more appropriate.

## **Alternative approaches**

Other qualitative approaches were considered for this study. Grounded Theory (Glaser & Strauss, 1967) aims to develop a theoretical account of a particular phenomenon (Smith et al. 2009). This approach has been used for various studies looking at psychosis, for example, responding to distressing experiences of psychosis (Abba, Chadwick & Stevenson, 2008) stigma and treatment delay in FEP (Franz et al., 2010) and recovery processes (Dilks, Tasker & Wren, 2010).

A grounded theory approach would have been appropriate if the aim of this study was to develop a potential theory about the process by which participants made inferences about their mental states and those of others. However, I am more interested in the experience and less so in the process involved. Although Grounded Theory can be used to understand a particular phenomenon, it is less focused on individual accounts and lived experience (Smith et al. 2009) and, therefore, IPA was deemed a more suitable approach for this study.

A narrative approach was also considered. This may have been an appropriate methodology as it is used to explore people's experiences through constructed stories and how they make sense of events (Riessman, 2002). A narrative approach has been used in several studies on psychosis, for example, looking at insight of having a mental disorder (Roe, Hasson-Ohayon, Kravetz, Yanos & Lysaker, 2008; Roe & Kravetz, 2003) and family therapy (Holma & Aaltonen, 1995).

Although participants were invited to share their stories, the focus was primarily on the meaning, experience and impact on the individual, rather than the content, structure and sequence of specific events. Therefore IPA was deemed more appropriate than a narrative approach.

## **METHOD**

### **Design**

Semi-structured interviews were used to explore individuals' experiences and sense making in relation to their relationships with others. Interpretative Phenomenological Analysis (IPA) was used to analyse the interviews.

### **Participants**

Ten participants were sought for the study. This is consistent with the recommendation of four to ten participants for a professional doctorate using IPA (Smith et al., 2009).

The inclusion criteria were that participants:

- Had the capacity to give informed consent to participate in the research study
- Have had experiences of psychosis at some point over their life
- Were able to engage in an interview about their experiences of interacting with others
- Were fluent in English

The exclusion criteria were that participants:

- Were not at significant risk of becoming distressed if they took part in the study (as assessed by the mental health staff involved in their care)
- Were not currently experiencing features of florid psychosis that would have made it difficult to engage in the interview

### **Recruitment**

Participants were recruited from a city wide rehabilitation service in a local mental health NHS Trust. All service users are admitted from acute services if they are considered to have specific rehabilitation needs which would prevent them from living

in independent accommodation. The aim is to provide an MDT service to facilitate recovery and improve everyday functioning. Staff include a range of professionals such as staff nurses, clinical psychologists, occupational therapists and doctors. The length of stay for service users varies, but they tend to remain on the unit for at least six months.

Recruitment relied heavily upon MDT members who made the initial contact with service users. They provided them with the participant information sheet and answered initial questions. The staff then obtained service user's verbal consent that I could come and meet the service user at the unit to discuss the study further. The staff and participant information sheets can be viewed respectively in appendix I and appendix II. Once the service user gave informed consent and had been interviewed I obtained some additional information about the service user from staff. An outline of the recruitment procedure can be viewed in appendix III.

## **Data collection**

### **Semi-structured interview**

The semi-structured interview guide can be seen in appendix IV. The schedule was presented to the NHS Trust R&D Service User Group for feedback and various changes were made in response to their comments. The aim was for the questions to be open and general in order to avoid leading questions or implying that there was a right or wrong answer. The Service User Group advised that some participants may struggle if the questions are too open ended and they emphasised the importance of prompts to help guide the interview. The opening question invited the participant to talk about some of the important people in their life. Further questions, probes and prompts were made depending on what the participant discussed in order to explore their experiences of interacting with these individuals, in response to the service user research group suggestion.

All interviews were audio recorded and then transcribed. I decided to transcribe the first two interviews so that I could familiarise myself with the process, but also to enable me to think about how I might change the way I did the following interviews. For example, in terms of the questions and prompts I used. A member of the University of Leeds who

signed an agreement stating that they would maintain confidentiality transcribed the remaining interviews. Once I received the transcription I listened to the audio recording with the script to check that it was accurate.

## **Measures**

### **The Hinting Task**

In order to provide some context to the data, The Hinting Task (Corcoran et al. 1995) was administered to measure ToM ability. The Hinting Task (see appendix V) consists of ten brief vignettes that test an individual's ability to make inferences from indirect speech. Each vignette consists of an interaction between two characters which ends with one of the characters making a hint. The participant is asked what the character really meant by their last comment. A score of two is given if the participant gives the correct answer. If they answer incorrectly they are given another hint and get a score of one if they then answer correctly. The vignettes are read out to the participant and are repeated if requested. This data was supplementary and used to compare with themes that emerged from the qualitative data analysis and to add some context to their experiences. The task was administered after the interview. At the end of the task, the participant was asked what they thought of the task and whether they had any experiences of being aware of other people using hints in everyday life.

### **Additional information**

Additional information was sought to provide some more background to the participant. The Service User was asked for this information and if there was anything they were unsure of I sought permission to clarify the information with staff. This information included:

- Age
- Ethnicity
- Year of first contact with mental health services
- Length of admission in rehabilitation ward
- Current/ most recent diagnosis

## **Ethical considerations**

### **Ethical approval**

Full ethical approval was sought and obtained from Leeds West National Research Ethics Service Committee (see appendix VI). Approval was also obtained from the Research and Development department of the NHS Trust where participants were recruited (see appendix VII).

### **Service User involvement**

The Research and Development service user group was consulted during the development of the information sheets, consent form and semi-structured interview as outlined above.

### **Managing the potential for participant distress**

Participants were asked to describe their interactions with others. This could have been distressing for those who may have had particularly difficult interactions or were socially isolated. Although it was not anticipated that the interview would cause significant distress, but would be an opportunity for the participant to share some of their experiences, precautions were taken. A procedure was agreed with the rehabilitation service staff to minimise the risk of distress and the steps to be taken if a participant experienced significant distress during an interview. The agreed procedure was given to staff with the staff information sheet (see appendix VIII).

### **Maintaining privacy and confidentiality**

Participants were asked to talk about their relationships with other people, some of which was potentially sensitive and personal. Thus a key ethical consideration was to maintain as much privacy and confidentiality as possible. Whilst informed consent was being obtained from the participant they were informed about the content of the interviews. They were advised to only share what felt comfortable and were informed that if necessary they could decline to answer questions.

In addition, as recommended by Smith (2004), interviews were audio recorded. This was explained to the participant prior to the interview when consent was being obtained and they were required to sign that they were aware of this on the consent form (see appendix IX).

### **Informed consent**

Part of the inclusion criteria was that staff only suggested participants who had the capacity to give informed consent. However, I also assessed their capacity at the beginning of the interview to determine whether they understood the requirements of the study and were aware of the potential risks, for example, becoming distressed. Although this did not occur, if it had appeared that the participant was unable to understand and remember the information then the interviews would not have continued.

### **Analysis**

It was important for me to find a process of analysis which suited me; therefore although I used the steps recommended by Smith et al. (2009) as a guide, I developed my own stages of analysis:

#### *Stage one: Initial analysis*

- 1) After each interview I wrote down my initial reactions and thoughts. This included my feelings towards the participant and how I made sense of some of the topics they discussed.
- 2) I listened to the audio recording once and wrote down any further things I noticed about the interview, particularly about how the participant described things, for example the tone of their voice. I also thought about my approach in the interview and what questions I asked and considered how this could be revised for the next interview.
- 3) Once the interview was transcribed I listened to the audio recording one more time to make sure the transcript was accurate. I then wrote a short summary of the content of the interview
- 4) I then began the process of line-by-line analysis by reading and re-reading the transcript. I considered a line to be a particular thought or comment. I did this in

Microsoft Word and used tracking changes to make comments in the margin. Each comment I made was supported by a quote. I made comments about the use of language, the experiences they described and our interaction in the interview

- 5) I repeated this stage for the remaining interviews

*Stage two: Individual analysis and pen portraits*

- 6) I returned to the first interview with a fresh perspective and read through the comments again and began to group them into themes. Comments were largely grouped together if they described the same experience or same aspect of a particular relationship. For example, throughout different parts of the interview the first participant spoke about the psychologist being good at her job, so any comments I made about this were all grouped together.
- 7) Comments were then colour coded as follows
  - a. Use of language
  - b. Phrases which expressed emotions and feelings
  - c. Non verbal emotions or emotions I sensed within the room, for example their tone of voice when they described an experience
  - d. Interactions between myself and the participant
  - e. Positive experiences with others
  - f. Negative experiences with others
  - g. The participant's sense making of their experiences
- 8) These themes were then used to write the pen portrait
- 9) At this stage the themes were printed off and I did the individual analysis by clustering similar themes together to form superordinate themes
- 10) I repeated this stage for the remaining transcripts.

*Stage three: Group analysis*

- 11) I did the group analysis in a similar way to the individual analysis. I compared the themes from the individual analysis across the cases, looking for similarities and differences. I then grouped the themes into superordinate themes.



## **Quality and reflexive positioning**

Elliott, Fischer and Rennie (1999) have set guidelines and recommendations to improve the quality of qualitative research. The guidelines include: owning one's perspective, situating the sample, grounding in examples, providing credibility checks, coherence, accomplishing general versus specific research tasks and resonance with readers. I took various measures to ensure I met these guidelines.

### **Owning one's perspective**

In terms of owning one's perspective, good practice involves the researcher being explicit about their theoretical stance, personal orientation, values and experience (Elliott et al. 1999). In a systematic review of qualitative research studies, Newton, Rothlingova, Gutteridge, LeMarchand and Raphael (2011) found that many researchers did not adopt reflexive positioning, meaning that subjective interpretations may have come across as objective.

I have never had any experiences of psychosis myself, and as far as I am aware, nor have any members of my family or friends. Therefore, my interest in peoples' experiences of psychosis is more of a professional one, stemming from my experiences of working with people with psychosis in a range of settings including inpatient settings and the community. From my observation, the priority of the services tended to be to reduce positive symptoms and risk. Many of the service users appeared to be very socially isolated; particularly in inpatient settings, some service users despite being on the ward for months, never had a visitor. Despite this, the staff and service users never spoke about the service users' relationships with other people. I was curious about why some people seemed to have no social contacts and whether this was a concern for them. I was also surprised that within these services these issues went unspoken.

It is this curiosity, which has led to this present study. Fortunately, within the literature social relationships and psychosis is something which is being spoken about. It seems clear that there may be some difficulties with social relationships and interactions in people with psychosis. There is a wide range of literature to support this. However, I feel that the quantitative data is narrow in its stance as the individual and personal

accounts and in depth experiences of people with psychosis appears to be missing. For example, the ToM studies may demonstrate that people with psychosis might lack the ability to infer others' mental states. However, I am interested in what this means for the individual in their everyday life. For example, does this have an emotional impact and prevent them from interacting with others?

ToM studies focus on, and imply that there is a problem with the individual, and neglect the impact of the wider social context and environment. It would be particularly interesting to explore how people make sense of any changes in their relationships and/or in social functioning and whether there is any indication that this may be a result of difficulties in understanding others. The qualitative studies (e.g. Mawson et al. 2011; Redmond et al. 2010; Knight et al. 2003) suggest that various factors including voice hearing, mistrust and stigma seem to affect the quality of relationships. It would be interesting to see whether people mention any of these experiences in their accounts.

As a black woman I have always felt strongly about society generalising people on the basis of the labels they attach to them. People will make assumptions about me because I am black and because I am a woman; however, within these contexts I have had my own experiences and life stories. In a similar vein, no two people with psychosis are the same; they each have their own narratives. Yet despite this I feel that within society they are often viewed as one and the same. I have found myself questioning where the individual is amongst all of this. I believe that society and systemic factors cannot be separated from the individual. I am strongly against someone wholly attributing my behaviour and experiences to me as an individual without encompassing the wider context. Therefore I have found myself getting rather frustrated when I have read a lot of the literature around psychosis which seems to suggest that the problem is within the individual.

Although I have no understanding of what it is like to have or witness a close friend or family experience psychosis I do have experiences of relating to and interacting with others, both positive and negative. I believe that within these experiences there is more than one truth, there is my understanding, the understanding of the person I am relating to and even the understanding of outside observers and the social political context.

My family in particular are the most important in my life, and we all value being close and in frequent contact. Therefore, to realise that other people do not have this, whether they want to or not, saddens me as for me, it is a basic human necessity. This has resonated with me quite strongly recently as I have moved away from London, where I grew up and where all my family and friends are. Some service users may have lost some contact with family and friends as a result of being on inpatient units and it has made me wonder how this change has impacted on them.

### **Situating the sample**

Good practice involves the researcher providing the reader with descriptive details about each research participant (Elliot et al. 1999). To provide some context around their interviews, for each participant I have provided the following details: age, gender, ethnicity, most recent/ current diagnosis, age at first contact with mental health services and length of current admission on the rehabilitation unit.

### **Grounding in samples**

The researcher should use examples from the data to support emergent themes (Elliot et al. 1999). Therefore, for each theme discussed, I have used direct quotes from the participants and some of their experiences to support the theme.

### **Providing credibility checks**

Elliot et al. (1999) suggest several ways in which researchers can check the credibility of their themes, for example, by going back to the original informant and checking it with them or by having other qualitative analysts look at the data. I maintained credibility by obtaining as many perspectives as possible, which I did in the following ways:

- I read the transcripts and analysed them several times. However, I also put them aside for a few days and came back to them with a fresh mind in order to see whether I had any alternative perspectives.
- I had regular supervision with three supervisors, all with different perspectives, which allowed us to think about a range of interpretations.

- I attended a regular supervision group where I discussed my own reflections in order to keep track of any biases and assumptions I was holding.
- Once I decided on the thesis topic I kept a reflective journal throughout the project duration where I noted down some of my thoughts, feelings and hopes for the project. In addition, I also made notes of some of my biases and assumptions. A transcript of my reflections can be viewed in appendix X.

### **Coherence**

The author should attempt to represent the data coherently, rather than as discreet and separate themes which do not seem to relate (Elliot et al. 1999). All the themes are grouped under a common superordinate theme and are supported by quotes from the participants.

### **Accomplishing general versus specific research tasks**

A distinction must be made between generalising a phenomenon and discussing something which is specific to an individual case. During the results and discussion I have made it clear when themes and experiences may be more generalizable to individuals with psychosis if they seem to relate to findings from other research. However, I have also been clear when themes and experiences may only relate to a few of the participants and perhaps may not be as generalizable.

### **Resonating with readers**

The participant's account should be presented in a manner which allows the reader to fully understand the participant's experiences in a personal and meaningful way. Adhering to all the guidelines previously discussed enabled me to provide a rich narrative of people's accounts. In order to document the various aspects of each participant's life I described their experiences and the themes that emerged from their accounts.

## RESULTS

### Overview of sample

Five participants agreed to take part in the study. The interviews ranged from 40 minutes to an hour and participants spoke about a range of relationships. Due to the inclusion and exclusion criteria only six participants were identified as suitable. One of the suggested participants declined to take part after meeting with me to discuss the study. Nonetheless, five participants is still within the four to ten participants suggested by Smith et al. (2009) for a doctorate study. An overview of the participant details is shown in Table 2, and Table 3 shows the different types of relationships discussed.

Table 2: Participant details

<i>Participant<sup>1</sup></i>	<i>Gender</i>	<i>Age</i>	<i>Ethnicity</i>	<i>Current/ most recent diagnosis</i>	<i>Length of current admission to the unit</i>	<i>Age at first contact with services</i>	<i>The Hinting Task score</i>
<i>George</i>	Male	43	White British	Paranoid Schizophrenia	3 months	21	19/20
<i>Robert</i>	Male	24	White British	Schizophrenia	4 weeks	16	19/20
<i>Therese</i>	Female	37	White British	Not disclosed <sup>2</sup>	4 months	35	15/20
<i>Henry</i>	Male	34	British <sup>3</sup>	Bipolar disorder	2 months	22	18/20
<i>Philip</i>	Male	42	Black British	Schizophrenia	10 months	22	10/20

---

<sup>1</sup> Participants have been given a pseudonym in order to maintain anonymity

<sup>2</sup> The participant preferred not to share her given diagnosis

<sup>3</sup> The participant was unsure of his racial heritage

Table 3: The types of relationships discussed by each participant

<i>Participant</i>	<i>Romantic</i>	<i>Parents</i>	<i>Siblings</i>	<i>Young family members (children)</i>	<i>Other family members</i>	<i>Peers, work colleagues</i>	<i>Service Users</i>	<i>Staff</i>
<i>George</i>			✓			✓	✓	✓
<i>Robert</i>		✓	✓	✓				✓
<i>Therese</i>	✓			✓	✓		✓	✓
<i>Henry</i>	✓	✓	✓	✓		✓		
<i>Philip</i>		✓	✓		✓	✓	✓	

## Individual analysis

All the participants spoke in considerable detail about their lived experiences and what they meant for them. I, therefore, obtained a wealth of information about various experiences and different types of important relationships. As I feel it was important to capture each story I have completed an individual analysis for each participant to demonstrate the variety of experiences described.

### George

George is a 43-year-old white British male. Our interview lasted approximately 45 minutes and focussed mainly on his relationship with the staff on the unit, his current relationship with his brother and his past social relationships. George also spoke briefly about his interactions with other service users on the unit.

The interview with George was my first and I was anxious about what to expect. This anxiety was increased by the fact that George had a speech impediment that made it difficult for me to understand him. George seemed to struggle when we were talking about particularly painful experiences and at times his speech was inaudible. On a few occasions George responded to questions by giving a nonverbal response such as shaking his head. George also found the semi-structured nature of the interview challenging and required a lot of prompts and further questioning. This seemed to be

due to his anxiety, but I also sensed that George was eager to help me and wanted to make sure he spoke about things that would be of interest to me.

George was very open about his experiences of voice hearing. This may have been because I was a psychologist and George’s experience of the psychologist on the unit was that she was someone who understood and was helpful. However, he noted that many of his relationships ended once he had told people about the voices. I wondered whether him telling me about the voices, was a means of testing me, to see if I would react in a similar way. Table 4 details the themes that emerged from George’s interview.

Table 4: Superordinate themes and themes for George

<i>Superordinate theme</i>	<i>Themes</i>
Qualities of a supportive relationship	Being understood
	Shared experiences
Talking about experiences of psychosis	People don’t want to hear about it
	Being open versus bottling up his experiences
	Difficulty understanding psychosis
Past, present and future relationships	Loss of past relationships
	Limits of relationships with staff
	Fear of future relationships

### **Qualities of a supportive relationship**

Being understood: “She knows what’s going on in me head” (Line 500, page 15)

George spoke of two positive experiences where he emphasised the importance of feeling understood. The first was when the psychologist came to check on him and noticed that he was struggling with the voices. The second was when another member of staff sought more information about psychosis so that she could better understand him.

*“She just picked up on it straight away, I didn’t think that was possible, but, there you go” (Line 89, page 3)*

*“She...got two or three books out on schizophrenia and hearing voices and read them so she could relate to me and I thought ooh that’s me, I appreciated that” (Line 180, page 6)*

George seemed surprised about these experiences, and he described feeling reassured and appreciative of these relationships. George had previous experiences of being rejected by others after telling them about his experiences with psychosis. It is possible that after these negative experiences George particularly valued people who showed understanding and acceptance regardless of his unusual experiences. In addition, these positive experiences may have shown George that despite his past experiences, it is possible to have relationships where people listen and try to understand you.

Shared experiences: "I used to think I was the only one, but this has helped me out"  
(Line 486, page 14)

George referred to himself and others with experiences of psychosis as "sufferers". He may have wanted to demonstrate to me that he is not dangerous or abusive, as the voices and society might want to suggest but that he is in fact a victim of his experiences. Being able to share his story with other "sufferers" and realise that his experiences are not unusual seemed to help George make sense of why people had let him down in the past:

*"You get views about being kicked out of society" (Line 478, page 14)*

*"They've all been through similar situations themselves" (Line 483, page 14)*

*"They don't really know about voices, they think you're crazy you know" (335, page 10)*

However, George also spoke about feeling ashamed about their shared experiences. When he spoke about being kicked out of society it made me think of them all being treated as outcasts, forced to live apart from others. Although George seemed to resent society for how he had been treated I sensed that he did not want to be connected with this out group but was longing to be accepted back into society.



## Talking about psychosis

People don't want to hear about it: "They didn't want to know about it, they said get lost, that's all" (Line 449, page 13)

George described two negative experiences where he told people about his experiences of psychosis. The first was when he told people at work about the voices and the second was when he told a friend. It was when George was talking about these experiences that he mumbled more and I found it difficult to understand some of the things he was saying. This demonstrated to me how painful these experiences were for him. He used very strong language to describe how he felt:

*"It felt like I got shit on from a high height" (Line 330, page 10)*

George seemed to emphasise not only how let down he felt but also that they made him feel inferior and less of a human. In addition, instead of receiving the help he sought, he was rejected and dismissed. Their reactions may have made him feel that he was not deserving of help and that his experiences of psychosis made him a bad person.

Being open versus bottling up his experiences: "You gotta shut up about it....gotta be careful what you tell" (Line 260, page 8)

George seemed troubled by a conflict between his value of being open versus his need to protect himself and his relationships. When George spoke about why he told people about the psychosis he reasoned that he needed to be honest:

*"You've got to have trust in a relationship haven't you?" (Line 437, page 13)*

This was despite the fact that George knew that he would most likely get a negative reaction. Although George anticipated that they would reject him he felt he needed to tell them as 'it felt sly and backstabbing'. This strong language reiterates how important it is for him to be honest.

George described his relationship with his brother as positive and important. Despite this George spoke about being scared and selective in how much he told his brother about the voices. Initially, I sensed that the fear was that his brother would reject him

like others had if he was fully aware of the content of the voices. However, as George seems to value being open I also wonder if there is another motive to keep quiet:

*“I go on out of the house, just come back, come back to [hospital]. [I feel] a bit let down but I have to cope” (Line 276, page 8)*

It is possible that George is trying to protect his brother from the abusive nature of the voices. George also spoke about times when staff told him to stop speaking about the voices:

*“Sometimes they say don’t go there, that was an experience, they’ll say shut up or they’ll go quiet” (Line 204, page 6)*

I wonder whether the fact that even the staff who are professionals find it difficult to listen, in addition to the reactions he has received from society, has made George decide that there are some aspects of voice hearing that should not be spoken about.

Difficulty understanding psychosis: “But it doesn’t make sense!” (Line 280, page 8)

Although it is important for George to feel understood, it seems that even he recognises that there is a limit to how much people will understand him.

*“He [brother] tries to understand what voice hearing is like, but it doesn’t make sense; I don’t know it’s like the lottery numbers” (Line 280, page 8)*

I took this to mean that voice hearing can be random and inexplicable and that it is not clear why it happens to some and not others. George also seems to view having experiences of psychosis as a stroke of bad luck rather than blaming himself or things that have happened in the past. I also wonder whether George feels resentful about the fact that he has to ‘suffer’ with these experiences whilst others do not. George also described experiences of feeling misunderstood by staff:

*“I think it’s real [the voices] and she’s trying to make me think it’s not real, but I understand it’s not real, but at the same time it don’t feel good to be told that” (Line 169, page 5)*

George seemed frustrated when he spoke about this experience and described it as upsetting. Although George values staff as professionals, experiences like these seem to have highlighted to George that their understanding of psychosis is limited. Whilst

George has a personal understanding of psychosis, the staff only have a professional understanding. Incidences like this may leave George feeling quite alone and isolated with his experiences.

### **Past, present and future relationships**

Loss of past relationships: "I've got a really empty life, not much going on" (Line 306, page 9)

Prior to George's experiences of opening up about the psychosis, George had an active social life:

*"So when I was working I used to go out all the time, but as soon as they found out about the voices, I stopped going out, I just don't go out" (Line 308, page 9)*

George considered his work colleagues as close friends and described it as a big loss. It was during this discussion that he gave the few nonverbal responses of the interview. This really reiterated how upsetting this loss has been for him. George described feeling 'disgusted and let down' and I got a sense that these experiences have had a lasting impact on him. It seems that he had lost more than just some friendships; he lost a part of himself, the person who goes out and socialises. I also get a sense that he lost faith in humanity and came to realise that people will let you down.

Limits of relationships with staff: "you can't have relationships with professionals, can't get too close" (Line 189, page 6)

Despite highlighting staff as important relationships George recognised the limits of these relationships. He spoke about needing to stay away from staff, but interestingly seemed to feel that this was necessary in order to protect the staff 'because they'll lose their jobs'. However, this may also be a way of protecting himself; if they lose their job then he will lose these important relationships.

I also sensed that his relationship with staff would never fill the void left by his lack of social relationships. When talking about the psychologist he spoke about her as a professional and made frequent references to her being good at her job. At one point in the interview when I queried further about the relationship he said: 'that's all there is about her', which really emphasises the lack of reciprocity in the relationship. I can

imagine that if George did have some social relationships where he had someone to talk to openly about his experiences he would perhaps not rate the relationship with the psychologist so highly.

Fear of future relationships: "I'm scared of every relationship...coz you get let down"  
(Line 385, page 11)

George spoke about his fears of developing new relationships. Despite being able to trust staff, he did not feel that this made a difference in how he trusted people in other relationships. I wonder if George felt that he could trust staff on a professional level. George seemed to recognise that this level of trust has not been experienced in his personal relationships.

*"I've been through so much, and you can't just tell anyone about it, it will ruin the relationship"* (Line 509, page 15)

George worries about how people will respond to him and consequently he is more guarded about who he will open up to. It seems that George's past experiences have made him question how supportive and trustworthy people can be.

### **The Hinting Task**

George performed well on the task (19/20) and seemed to enjoy doing it; for example, he laughed at many of the hints the characters used. George described them as 'psychological twisters':

*"Someone says something but they wanna say something else"* (Line 566, page 16)

George seemed confident about his ability to understand others, and recognised that people use hints in real life. Despite this, by describing them as 'psychological twisters' George seemed to be implying that when people use hints they are being deceptive. This seems to fit with his experiences of being let down by others and his current difficulty in trusting others. I wonder whether these experiences have made him question the motives behind why people might use hints.

In summary, George emphasised the importance of feeling understood by others, particularly staff on the unit. Being able to share experiences with other service users

helped him make sense of some of his negative experiences. These negative experiences have had a lasting impact as George is now more hesitant about who he trusts and how much he discloses about his experiences with psychosis. George performed well on The Hinting Task but seemed to feel that using hints is deceptive.

## Robert

Robert is a 24-year-old white British male. The interview lasted approximately 46 minutes. Robert mainly spoke about his relationship with members of his immediate family. Before the interview he specified that he did not want to talk about romantic relationships. Robert also spoke about his relationship with staff on the unit.

From the beginning of the interview Robert spoke in depth about his relationships and experiences. In contrast to George's interview I felt led by Robert's chosen topics and did not have to use many prompts. Throughout the interview Robert spoke about struggling for independence and disagreeing with how his parents treat him. The fact that he led the interview seemed to reinforce this idea of wanting independence. Although I admired his assertion that he did not want to talk about romantic relationships I was left intrigued. Robert spoke openly about his other relationships and did not seem to shy away from talking about the negative experiences, thus I was curious as to why he chose to avoid the topic of romantic relationships. I wonder whether he felt that despite the negative experiences with his parents they were perhaps quite common and understandable and nothing to be ashamed of. Whereas as a young man he may have felt that a lack of a romantic relationship is something to be embarrassed about. The themes from Robert's interview are shown in Table 5.

Table 5: Superordinate themes and themes for Robert

<i>Superordinate themes</i>	<i>Themes</i>
Family friction	Family breakdown
	Relationships are only current
	House is no longer a home
	Fighting for control
Ideal relationships are	Balanced
	Reciprocal
	Unconditional
	Supportive

## **Family friction**

Family breakdown: "I caused the family to collapse" (Line 400, page 14)

Robert spoke about the events that led to him having contact with mental health services. Although he now describes it as paranoia, at the time he was suspicious that his step dad was harming his younger brother. This resulted in Robert being 'kicked' out of home and spending a few months in a homeless hostel. It was when Robert spoke about these experiences that he really led the interview. I spent much of the time listening to what he said and found it quite difficult to ask many questions. The experience appeared to be a big burden for Robert to carry and the in depth detail he used to describe the experience and his feelings demonstrated that it still had a present and lasting effect on him:

*"I was suffering at homeless hostels and coming very close to suicide...I survived on £60 a fortnight....it was called severe hardship money, I'll never forget it" (Line 422, page 15)*

Describing the family as having collapsed suggests the enormity of the experience, that a once strong family unit was reduced to a mess and that it perhaps cannot be rectified. However, in addition to feeling some guilt about his perceived role in the family collapsing it seemed that his ideal of a strong and supportive family also collapsed:

*"I kind of sometimes blame my family for all these different things" (Line 435, page 15)*

Relationships are only current: "I have got a good relationship for the time being" (Line 456, page 16)

On several occasions Robert described his relationships as current, as if to say that he recognises that they are not stable.

*"When I saw [nephew] a week ago he seemed err, not to be, he probably doesn't remember who I am really.....he's probably not really aware of who I am" (Line 166, page 6)*

Robert seemed resistant to any changes and made various efforts to keep things the same. For example, despite being in hospital he wants to buy sweets for his nephews when they come to visit just as he did before he went to hospital.

It is possible that when the family 'collapsed' Robert came to realise that even close relationships are vulnerable to change. When Robert lived in the homeless hostel he lost all of his relationships. This experience may have taught Robert that relationships are vulnerable to change and I expect that he must have had to put in a lot of effort to re-establish them and to remain accepted by and connected to the family. This might make Robert even more protective over his family relationships.

House is no longer a home: "When I go back to living with them" (Line 465, page 16)  
I noticed during the interview that Robert would never call his home 'home' but would often refer to it as his parent's house. On one occasion he said 'my house' but then quickly corrected himself and said 'parents' house'. I wondered whether the fact that he was kicked out of home meant that he no longer saw it as a comfortable and secure base that he could call home. By kicking him out of home his parents conveyed to him that it is their house and they decide who lives there. In relation to the previous theme about the family collapsing, his ideal secure home had also collapsed and was seemingly beyond repair.

In addition, although he is not happy with things at home, he described how he often refrains from speaking out:

*"I was scared of getting sent back to the homeless hostels.....and cos I had nowhere else to go I just had to keep my mouth shut"* (Line 475, page 16)

Robert's experiences have taught him that when he speaks out, he risks being kicked out. Thus it seems that he is not living in a comfortable environment where he is able to be himself. However, his desire to maintain his relationships makes him focus on how he can manage the situation:

*"When I go back to living with them, which is the plan, it'll take a while for me to adapt to being back with them and then I should be OK"* (Line 465, page 16)

Fighting for control: “My parents want me to be dependent on them” (Line 326, page 11)

Robert frequently referred to himself as being an independent person. However, he expressed frustration at his parents’ inability to recognise this:

*“[I’m] growing older and maturing and things....It’s like they’re three years behind the person that I am now” (Line 245, page 9)*

Robert spoke about this struggle he has with his parents and he used some strong terms such as ‘manipulative’ and ‘bending reality’ to describe his experiences of them. In the interview I experienced Robert as very defensive about the situation, I sensed that he felt it necessary to prove to me that he was in fact independent and it was his parents who had the problem. Although Robert seemed confused about “what’s going through their heads”, he seemed to make sense of their approach in two ways. First he attributed their behaviour to his experiences of psychosis:

*“Because I’m mentally ill....they think I’m not as capable to do things and take care of myself” (Line 260, page 9)*

Second, Robert senses that his parents are motivated by a need to control him:

*“I think that’s something that’s really important with my parents, it’s control. They want to control me and my two brothers” (Line 292, page 10)*

I wonder whether the fact that Robert points to them wanting to be in control and the fact that they also try to control his brothers means that he is not the one with the problem, it is his parents. Robert may feel that he being ‘mentally ill’ may just be the excuse they use to exert their control.

### **Ideal relationships are:**

Balanced: “They’re hands off you know, they let you get on with it” (Line 595, page 20)

Robert described having a very positive relationship with staff on the unit and I sensed that he compared these relationships with that of his parents. He spoke about their influence being the right amount and that they ‘don’t intervene [they’re] there to advise’. It also seemed that the fact that this balanced relationship with the staff was successful



seemed to affirm his beliefs that his parents' need for control is the problem rather than his lack of maturity.

Reciprocal: " You know the staff ask me how I'm doing...and I ask how they're doing...it's kind of mutual concern" (Line 658, page 22)

Robert seemed to value the fact that he could have everyday conversations with the staff on the unit and experience 'a bit of normality'.

*"They tell me about what grades their son got at school and I tell them how I've been doing during the day" (Line 659, page 22)*

Again I wondered whether this was a comparison to his experiences outside of hospital where he is treated like an "invalid" and does not experience much 'normality'. In addition, by sharing things with Robert, staff are perhaps showing that they respect him and recognise his maturity.

Unconditional: " They understood and were sensible about it... they didn't you know do anything silly" (Line 568, page 19)

Robert described an experience where he brought vodka onto the unit and a member of staff found it. Robert described it as a positive experience because the staff did not "come down heavy handed" and were understanding about the situation. I found this very interesting and wonder whether he was perhaps testing the relationship he had with staff. Robert's experience at home had taught him that his place at home was conditional; when there was conflict he was kicked out. I wonder whether bringing vodka onto the unit was Robert's means of testing the security of his place on the unit and his relationship with the staff. Several times Robert spoke about blaming his parents for kicking him out and I wonder whether experiences like this with the staff where they have not reacted in an extreme way has made him more critical of how his parents handled the situation.

Supportive: "He's like a mate....someone to talk to...share things with" (Line 88, page 3)

Robert spoke about the positive relationship he has with his younger brother because they share similar experiences and are supportive of each other. I noticed a sense of pride in Robert whenever he spoke about his younger brother, he seemed to regard him as a role model:

*"I have got a lot of admiration for the way he approaches life in a very dignified and positive way towards developing and improving himself....he's achieved more than I've achieved" (Line 94, page 3)*

Robert did not speak as if he was resentful of his brother even though he is younger than him. I wonder whether this is because his brother brings out the best in him:

*"He brought me out of my shell a little bit and got me to enjoy myself a little bit" (Line 82, page 3)*

### **The Hinting Task**

Robert performed well on the task (19/20) but recognised that it is not representative of real life experiences:

*"In real life, I don't pick up on these hints, they were quite simple ones there and I'm proud that I actually got them" (Line 774, page 26)*

Robert knew that he was being asked to pick up on hints and therefore he was able to do the task. Robert recognised the importance of being able to understand peoples' intentions:

*"It's very difficult, if I knew the answers I probably wouldn't be here" (Line 813, page 28)*

However, Robert seemed to feel that his difficulty was not missing the hints that people use but reading too much into what people say:

*"I think part of me wants to pick up on hints that are not really there, and pick up on signals that are not there, which affects my relationships in some ways" (Line 778, page 26)*

During the interview Robert spoke about causing the family to collapse and blamed it on being paranoid. I wonder whether he feels this is an example of him reading too much in to things. In addition, when Robert spoke about having to keep things to himself in order to continue living with his parents it seemed to be in regards to holding back his frustrations about how they treat him. However, it is possible that he may also feel the need to keep any suspicious thoughts to himself in case it causes further disruption to the family.

Although Robert recognised that he had some difficulties, he also seemed frustrated about people using hints:

*"I wish people would just make it more simple, cos I'm very honest and I don't know how to lie really, it doesn't cross my mind to tell lies" (Line 833, page 28)*

It seems that Robert feels that people use hints to be deceptive and does not feel that there is any good reason to use hints. Instead he would prefer people to be more direct and honest.

In summary, Robert spoke about the important relationship he has with his family. However, he also described negative experiences of trying to maintain his relationship with them but also maintaining his sense of independence. He spoke positively about staff on the unit and seemed to value the balanced and mutual nature of the relationship. Robert performed well on The Hinting Task but felt it was not a realistic test of his ability. However, he acknowledged that he often looks for hints that are not there and that this may have an impact on his relationships.

## **Therese**

Therese was a 37-year-old white British woman. She was the only female participant and was the only one who was married and was a parent. Therese spent the majority of the interview talking about her relationship with her husband and daughter. Therese was very literal in the way she spoke about things and often showed little emotion when talking. However, at times when she was talking about difficulties with her daughter she spoke about being 'stuck' in her throat, which I interpreted as her becoming anxious and emotional about what we were talking about.

I found the interview with Therese quite difficult to do as I found it challenging to maintain my research mind and focus on the aims of the study. Talking about her marital troubles and being away from her daughter was understandably difficult for Therese and at various points she said that we needed to change the topic as it was too much for her. Despite this she would often come back to these difficult topics and on these occasions because I did not want to cause any distress I chose not to ask any

further questions but let her speak. Consequently, there were quite a few times when I would have liked to have known a bit more but my clinical mind told me not to probe further. Table 6 displays the themes from Therese's individual analysis.

Table 6: Superordinate themes and themes for Therese

<i>Superordinate themes</i>	<i>Themes</i>
Managing relationships	Dealing with separation
	Working through difficulties
	Continuing to parent
The importance of shared understanding	Shared experiences
	Staff don't understand

### **Managing relationships**

Dealing with separation: "I haven't done an awful lot with her because I've been in hospital" (Line 29, page 1)

Therese has a five-year-old daughter and understandably misses not seeing her every day. Although Therese did not go into depth about it, I noticed that Therese had missed part of her daughter's first year at school and I wondered how she felt about this. When she spoke about it she said "I think she's enjoying it" which did not necessarily describe a wealth of information but reiterated a sense of loss which was perhaps too painful to acknowledge.

Therese spoke about the impact of the separation on their relationship:

*"Because I'm not around at the moment, I'm in the unit; she's not used to my company" (Line 144, page 5)*

Therese spoke of her daughter being distant over the last few months and that her daughter did not always want to hug her or play with her when she visits. Therese described how she often just watches her daughter play. This gave me the impression that she has been excluded from playing with her daughter and is now merely an observer. Therese struggled to describe how she made sense of this, and I felt that she did not want to blame herself for the distant relationship:

*"I can't help the fact that I need to be [on the unit]" (Line 152, page 5)*

Instead Therese said she wondered whether it was to do with her daughter's mood. In addition, it seemed that Therese's way of coping with this was to focus on what was left of the relationship:

*"We do have a decent relationship, she isn't always distant with me.....sometimes she'll come over and say 'mother you're here, come and have a big hug' which is lovely" (Line 216, page 8)*

Working through difficulties: "We're actually going for counselling now" (Line 268, page 9)

Therese described difficulties in her marriage. Although she did not explain how she came to hospital it appears that these marital difficulties may have contributed to her admission:

*"At one point I thought he was having an affair although I didn't see any evidence of him having an affair it was just, he was very distant and not very physically demonstrative" (Line 255, page 9)*

I got mixed messages about how Therese felt about her marriage and I wonder whether this reflected her mixed feelings. Therese seemed to suggest that the marital difficulties were temporary and thus could be worked through:

*"Our relationship's at a difficult position at the moment" (Line 305, page 10)*

*"We're going through a sticky patch at the moment" (Line 294, page 10)*

Despite this, although Therese spoke about having marriage counselling and seemed upset about this she admitted that she was not sure whether she wanted the marriage to continue:

*"He actually wants to stay married...I've said to him I can't make any promises about the marriage" (Line 317, page 11)*

Continuing to parent: "We just have to negotiate and erm sort out when she takes a turn...and when her friends take a turn" (Line 71, page 3)

Despite the relatively unusual situation of being in hospital and away from her daughter, Therese still spoke about the common difficulties experienced by parents. It seemed that in spite of being separated, Therese did not feel her role and identity as a

mother had changed. Therese spoke about the difficulty of managing her daughter's behaviour:

*"She doesn't understand sometimes or doesn't appear to understand that if she's had a go her friend might want to have a go as well, she can be quite tearful" (Line 108, page 4)*

Therese spoke about her frustration at having to repeat the concept of sharing to her daughter. I was interested in how she seemed to make sense of this. The majority of the time she spoke about her daughter being a 'tricky' child who at times can be 'a real madam'. However, she did speak about her ability as a parent:

*"I find it tricky because I'm not very experienced with children...I haven't had another one since" (Line 78, page 3)*

### **The importance of shared understanding**

Shared experiences: "She's been through feeling mentally unwell as same as me"  
(Line 499, page 17)

Therese described having a positive relationship with another service user on the unit because they had shared experiences:

*"It helps because erm there's common ground and common understanding" (Line 508, page 17)*

Despite this, Therese spoke about this relationship as just an acquaintance. It seemed that this shared experience was all that connected them and that it was not enough for her to regard it as an important relationship. In addition, Therese was focussed on leaving the unit and being back with her daughter and thus I expect that she perhaps regarded it as a temporary relationship. It is possible that Therese regarded it as a useful relationship whilst she was on the unit, but that it would not be necessary once she returned to her usual routine.

Therese also spoke about the close relationship she had with her late grandmother. Therese spoke fondly of how similar they were and that her grandmother was able to understand her. Again they both had a shared experience in that they both had dyspraxia:

*“We had an affinity to understand each other” (Line 392, page 13)*

Therese also spoke about them having similar struggles:

*“Cos she struggled with some, doing some tasks” (Line 385, page 13)*

Although her late grandmother may not have had experiences of psychosis, Therese felt that she would have been able to offer her support and advice to help her manage her current difficulties:

*“She’d tell me to keep my head up...keep battling through” (Line 413, page 14)*

For Therese it seems that the importance of having shared experiences and understanding is not enough for a true friendship. Instead it seems that having shared experiences means that they can support each other. I also wonder whether this is what was missing from her relationship with the service user.

Staff don’t understand: “Because they haven’t been in that position” (Line 458, page 15)

Therese did not speak much of her relationship with the staff on the unit and I took that to mean that she did not regard them as important relationships:

*“I think they’ve tried but how much they understand I don’t know” (Line 468, page 16)*

She explained that this is because she is a private person but it seems that their inability to understand due to the lack of shared experience means that she does not want to open up to them and get support from them.

### **The Hinting Task**

Therese struggled with some of the questions on The Hinting Task (15/20) and explained that she found them tricky. She agreed that she notices that people use hints and at times she is not always sure what they mean. In these circumstances Therese admitted that she often has to guess their intentions. She was unable to give an example of trying to work out others' intentions but gave an example of a time when

she had used hints. Although Therese found the task difficult and seemed to recognise that it can be difficult to understand people's intentions, she did not seem to be concerned about it.

Therese's performance and reflections on The Hinting Task may add some context to how she makes sense of her relationship with her daughter. She seemed to recognise that being on the unit may have had an impact on their relationship, but I got the sense that she did not have a full appreciation of what her daughter's perspective might be. For example, she could not understand why her daughter might be distant at times when she went to see her. It is possible that Therese may struggle with making sense of what people do and say.

In summary, Therese spoke about how being on the unit had changed her relationship with her daughter. Despite this, she still values her role as a parent and spoke about some of the challenges of looking after her daughter. Therese also spoke about difficulties in her marriage and the uncertainty about whether it would continue. Therese found The Hinting Task difficult and described having difficulties understanding people's intentions.

## **Henry**

Henry is a 34-year-old British man of dual heritage. Henry spoke about the difficulties of growing up in care and not knowing his biological family. He also spoke about his time working as a police officer and the difficulties he experienced trying to make friends.

During the interview Henry spoke very confidently and was open to talking about his experiences. He seemed eager to tell people his story at any given opportunity. For example, he spoke about telling the doctors on the unit about his experiences and he also offered to do a further interview with me to provide me with more information if necessary. I found Henry very approachable and friendly and found it hard to imagine that he was not able to make friends. However, he was very open in the interview and not afraid to voice his opinions and I wondered whether some people found this uncomfortable.



I did not need to prompt Henry much as he seemed to naturally talk about what his experiences meant to him and how he made sense of them. However, I often found it difficult to follow some of the things he was describing as he often jumped from one topic to the next. However, this made me see Henry’s experiences from his point of view. It seemed as if Henry was still trying to make sense of them and as a consequence the interview was difficult to follow. My experience of the interview seems to mirror Henry’s attempts to understand it all. Table 7 displays the themes from Henry’s interview.

Table 7: Superordinate themes and themes for Henry

<i>Superordinate themes</i>	<i>Themes</i>
Establishing an identity	Who are my family?
	Finding my racial heritage
	Being part of a team
Barriers to relationships	Being on the unit
	Not fitting in
	Isolating oneself
	Knowing who to trust
Self-empowerment	Getting back on my feet
	Fighting the powerful

### **Establishing an identity**

Who are my family?: “I have some concerns about where me and [sister] are from...family issues aren’t right.” (Line 33, page 1)

Henry and his sister grew up in various care homes with different families. The way he spoke about these families suggested that he never felt a part of them:

*“I’ve been around lots of different types of families” (Line 46, page 2)*

Henry’s childhood also seems to have been a very confusing time. He described how he was ‘snatched’ several times by someone. Henry seemed to believe that this is because he was worth something to someone. It seemed that whilst being moved between different families made him feel less important, being ‘snatched’ by someone made him feel valuable and wanted.

Not knowing his family seems to have created a lot of confusion for Henry and he described being in conflict as to how much he should delve into his past:

*“I don’t know how far I’m allowed to look into it ‘cos I’m not sure if me dad wants me to trace him” (Line 84, page 3)*

Henry seemed to be more concerned about who his family are rather than establishing a relationship with them. He stated that if his dad was not interested then he would ‘walk away’ and start his life. This emphasised how this uncertainty is preventing him from living his life and that any answer would at least provide him with some closure in order to move forward.

Finding my racial identity: “I’m not sure whether I’m an Irish Catholic Jamaican.....or whether I’m an Arab kid” (Line 47, page 2)

Henry was troubled by the lack of certainty about his ethnicity. He seemed confused and anxious about it and I could tell that it was really important for him to establish his sense of self. Awareness of race and being different appears to have been a frequent theme for Henry and race came up often throughout the interview:

*“We were brought up in a white village and we went to an all-white school and that was difficult” (Line 155, page 4)*

As a child Henry may have always felt different and alone but without knowing his own racial identity I wondered whether Henry also felt that he had no one he could identify with.

Being part of a team: “It was everything I wanted to do, it was my dream job.....I did it ‘cos I wanted something special to do in my life” (Line 225, page 6)

Henry spoke about his life - long dream of working for the police. Given Henry’s early experiences of moving between families and not knowing where he fits in I wonder whether he looked up to the police as some sort of close knit team or family. As a child, joining the police may have seemed attractive to Henry, as it would have enabled him to identify with a group, something that was missing in his life.

Henry described many negative experiences with the police including racial discrimination, being left out and feeling targeted by the police. Despite this I got mixed

emotions from Henry in regards to how he felt about the police. I saw this as a conflict between his idealised childhood perceptions of the police versus his actual experiences:

*“I think because I’ve been looking at it since I was so young, I think I became institutionalised like I daren’t leave” (Line 348, page 9)*

The fact that he described himself as institutionalised suggests that he felt very strongly connected to the police and felt that he could not survive without them. In addition, although he eventually left the police because of his experiences he remained disappointed that the police did not contact him to see how he was. This to me demonstrates that he was still holding onto the idea of being part of a team of people who cared for him and provided him with a sense of belonging.

### **Barriers to relationships**

Being on the unit: “I’m on a mental health unit so that’s not very attractive to, to girls at the moment” (Line 684, page 17)

Henry felt that being on the unit and not having a job or house were barriers to him developing a romantic relationship. Henry did not appear sad when he spoke about this but seemed quite matter of fact and even laughed at the thought of having a girlfriend whilst on the unit.

*“I don’t have anything to offer, I don’t have err a house, I don’t have a job” (Line 681, page 17)*

I sensed that Henry felt that his lack of a current romantic relationship was more circumstantial and that once he was off the unit he was confident that he would soon be able to develop a relationship. He also described how he had had many relationships in the past because he was a police officer. Often in the interview Henry spoke about not taking things personally and I felt that the fact that he attributed his lack of a current romantic relationship on situational factors rather than personal factors fits this belief of not taking things personally.

Not fitting in: "I tried to make friends but nobody was interested" (Line 254, page 7)

Despite Henry's attraction to joining the police, the experiences he had with the force were largely negative. There was a mixture of anger and sadness when Henry spoke about this. The interview was heavily focused on Henry's experiences with the police and even if we did discuss another topic Henry soon brought it back to the police. To me this demonstrated how present the issue was for Henry and how he continues to spend a lot of time processing the experience and making sense of it. Henry offered various reasons for why he did not get on with the police:

*"I think it's for lots of different reasons, I think my colour's a problem"* (Line 254, page 7)

This seemed to parallel his description of growing up in a white village and going to a white school; Henry appears to question whether it is perhaps because he is different. However, again due to Henry's approach of not taking things too personally, he also offered other explanations:

*"I've got to be careful not to take it too personally.....there's a possibility that there were loads of other things that there shouldn't have been, and I'm glad I wasn't there for that reason"* (Line 278, page 7)

This possibility seemed to sit more comfortably with Henry as he reasoned that if this was the case then it was best that they did not invite him out. In addition, it also means that he does not have to take it personally, which perhaps prevents self blame and self criticisms.

Isolating oneself: "I like to stay in seclusion I feel a lot safer" (Line 664, page 17)

Henry said that he kept to himself on the unit, and preferred not to spend time with staff and other service users. This seems to be in contrast to how he described himself when he joined the police. He seemed like someone who wanted to socialise and meet new people. Henry said that he has 'cut things down' which suggests that there has been a drastic change in how much he interacts with others. Henry seemed to recognise that this was not always helpful and 'it's not the healthiest way to live' however, he seemed to feel that it was necessary in order to protect himself.

I thought that there may be two possible reasons for this. It would seem understandable given his experiences with the police that Henry is more suspicious of others and therefore wary about being around them. However, I also suspect that Henry is concerned about trying to make friends and perhaps being rejected again. When Henry spoke about how he made sense of his experiences with the police he tried to avoid taking it personally. I wondered, if he did experience rejection on the unit, whether it might make him question whether there is something wrong with him.

In addition, Henry seemed to be motivated to join the police force in order to establish an identity and feel part of a team, almost like the family he did not have. However, as a result of his experiences he no longer feels this is possible:

*“I think I’d like to work for myself after all I’ve been through.....I want to work for myself ‘cos I don’t trust working for anybody else” (Line 718, page 18)*

Knowing who to trust: “I just keep getting double crossed you know by people” (Line 520, page 13)

Henry spoke about various occasions of being let down by others:

*“I didn’t realise they [the police] were taking the piss out of me after I left and I worked it out, that was one of the reasons why I didn’t want to come back” (Line 305, page 8)*

*“The force doctor, I felt like he’d conspired against me and I got my back up and I struggled to trust anyone after that” (Line 387, page 10)*

*“I was tricked into going to [hospital name] they never told me I was going to be detained for a month” (Line 512, page 13)*

Several times Henry laughed about these experiences. It was difficult to make sense of the laughter but it seemed to be an exasperated laugh where he has come to the conclusion that it is inevitable that people are going to double cross him. It is perhaps this inevitability, which has made Henry determine that he needs to work on who he trusts:

*“I think I do need to change but I think it’s therapy that I need to change, I tend to trust people then they let me down” (Line 534, page 14)*

## **Self-empowerment**

Getting back on my feet: "I fall a lot in life but I also get back on my feet as well" (Line 689, page 17)

I felt overwhelmed by Henry's accounts of moving between families, not knowing his racial identity and experiencing discrimination from the police. I was curious to know how all these experiences had impacted on him. Initially, I was surprised by his immediate answer that it had made him more resilient. However, after reflecting on how Henry was in the interview I remember that he spoke unashamedly about his experiences and portrayed himself as someone who was not going to let it get him down:

*"Every time I fall something happens, I crack and get back on my feet again and I'm a lot stronger than I was last time. I think if anyone tries to take me down again I'll be lethal next time" (Line 691, page 17)*

I felt a lot of admiration for Henry when he said this; it did not come across as threatening or extreme. However, it seemed sad that Henry expects it to happen again and I imagine that he perhaps feels he needs to be more vigilant in order to protect himself. It appears that Henry has come to realise that he can only rely on himself and that he needs to defend himself when necessary.

Fighting the powerful: "I caught a lot of people out, off guard and I think that generated a shit storm in the force" (Line 406, page 11)

After leaving the police Henry sued the force for racial discrimination and because he felt that he was entitled to a bigger pension. Although this would seem like a big case to take on, Henry was fully aware of this:

*"It's a really tough institution and you've got to know what you're getting into, how to last in there and how to last when you leave" (Line 344, page 9)*

I feel that Henry was not necessarily expecting to win but put forward the case as a matter of principle:

*"You can't fight an institution like that you can only learn to cope with it" (Line 212, page 6)*

Henry seemed proud that he had 'generated a shit storm'; he caused trouble for the force and showed them that he was not going to tolerate how they treated them. However, I imagine that Henry would have found it difficult to confront an institution that he seemed to admire. Despite this, I think the need to not be seen as weak and to stand up for himself was stronger and enabled him to fight back:

*"But walking away with only a few on the dole, it was something I struggle with" (Line 199, page 5)*

### **The Hinting Task**

Henry performed well on the task (18/20) and recognised that he was able to do this:

*"I analyse information, I can pick out what people are thinking" (Line 792, page 20)*

Henry saw it as a natural skill that was necessary in order to protect himself from others:

*"I can psychoanalyse information and make it work for myself and erm guard myself from people who might take the piss out of me" (Line 805, page 20)*

As Henry has had many experiences of people letting him down, it seems understandable that he should be more suspicious of people. During the interview he described difficulty in knowing who to trust thus it is possible that this suspiciousness means that he pays more attention to what people say and is more cautious about the meaning behind people's intentions.

In summary, Henry spoke predominantly about his experiences working with the police and making sense of why it was difficult to establish relationships with his colleagues. Race was an important topic for Henry; his uncertainty about his heritage seems to affect his self-identity. In addition, Henry offered his race as a possible explanation for not fitting in with the police. Henry did well on The Hinting Task and seemed confident about his ability to understand other peoples' intentions.

## Philip

Philip is a 42-year-old black British male. Philip described having many positive relationships and regular contact with long-term friends. He reported no negative experiences or difficulties with these relationships.

Philip was polite throughout the interview; however, I did not get a real sense of him as a person. He struck me as a very private person and there were a couple of times when I asked him to explain something in more detail and he said he would prefer not to. Philip did not seem anxious in the interview but he seemed uninterested in some of the questions I was asking him. It felt like Philip was unsure about why I was interested in his relationships and did not understand the rationale of some of the questions. I assume that this was because he has had positive experiences with others and did not think there was anything particularly unique about this.

I was pleased to hear that Philip had maintained many positive relationships despite spending a considerable amount of time in and out of hospital. I felt that this gave an alternative narrative to the numerous research studies that have suggested social dysfunction in people with experiences of psychosis. However, it was difficult to elicit from Philip how he made sense of these positive experiences. Philip often gave short answers to my questions and when prompted to discuss further would often merely repeat himself or say he did not know.

Phillip was my second interviewee; however I chose to analyse his interview last because I felt it was the interview that I got the least out of and I felt I would feel more confident analysing it once I had completed analysis of the other interviews. The themes for Philip are shown in Table 8.

Table 8: Superordinate themes and themes for Philip

<i>Superordinate Themes</i>	<i>Themes</i>
Remaining connected	Maintaining regular contact
	Remembering the past
	Avoiding conflict
Being on the unit	Shared experiences
	Getting support



## **Remaining connected**

Maintaining regular contact: "It's through keeping in touch with each other all the time, we're always talking on the phone" (Line 144, page 4)

Philip described having a lot of friends who he saw regularly, many of whom he grew up with. Philip did not elaborate on the experiences he had with these friends but interestingly they all seemed to have scheduled time together:

*"My best mate [name] is what they call him, he picks me up once a fortnight and takes me to his house" (Line 150, page 4)*

Philip explained that every experience with this best mate is good. Although I thought the idea of having an allocated time seemed rather rigid and obligatory, I sensed that it made Philip feel important. Having a protected regular time in which he could catch up with his best friend seemed to make Philip feel important and connected with his friend. Philip seemed to believe that the main factor that has enabled him to maintain his friendships is this idea of maintaining regular contact. Therefore, Philip may not see the regular contact as forced and obligatory but more as a means of making an effort.

Philip appeared to be highly motivated to maintain these relationships and regarded them as important:

*"Because people are vital in my life" (Line 285, page 8)*

Philip also described his relationships with his family in a similar way in that they see each other regularly and keep in contact. Again he did not elaborate on why these experiences were all positive but maintained that they retained their relationships by making an effort to remain in contact.

Philip has an identical twin brother who lives outside of the city and although he 'comes now and again' he does not visit Philip as regularly as his other brother does. Although Philip seemed understanding of this, I sensed some resentment in his tone, especially as he said his brother has his own family and children. As someone who regards keeping in contact as the main factor in maintaining relationships Philip may worry about his relationship with his twin brother.

After speaking about being in contact with his brothers and not having any negative experiences Philip suddenly mentioned his dad:

*"Me dad lives in West Indies, he's got [inaudible word] some family over there, I think it's erm, Antigua, yeah" (Line 89, page 3)*

This sudden change in topic took me by surprise. I found myself using a lot of prompts in the interview, thus when Philip seemed to freely give some information it seemed like he was making a very important point. Philip had just been talking about his brother who lived some distance away and there is a possibility that he worries about how this will affect his relationship. The fact that he then went on to talk about his dad being in a different country with his own family made me wonder whether he fears the same may happen with his relationship with his brother.

When I queried whether Philip had any contact with his dad he said:

*"No, I feel like I'm falling asleep" (Line 99, page 3)*

Again this led to a change in topic and we did not discuss it further. When Philip said this he put his head down as if to say he was tired, but I felt that it was because he was feeling sad and he wanted to hide his emotions from me. Clearly, it was a difficult topic for Philip to discuss, and he seemed to be communicating to me that he no longer wanted to talk about it, but also did not want to express his emotions about it.

Philip did not feel that his relationships had changed at all since being on the unit, despite being in hospital for nine years. I sensed that for Philip, as long as he maintained regular contact with his friends then there was no reason to expect the relationships to change. However, when we were discussing the impact of being in hospital for a long period of time, similar to the manner in which he brought up his dad, Philip seemed to jump topic and suddenly mentioned his mum:

*"I've been in hospital 9 years and three months on the 27th July. My mum died six years ago, while I was in hospital" (Line 241, page 7)*

I wondered whether Philip felt that by being on the unit he missed out on spending time with his mum or seeing her before she died.

Remembering the past: "By getting along, interacting with each other and talking about the old times" (Line 317, page 9)

Philip spoke about his positive experiences of talking with his friends and interacting with them. Often they would speak about the 'old times' and Philip explained why he finds these discussions important:

*"I've kept me roots....school children are where your roots are" (Line 272, page 8)*

It was when Philip said this that I got a rare sense of emotion from him. I could tell that he felt very strongly about this, he looked me directly in the eye when he said it and clarified whether I understood what he meant. The emphasis on keeping his roots seemed to be a focus on acknowledging where he comes from and remaining true to this. Keeping in contact with the friends he grew up with would enable him to do this.

I also wondered why it was so important for Philip to keep his roots. Although I do not know much about Philip's past, he had his first contact with services when he was 22 years old and has spent a lot of time in and out of hospital. It is therefore possible that keeping his roots is important for two reasons. First, Philip's early relationships may be a reminder of how things were before his experiences of psychosis. Keeping in contact with them may be a way of maintaining some normality. Second I wonder whether being in and out of hospital has made it difficult for Philip to develop new relationships and this is why he is keen to hold onto the ones he already has.

#### Avoiding conflict

Although Philip did not say anything that would directly suggest that he avoids conflict with his friends, some of his responses made me question whether he feels that in order to have good relationships one must always be positive about them. When I asked him about his relationships and whether there had ever been any difficulties or negative experiences he was very quick to say no and at times it felt very forceful, as if to say it was something he did not want to even think about. When queried about avoiding disagreements Philip agreed that it is something that he and his friends do. However, when I asked him what would happen if he did have a disagreement he seemed confused as if to say he did not think it would ever happen. However, upon further prompting he simply said:

*"Yeah we'd be able to sort it out" (Line 350, page 10)*

He repeated the phrase and again it felt rather forced.

### **Being on the unit**

Shared experiences: "yeah, I've met some nice people in hospital" (Line 293, page 8)  
Philip said he finds it helpful being amongst other service users and sharing their experiences about being in hospital. However, he did not want to go into detail about it with me, perhaps because I do not share these experiences. In addition, Philip did not seem very enthusiastic about these relationships, which makes me wonder how important they are for him. If Philip is focused on his other relationships because they help him maintain his roots, then relationships on a unit that is perhaps keeping him from these roots may not be important for Philip. In addition, it is possible that Philip does not want a network solely based on shared mental health experiences, instead he values maintaining contact with people outside of the service.

Getting support: "I don't think I would have been able to cope by myself" (Line 257, page 7)

Philip described being grateful for the support he received from the unit when his mum died. Although he was unable to explain what it was about being on the unit that enabled him to cope with his mother's death; I wonder whether it was the support of the staff. Interestingly, Philip seems to suggest that if he was not on the unit he would be by himself and this made me wonder about the type of relationships he has with his friends. It seems that he does not feel that he would have got the emotional support he needed from them. In addition, if he has suggested that they are relationships based on talking about the past then perhaps there is not much focus on present feelings and supporting each other.

### **The Hinting Task**

Despite having the most positive experiences and relationships Philip had the lowest score on The Hinting Task (10/20) compared to the other participants. Whilst doing the task Philip either responded immediately or said he did not know, he did not take his time thinking about the questions. At the end of the task he agreed that he had noticed

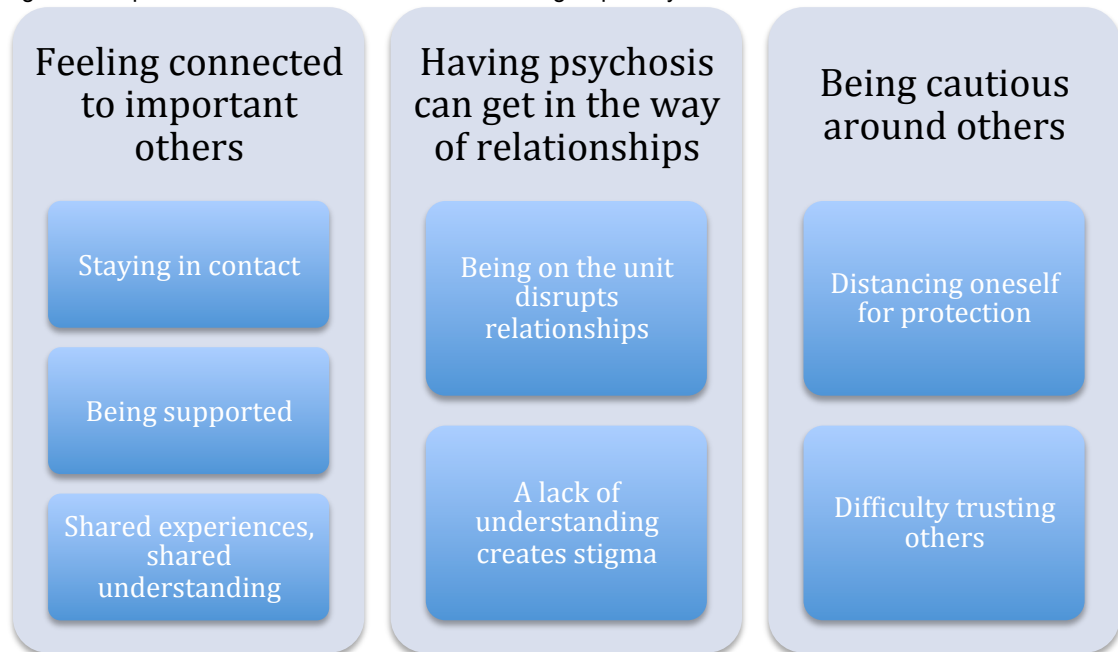
that the people in the vignettes were using hints to communicate something. However, he said he did not notice people doing this in everyday life. He also said that he did not experience any difficulties trying to make sense of what people are saying. Philip's performance on the task made me wonder whether it is not necessarily the person's actual ability at making sense of other people but how they perceive their ability. Thus, for Philip, although he did not perform particularly well on the task, the fact that he did not recognise this protects him from worrying about how he relates to and understands others. This may explain why Philip did not express any concerns about his relationships and did not have any examples of significant difficult experiences with important others.

In summary, Philip described many positive experiences in relating to others. He appeared to reason that this was because they maintained regular contact with each other and have a shared interest in talking about the past. Although Philip may value the support he receives on the unit, he seems to view his childhood friendships as more important. Philip scored relatively low on The Hinting Task and could not relate the examples to everyday experiences.

## Group analysis

Following the individual analysis the individual themes across the five participants were compared for similarities and differences. These themes were then grouped under superordinate themes. Any differences and similarities are described within each theme. The themes and superordinate themes are shown in figure 1.

Figure 1: Superordinate themes and themes for the group analysis



### Feeling connected to important others

#### Staying in contact

Some participants highlighted the significance of having regular contact with important others. It seemed that despite being on the unit, they felt it was important to continue to see others regularly. Making an effort to remain in contact seemed to enable them to still feel connected to important others, despite being on the unit. Therese, Philip and George spoke about having set days when they visited family:

*Interviewer (I): .....how often do you get to see your daughter then?*

*Participant (P): Erm, well Mondays and Wednesdays and I stay over Saturday*

*I: You stay over at your home?*

*P: Yeah and then all of the Sunday and then back to Monday again*

*(Therese on spending time with her daughter and husband, line 202, page 7)*

*I: is there anyone else in your family that's an important relationship for you?*

*P: Yeah me aunty and me uncle*

*I: Ok, and why is that?*

*P: Coz I meet up with them all the time, once a fortnight*

*I: Hmmm mmmm*

*P: I keep in touch with them regularly....just talking*

*(Philip, Line 107, page 3)*

*P: I see him once a week, on a Friday, go down to his house*

*I: mmm hmm..what types of things do you do?*

*P: Just watch DVDs and things like that.....every time is about the same*

*(George on visiting his brother, line 240, page 7)*

Philip seems to suggest that it is this regular contact which makes the relationship important. He goes on to suggest that maintaining regular contact with others maintains his sense of self:

*P: I've kept me roots*

*I: You've kept your roots?*

*P: Yeah*

*I: What do you mean by that?*

*P: Erm..school children, School children are where your roots are*

*(Philip, line 272, page 8)*

When the participants gave examples of some of the positive interactions they had with important others it was evident that the nature of the activity was not important, For example, George states that 'every time is about the same'; suggesting that him and his brother tend to do the same activities. Thus, it is the regular contact which he appreciates, rather than the actual activity. Therese spoke about spending time with her husband, but emphasised that it was his company she enjoyed rather than the actual activity.

Robert also spoke about positive experiences with his younger brother. However, he was not so enthusiastic about his relationship with his older brother:

*P: Me and my younger brother get on well yeah*

*I: What do you think it is about you two that means that you get on very well?*

*P: Erm my old. My older brother is erm, err just is a, is all about himself and his own family*

*I: Mmm*

*P: And he's living in his own little bubble, he likes to be in his own bubble with his girlfriend or his, when he was with his ex or, his own little family bubble he doesn't, he doesn't really err*

*want to erm have fun really, he seems a bit, he's a bit err he's a bit boring and my younger brother's more lively and likes to enjoy himself more  
(Robert, line 358, page 13)*

Robert appears to be suggesting that his older brother's focus on his own family means that he does not get on as well with his brother. By describing his brother as being in his own bubble Robert seems to be indicating that they are cut off from each other and this prevents them from having fun and spending time together. It is this lack of contact which makes him feel less connected to his older brother.

### Being supported

Each individual except Henry highlighted the value of the support and encouragement they receive from important others. Being supported seemed to help them feel connected to others as it made them feel cared for and understood:

*"I think they understand, they adapt and they're very versatile you know with each different case....it's just nice to know someone cares, they're interested and they want to see me improve"  
(Robert, line 599, page 21)*

Often the participants spoke about receiving support in regards to their experiences of psychosis:

*"I keep in touch with them regularly, just talking, about the hospital and stuff, about me being sectioned" (Philip on talking to his Aunt and Uncle, line 109, page 3)*

*"Erm the staff here are important in my recovery and every, well, list is endless what, for how, how much they are, different areas of my life that they help me with. Dr [NAME] has a lot ultimately responsible over me to a certain extent. Erm I've got a lot of respect for him."  
(Robert, line 23, page 1)*

George highlights the value of a supportive relationship by stating that he would not have managed without the psychologist on the unit:

*P: at times with the voices [inaudible], she's really been there, she really helps with them*

*I: so that's an important relationship for you?*

*P: Yeh*

*I: Yeh...so how is it important for you?*

*P: It just helps me, cope with voices, she says something, it calms me down.....*

*I: And what is it they do that makes it helpful?*

*P: Show me different ways to cope, erm, coping strategies and things like that.....*

*(George, line 9, page 1)*



It seemed that George and Robert valued this aspect in particular because these experiences of getting support and encouragement are rare for them. The negative experiences George described were all occasions when he did not receive the support he sought in order to manage his psychosis. Whilst Robert seemed to contrast the support he received from the staff with the support he received from his family:

*"My parents I love very much and I err, you know I respect them at different times, we don't always get along, it's not like a relationship with a doctor it's a erm, a family relationship it's, there's ups and downs"*  
(Robert, line 26, page 1).

Thus for George and Robert the relatively unique experience of getting support meant that they valued these relationships and regarded them as important.

Therese did not speak of any current relationships that were particularly supportive and this may be because, as Therese described herself, she is a very private person. However, Therese spoke about how her late grandma was very supportive and how she would value her encouragement during this difficult time for her:

*"I'd love to talk to her about it and get comfort from her, she'd tell me to keep my head up and keep battling through and keep strong"*  
(Therese, line 411, page 14)

Henry was the only one who did not speak about the importance of having support and encouragement from important others. He seemed to suggest that given his past experiences he is used to being alone and thus having to support himself:

*P: I tend to, I've tend to kept myself to myself here, I say hello to people, have a quick chat with them. I spend most of my time in the room. I've been to a few of the groups they do here, 3 or 4 groups erm, I'm happy to do that, but most of my time I like to sit stay in seclusion*  
*I: Yeah, and why, why do you think that is, that you prefer to...*  
*P: It's the way I've grown up I've grown up in isolation up to 16, that was with my sister and after that isolation. Erm I can, I can live like that.*  
(Henry, line 662, page 17)

Shared experiences, shared understanding

There seemed to be a general consensus of the value of important others being able to understand their experiences and offer support. Despite this, there seemed to be some realisation that there is a limit to how much important others, particularly staff and family, fully understand the individual experiences of psychosis:

*P: me primary nurse....*

*I: Could you perhaps tell me a little bit more about the relationship with her?*

*P: I tell her about the voices and she tells me that it's all in me mind.....But it's upsetting sometimes I think its real, they seem real (George, line 157, page 5)*

George described feeling sad and let down when staff dismissed his voices as merely being in his head. It seemed that the staff's lack of shared experiences with George meant that they could not appreciate the emotional impact of hearing voices. Therese described how she is not very forthcoming with staff because she doubts how much they would understand because they have not been through the same experiences:

*I: OK. Talking about people understanding you, is there anyone else that you feel that understands some of what you're going through now?*

*P: Erm not really no.*

*I: Why do you think that is?*

*P: Erm because they haven't been in that position.....it's tough I think to explain*

*I: Yeah, what about on this unit? Do you think there's anyone who understands or has tried to understand what's going on for you?*

*P: I think they've tried but how much they understand I don't know, I mean I'm not forthwith in talking.....About a lot of stuff*

*I: Alright. So when you say they, you're referring to staff?*

*P: Yeah staff*

*(Therese, line 454, page 15)*

George, Therese and Philip spoke about the importance of being able to talk to other service users on the unit:

*I: have there ever been times when you have told people and you've had a positive response at all? Where people have been ok when you have told them about the diagnosis?*

*P: Just other sufferers and that*

*I: So other people, who've-*

*P: Got schizophrenia*

*I: Ok, so why do you think that is, that their responses have been ok?*

*P: Well they know a lot more about it...about the suffering and that, they understand 'em (George, line 468, page 14)*

*P: And erm she's been through experiences that I haven't but then erm she's been through feeling mentally unwell as same as me*

*I: Yeah. So it sounds like maybe some of the life things that happened may be not the same but in terms of how you feel mentally you said*

*P: Mmm there's similarities*

*I: So how does it help then, talking to someone who has shared some of these similarities?*

*P: I feel it's good, it's good*

*I: Yeah*

*P: Good erm, it helps because erm there's common ground and common understanding (Therese, line 499, page 17)*

*"I've met people in hospital...Yeah I've met some nice people in hospital. We talk about what it's like to be in hospital"*

*(Philip, line 291, page 8)*

Being connected to other service users with similar experiences seemed to be important as they provided the participants with an opportunity to talk through their experiences with someone who can relate to the emotional impact of psychosis. Although staff and family members are able to offer support, it seems that being able to share with other service users was particularly valuable. For George, it was a way to make sense of some of his negative experiences:

*P: They've all been through similar situations themselves really*

*I: Mmmm..so how does that feel, knowing that you're not the only one who's been through similar experiences?*

*P: I used to think I was the only one, but this has helped me out (George, line 484, page 14)*

## **Having psychosis can get in the way of relationships**

### Being on the unit disrupts relationships

As a result of having experiences of psychosis, many of the participants had spent a considerable amount of time as an inpatient on various mental health units. Although many of the participants remained in contact with important others during these periods, there was a feeling that being on the unit negatively impacted on some of their relationships.

Therese found it difficult talking about being away from her daughter and how things had changed. Not only had Therese missed out on her daughter's first year at school, but she noticed that her daughter had changed; she was more distant with her and seemed used to spending time with her dad:

*"I haven't done an awful lot with her because I've been in hospital at the [hospital name] and I'm obviously at the unit here"*  
(Therese, line 29, page 1)

*"Well she's used to erm speaking to her daddy...And having a, having more time with him so she naturally gravitates to my husband...Because I'm not around at the moment I'm in the unit, she's not used to my company"*  
(Therese, line 139, page 5)

Henry and Robert both spoke about having a close relationship with their nephews, but recognised it was difficult to maintain this whilst on the unit. Although they did not want to lose the relationship they did not want them to see them on the unit:

*"Then I got taken into hospital and I didn't see him for a long time, I didn't want him to come and see me in the hospital or anywhere like that"*  
(Robert, line 173, page 6)

*"Well [nephew] doesn't [visit] because of the nature of the unit.....I miss him"*  
(Henry, line 645, page 16)

In some ways this theme compliments the previous theme 'staying in contact' as it suggests that missing out on this regular contact means that participants no longer feel connected, resulting in the relationship deteriorating. However, the participants seem to suggest that for some relationships, it is not just about the contact but also the activity involved. For example, although Robert now saw his nephews regularly, it did not seem to be enough; he described being disappointed that he was not able to do the things he used to do with them before he went onto the unit:

*"I used to buy them [nephews] sweets, there's a sweet shop close to my house, parents house and I err I used to go there when I knew they were coming and get them some sweets, or I'd take the, the oldest one up to, up there"*  
(Robert, Line 207, page 3)

Therese also suggests that despite seeing her daughter regularly, the time spent together is not the same:

*P: She's [daughter] sometimes closer and sometimes more distant*  
*I: Mmm...when you say more distant, what do you mean by that?*

*P: Err that she, well that she erm, she doesn't always want to come over and give me a hug...And doesn't want to play  
(Therese, line 166, page 6)*

For both, Therese and Robert, there was a sense that they were missing out on important experiences with the children. It is possible that with young children, regular contact, if possible, is not sufficient, it is also important to continue the relationship as normal. However, being on the unit means that this is not possible.

#### A lack of understanding creates stigma

In the theme 'shared experiences, shared understanding', the participants emphasised the importance of feeling understood and how this led to positive experiences with others. In contrast, feeling misunderstood led to negative experiences. George, Henry and Robert spoke about experiences where others' lack of understanding and prejudiced views of psychosis got in the way of their relationships.

Henry described how his work colleagues treated him when he went on sick leave:

*"No, no one contacted me. Erm I think the rumour was I was a suicide risk. I think that was the rumour. But I wasn't, I was stressed. Erm, stress can lead to suicide and I'll accept that but I never told anyone I was suicidal, I think that's what they were thinking. Erm, they can think what they want, if they'd have bothered asking me I'd have just said I'm just lonely, you lot don't give a shit"  
(Henry, line 320, page 8)*

Robert described how his parents treated him differently because of his psychosis:

*"Because I'm mentally ill, they see me that I'm not, they think I'm not as capable to do things and take care of myself as I am. It's, they treat me like an invalid sometimes and it really gets on my nerves" (Robert, line 260, page 9)*

Central to what the participants seem to be describing is a lack of understanding in regards to their experiences of psychosis and what they are capable of. It is this lack of understanding which creates stigma and has a negative impact on relationships. Henry seems to indicate that his colleagues lack of understanding meant that they did not approach him to offer support. Whilst Robert suggests that his parents' perception of psychosis meant that they see him as someone who is unable to take care of

himself. In all these circumstances the stigma acted as a barrier to the relationship as it created a sense of frustration but also meant that their needs were not being met.

George describes this lack of understanding as people thinking that those with psychosis are dangerous:

*"People think that paranoid schizophrenics are dangerous you know...Lots of people think that, that we're not nice you know, that sort of thing" (George, line 458, page 13)*

Henry also stated that having psychosis and the stigma associated with it might get in the way of him having a romantic relationship:

*"Erm I don't have money I don't have a way of life yet and and in a centre like this I feel like I'm at bottom in some ways on my own. I've nothing to offer erm I'm on a mental health unit so that's not very attractive to, to girls at the moment. (laughs) Err just the way it is"*  
(Henry, line 683, page 17)

Henry appears to be suggesting that he is considered as being at the bottom, perhaps not worthy and that a woman would not be interested in him because he is on a mental health unit.

## **Being cautious around others**

### Distancing oneself for protection

Henry, George and Robert spoke about keeping themselves to themselves. It seemed that they were putting up a barrier or distancing themselves from others because they were cautious about being around others:

*"I'm not very sociable and I don't really go out and meet like friends or mingle in social groups"*  
(Robert, line 77, page 3)

*"Most of my time I like to sit, stay in seclusion I feel a lot safer."*  
(Henry, line 662, page 17)

This caution appears to be in response to past experiences. George seems to avoid going out because he has been shunned by his friends and perhaps no longer has the opportunity to go out:

*"I used to go out all the time, but as soon as they found out about the voices I stopped going out, I just don't go out" (George, line 308, page 9)*

Whilst Robert seems to suggest that part of the reason why he does not go out is because he has, or anticipates, bad experiences with others:

*"When I did go out I really enjoyed it. He [brother] brought me out of my shell a little bit, and I got to enjoy myself a little bit more 'cos I'm not very good with anybody coming against me" (Robert, line 82, page 3)*

Both Robert and George indicate that going out is something that they can and do enjoy. However, their caution about being around others gets in the way. Henry suggests that although distancing himself from others is not ideal, his experiences of growing up without a stable family means that he is used to it:

*"Seclusion it's not the healthiest way to live, but I can live like that 'cos I watch my films or I watch something on telly erm...It's the way I've grown up" (Henry, line 670, page 17)*

George also distances himself somewhat from his current relationships. He described how he often limits how much he shares about voice hearing with his brother.

*"Gotta be careful what you tell him, bout erm, about the voices and all that, the content you know...you end up getting upset, that's what you get scared about all the time" (George, line 260, page 8)*

When the voices get too intense George will leave his brother's house and go back to hospital. In these situations, he appears to be distancing himself in order to protect the relationship but perhaps also to protect himself from being rejected.

#### Difficulty trusting others

All of the participants, except Philip, spoke about experiences of difficulties trusting other people. The participants seemed to suggest that they had not always had these difficulties. However, past experiences had taught them that they need to be more cautious about others. Henry and George blamed this difficulty on their experiences of being let down by others:

*"It's trusting people, I've changed about trusting"*  
(Henry, line 375, page 10)

*"It will be some time before I can trust them; I've been through so much"*  
(George, line 506, page 15)

Although it appears to be an adaptive response as a means to protect themselves, both Henry and George suggest that it is something that they need to work on. By saying that 'it will be some time' I sensed that George was saying that he will not always have difficulty trusting people and that given time he will learn to trust again. Henry also spoke about how he needs to change:

*"Erm I just keep getting double crossed (laughs) you know by people erm and when people double cross me it gets my back up and I find it hard to tell them what I think and what I'm feeling. I'll have to learn to start trusting otherwise I know I won't get anywhere. Yeah I think I do need to change but I think it's therapy that I need to change."*  
(Henry, line 520, page 14)

When Henry, George and Robert spoke about The Hinting Task they all indicated that using hints can be deceptive. George described them as 'psychological twisters' whilst Robert expressed his frustration that people using hints are lying and that he would prefer people to be more direct with what they are saying. Finally, Henry suggested that it is important to be able to pick up on people's hints in case they are double crossing him.

Therese also spoke about difficulties with trust, but it was in a different context to the others:

*"Our relationship has been quite difficult, at one point I thought he was having an affair....he was very distant and not very physically demonstrative"* (Therese on her marriage, line 254, page 9)

For Therese, the way her husband responded to her made her question whether she could trust him. It is this lack of trust that has affected their relationship, making her more cautious about it and questioning whether she wants to continue with the marriage. This emphasises the importance of trust for Therese and how a difficulty trusting someone can have a big impact on the relationship.



Philip did not express any concerns about trusting others; this seemed to be for two reasons. First, unlike all the other participants, Philip described only positive experiences with important others. Second, Philip was confident that if there were ever to be any difficult interactions or experiences with others then they would be easily resolved:

*I: So if you, one of your friends made you unhappy about something, do you think you'd be able to say or*

*P: -to talk about it? Er, To talk to someone about it in the first place?*

*I: Do you think you'd be able to tell?*

*P: Yeah we'd be able to sort it out, yeah we'd sort it out  
(Philip, line 339, page 9)*

Overall, the participants felt it was vital to remain connected with important others, particularly whilst being on the unit. They valued the support and encouragement they received from them and this aided recovery. This support was particularly valuable from people who had shared experiences as they have a better understanding of their difficulties. In contrast, feeling misunderstood and thus unsupported resulted in negative experiences with others. In addition, being on the unit seemed to have an impact on some relationships, particularly those with young children. Finally, the negative experiences and response from others made participants cautious; they were more likely to distance themselves from others, and question whether they should trust them.

## **DISCUSSION**

An Interpretative Phenomenological Approach was adopted in order to explore the personal meaning of relationships among individuals with experiences of psychosis. Five participants from a rehabilitation service took part in the study. The rationale for the study was to move away from quantitative studies that have implied that individuals with experiences of psychosis experience difficulties in their relationships due to a deficit in their social functioning, such as Theory of Mind, and to elicit individuals' personal sense making of relationships with significant others. The research aim was, therefore, to answer the following two questions:

1. How do people with experiences of psychosis make sense of their relationships with important others?
2. How do they make sense of any difficulties they experience with important others?

Participants spoke about a range of relationships within their family, social world and also on the rehabilitation units. There was a strong sense that relationships were an important source of support, providing a sense of belonging. Generally participants seemed to make sense of any difficulties with others as due to issues around the impact of psychosis; for example, being separated from important others and the experience of stigma.

The results from the individual and group analysis will be discussed in order to answer the two research questions. These results will then be discussed within the wider literature.

### **How do people with experiences of psychosis make sense of their relationships with important others?**

This question aimed to explore whom individuals identified as important and how they experienced and made sense of any interactions with them. The participants identified a range of important relationships with family, staff and other service users on the unit.

Participants seemed to make sense of these relationships in various ways. A key finding seemed to be that relationships with other people serve some sort of function; namely support and recovery, but also to provide a sense of belonging.

### **Relationships provide support and aid recovery**

In relation to support and recovery, participants predominantly spoke about their relationship with staff on the unit. The staff-service user relationship is important as it facilitates the service user's care and treatment (Garman, Corrigan & Morris, 2002). Both George and Robert emphasised how they valued having contact with staff. They suggested that they were quite socially isolated and it seemed that having relationships with staff provided them with some social contact. This is supported by a user-led study by Pitt, Kilbride, Northard, Welford and Morrison (2007), who found that staff provided important social support, particularly for those who were socially isolated.

Robert in particular, described how his relationship with staff maintained a sense of normality and that he enjoyed being able to talk about everyday topics. McCann and Baker (2001) found that participants felt that staff should be friendly towards service users in a similar way to how they would relate to their own friends. They also found that participants valued nursing staff sharing information about themselves in order to demystify their professional role. Robert suggested the importance of this for him when a staff member told him about their children's grades at school.

The therapeutic relationship with staff is also important in determining service user outcome (Howgego, Yellowlees, Owen, Meldrum & Dark, 2003). However, the way in which staff provide support is very important in determining whether service users view them as positive relationships leading to positive outcomes. Robert seemed to suggest that it was not just the support that staff provided which was important, but the fact that they let him maintain some control and make his own decisions. Similarly, Grealish, Tai, Hunter and Morrison (2011) found that individuals identified the importance of having personal control over their life choices. Thus they were more favourable about staff that were flexible and allowed them to be more involved in their own care.

Research has supported the importance of having the right balance of support in staff-service user relationships. Borg and Kristiansen (2004) found that participants described helpful relationships with staff as those that were collaborative and supportive. Collaboration may lead to a shared care plan and this has been shown to improve recovery outcomes (Lasalvia, Bonetto, Tansella, Stefani & Ruggeri, 2008) and treatment adherence (Day et al. 2005). However, the concept of treatment adherence may suggest that the service user is in agreement with their diagnosis and thus more willing to work collaboratively with staff. It is therefore possible that agreeing with staff about their diagnosis and having contact with services may be a factor that affects the staff-service user relationship.

Staff who are seen as controlling and restrictive tend to be viewed less favourably and this may contribute to aggressive behaviour on inpatient units (Duxbury, 2002). Thus it seems that relationships with staff are more positive if the staff member is not seen as an authoritative figure, but someone who collaborates with and works alongside the service user.

Research has also found that service users emphasise the importance of feeling listened to by staff (Gilburt, Rose & Slade, 2008; Grealish et al. 2011; Pitt et al. 2007; Shattell, McAllister, Hogan & Thomas, 2006) and being able to trust staff (Gilburt et al., 2008). Hansson, Bjorkman and Berglund (1993) found that service users highlighted staff empathy as the biggest factor in determining their satisfaction with inpatient services. Those who feel that they are not being listened to tend to feel worthless and view staff as not interested in their opinion (Kilkku, Manukka & Lehtinen, 2003). This seems to relate to George's positive experiences of feeling heard and listened to by the psychologist, this may also explain why he regards it as a positive relationship.

Some of the studies looking at the staff-service user relationship have been qualitative studies with a small sample size (e.g. Gilburt et al. 2008; McCann & Baker, 2001; Pitt et al. 2007). Although these have the advantage that they provide insight into the subjective experience of these relationships, the small sample means that there are limits to how much the findings can be generalised. In addition, in the Pitt et al. (2007) study the participants were recruited from service user groups, which may suggest that they had a good relationship with services. This means that perhaps other service

users with negative experiences may be less likely to have the opportunity to talk about their relationships with staff. For example, BME service users are more likely to report dissatisfaction with mental health services (Walling, Suvak, Howard, Casey & Murphy, 2012); however, many of the studies looking at the staff-service user relationship have included predominantly white participants (e.g. Grealish et al. 2011; McCann & Baker, 2001).

Family members may also play an important role in support and recovery (Andersen, 2013). All of the participants spoke about different family members, but there was some variation in the quality and type of support they valued from their family. Participants seemed to suggest that although family members were supportive and available to talk to, they were limited by their lack of understanding of psychosis. Addington, McCleery, Collins & Addington (2007) suggest that some families' lack of understanding and experience with psychosis may make it difficult for them to know how to manage and respond to it. This may relate to Robert's experiences where his family were no longer able to cope with his unusual beliefs and behavior and responded by kicking him out of his home.

Various reviews and meta-analyses have suggested that family interventions for psychosis are beneficial; however, there tends to be variation in what a family intervention consists of (Lucksted, McFarlane, Downing, Dixon & Adams, 2012). For example, although psychoeducation for family members of individuals with psychosis is not new, they tend to focus on psychosis as a medical illness where the staff are the professionals and the problem is located in the individual rather than viewed as a systemic problem (Dixon, Adams & Lucksted, 2000). In the present study, however, participants seemed to imply that it was the lack of understanding of the experiences of having psychosis that made it difficult for them to talk to family members. For example, George left his brother when the voices became too much, perhaps due to feeling ashamed. It seems that these are some of the things that they felt family members did not understand. Therefore, if family work were to be offered, it may be more beneficial if the focus was on an individuals' experience of psychosis than on education in the medical model of psychosis.

Much of the literature, which has emphasized the importance of family for recovery in psychosis, has looked at FEP (e.g. Andersen, 2013; Mackrell & Lavender 2004). There are therefore limits as to how much the findings from these studies may relate to the present study. None of the participants were interviewed during their first episode, and it is possible that if they had been, they may have made sense of their relationships in different ways. In addition, as most of them were a lot younger during their FEP they may have received more support from their family members during that time compared to now. However, as this was not discussed these possibilities remain speculative.

The importance of support in relationships is not unique to people with experiences of psychosis. Shared interests and support are considered important aspects of close relationships in general (Parks & Floyd, 1996) and are important in various contexts for example, at work (Corsun & Enz, 1999) and school (Klem & Connell, 2004). It is also important in other health care settings, for example, in diabetes management (Vest et al. 2013) and for breast cancer survivors (Hughes et al. 2014).

Thus it could be argued that the findings from this study are not novel. However, the value that the participants placed upon the role of support from others challenges some of the common narratives of psychosis that suggest individuals socially withdraw from others (e.g. Stain et al. 2012), have difficulties with social roles (e.g. Bellack et al. 2007) and poor interpersonal functioning (Collip et al. 2011). The fact that participants highlighted aspects that are important in all types of relationships emphasises the notion that people with psychosis can seek and experience relationships in the same way as others.

In summary, staff are important in recovery for several reasons. First, they can provide the individual with the opportunity to talk about their experiences of psychosis. This can be particularly valuable and empowering for those who may have had negative experiences when disclosing to others. Second, staff can be a source of social support for service users, not only to talk about their experiences but also about everyday situations. Third, staff can help to support the service user by being there for them, but also allowing them to make important decisions about their care. Family members may also be important for support and recovery, however they may struggle to fulfil this role if they lack awareness around experiences of psychosis.

### **Relationships provide a sense of belonging**

According to Baumeister and Leary (1995), as humans we are motivated to belong, we are driven to form and maintain lasting and positive relationships. Many of the participants suggested that an important feature of relationships was having something in common, they mainly spoke about shared experiences, but there was also an emphasis on the importance of shared activities. It seemed that these relationships enabled the participants to develop a sense of belonging.

Being around other service users seemed to provide George, Therese and Philip with a sense of belonging. They stressed the importance of being able to talk to others about their shared experiences of being in hospital. This was particularly important for George because he had lost his social network, but also because it allowed him to make sense of some of his negative experiences.

The value of being able to talk with and gain support from other service users is a common theme in research. Newton, Larkin, Melhuish and Wykes (2007) interviewed individuals about their experiences of taking part in a group intervention for people with experiences of psychosis. One of the themes was that it provided them with 'a place to explore shared experiences'. For some, it was the first time that they had spoken to someone else with experiences of voice hearing. This normalised and destigmatised their experiences. The participants felt that this shared experience made them more understanding of each other and thus more able to offer support than other peers who did not have similar experiences.

Kilkku et al. (2003) found that participants spoke of feeling relieved at finding out that others also had experiences of psychosis and have found ways to manage it. In addition, being able to talk to people with similar experiences can be empowering and allows service users to develop new social circles and a sense of belonging (Pitt, Kilbride, Welford, Nothard and Morrison, 2009). Finally, MacDonald, Sauer, Howie and Albiston (2005) found that young people with FEP tended to seek company with peers with similar experiences, they described feeling safer and more relaxed. Individuals were able to share personal experiences and feel supported rather than mocked.

However, again many of the studies looking at the role of other service users have been focussed on FEP. Although the findings relate to some of the themes found in this study, the role of other service users may be more important for individuals with FEP. As individuals with FEP are experiencing psychosis for the first time, they may be unsure about what is happening to them. In this case being around other service users who may help them make sense of these experiences would be particularly valuable. In the present study many of the service users had had contact with services for several years and this may have impacted on how much they valued being around other service users.

Some research has suggested that some service users want to separate themselves from other service users because of the negative label attached to them (Knight et al., 2003; Perry et al., 2007). Although George did not talk about separating himself from other service users, he acknowledged that it can be shameful talking about their shared experiences. The fact that Robert emphasised talking to the staff as a means to maintain some normality suggested that he might not gain this from other service users. In addition, Philip's emphasis on keeping his roots may have been an attempt to maintain an identity separate from that as a service user.

Both Philip and Henry suggested that being part of a group was not only important for giving them a sense of belonging but it also provided them with an identity. Being a member of a particular social group gives an individual a self-concept and social identity (Tajfel, 2010). Philip seemed to feel connected to his group of friends by frequently talking about past events. Henry seemed to lack a sense of belonging in life; he spoke about moving between different families and the impact of not knowing his parentage on identity. It seemed that joining the police and seeking relationships within the force was his way of trying to belong to a group.

Similar to the importance of support in relationships, the value of belonging to a group is not unique and is often an important aspect amongst many groups, including peer relationships (Newman, Lohman & Newman, 2007) and religious groups (Smith, 1998). It also seems to be particularly important for groups that face discrimination, including ethnic minorities (Mossakowski, 2003) and LGBT groups (McCallum & McLaren, 2010;



McLaren, 2009). As the participants in the present study spoke often about the lack of understanding from others and the stigma they experienced it seems that it was not only the sense of belonging itself that was of value, but the fact that this identity gave them a safe place to share their experiences and make sense of them.

Additionally, McClaren (2009) and McCallum & McLaren (2010) argue that although it is beneficial for members of groups to share a sense of belonging, they also found that having a sense of belonging with wider society improved mental health. Thus, although it seems important to encourage service users to connect with each other and share experiences, this should not be to the extent that they withdraw from the larger community. This seems to fit with Philip's emphasis on maintaining his roots.

In summary, an important aspect of relationships is to feel connected and it appears that due to experiences of rejection from other social groups, contact with other service users is invaluable to the participants. This sense of belonging provides them with a unique opportunity to share their experiences with like-minded people who will not judge or reject them. However, perhaps due to stigma, participants also seemed to feel it was important to remain connected with others.

Overall, individuals with psychosis seem to make sense of their relationships in similar ways to many types of relationships. They make sense of them in terms of the function they serve, namely for support and recovery and to provide them with a sense of belonging. These are not unique features of relationships but it is important to acknowledge why they were highlighted in this study. It appears that support and recovery were valued, perhaps due to previous experiences of not receiving support. In addition the distress of unusual experiences and the response from others has led people to value receiving support. In addition, having a sense of belonging was more than having shared interests and something in common; it provided the individuals with a safe space to make sense of their experiences with peers.

## **How do they make sense of any difficulties they experience with important others?**

Participants spoke about various difficulties they experienced in their relationships with other people. Although the participants did not seem to directly blame their experiences on having psychosis, they seemed to suggest that some of the indirect experiences associated with psychosis might have had an impact, for example, stigma and being separated from loved ones whilst on the unit. None of the participants seemed to suggest that they had any particular difficulties understanding others; however, due to some of their negative experiences with others they seemed to recognise that this had impacted on how they interacted with others. Therefore, there seemed to be three main ways in which participants made sense of any difficulties in their relationships. First, the participants felt that many people did not understand their experiences of psychosis and this often led to stigma and discrimination. Second, participants recognised that their relationships are vulnerable to change. Finally, participants spoke of their fears about developing new relationships.

### **Lack of understanding and stigma**

As many of the participants spoke about the importance of understanding in their relationships, a lack of understanding was seen as an explanation for difficult experiences within relationships. Therese described having marital difficulties and part of this difficulty was that she felt that her husband did not seem to understand her needs for affection. Henry seemed to feel that his negative experiences with the police were confounded by their lack of understanding; he described them as not being aware of the nature of his distress.

In particular, there was a sense that a lack of understanding explained why some of the participants felt that people discriminated against them because of their psychosis. Although many individuals with mental health difficulties experience stigma, it is particularly experienced by people with psychosis (Dinos, Stevens, Serfaty, Welch & King, 2004). Pitt et al. (2009) used IPA to explore the impact of being given a diagnosis of psychosis. They found that for many of the participants their diagnosis led to them being socially excluded.

However, some research suggests that it is the fear of stigma that is the main barrier to relationships; because people anticipate it they begin to distance themselves from others. Bassett, Lloyd and Bassett (2001) found that participants spoke about experiencing loss; they pushed their friends away whilst they were in hospital causing them to feel lonely and low in self-worth. Participants felt that once people knew they had a diagnosis they would not want to know them because of the stigma around mental health problems.

Similar findings suggest that fear of stigma and judgment of others can affect how much individuals engage in activities with others (Boydell, Gladstone & Volpe, 2006; Macdonald et al. 2005; Moriarty, Jolley, Callanan & Garety, 2012), how much they share their experiences with others (Judge, Estroff, Perkins & Penn, 2008) and can result in treatment delay (Franz et al. 2010). Birchwood et al. (2007) suggest that social anxiety, which can be associated with psychosis, may make individuals more likely to attach shame to their diagnosis and thus affect social interactions.

It seems that in regards to stigma it works both ways; individuals with psychosis may anticipate stigma and therefore withdraw from others, however, this is most likely in response to society's treatment of people with mental health difficulties. Mackrell and Lavender (2004) found that participants described increased isolation from their peers during and after they experienced a phase of psychosis. Participants seemed to attribute some of this to them feeling uncomfortable and wanting to avoid others due to 'paranoia'. However, they also seemed to be treated differently by their peers and experienced some hostility and rejection.

George and Henry's experiences of not being supported at work are not unique. Nithsdale, Davies and Croucher (2008) interviewed individuals about their experiences of psychosis and employment. A lack of support from their workplace regarding mental health problems was common. Like George, often their disclosure would result in them being given fewer responsibilities at work or being persuaded to leave. However, some found that when they did disclose to work colleagues, although some were awkward and avoidant about it, they eventually came to accept it. Many of them attributed any negative responses to their disclosure as ignorance on the other person's part.

Given some of the experiences described by the participants in this study and other studies, being cautious about others seems a reasonable consequence. Thus it may not be accurate for diagnostic labels such as 'social anxiety' and 'paranoia' to be attached to these behaviours. In some cases, being more careful can be seen as an adaptive way for the individual to protect themselves from the realistic chance that they might experience further distress at the hands of others.

Research has highlighted that psychosis is associated with difficulties with social relationships (Bratlien et al. 2013; Stain et al. 2012) and interpersonal functioning (Collip et al. 2011). However, a limitation of many of these studies is that they focus more on the perceived degree of social dysfunction rather than the reasons behind it. For example, Bratlien et al. (2013) use a scale to measure social functioning and this neglects to determine why someone may interact less with others. It is possible that the fear of stigma is an important factor that makes individuals with psychosis wary of interacting with others during and even after their experiences of psychosis.

Robert spoke differently about issues relating to stigma and lack of understanding. Robert described his parents as very controlling and spoke about trying to establish his own independence. Some people commonly view those with psychosis as being vulnerable and try to help them as much as possible; however, this may be particularly inappropriate for younger clients such as Robert who may function well after an episode (Addington, McCleery, Collins & Addington, 2007). Developing autonomy from parents is a basic psychological need (Harrop & Trower, 2001) and Robert seemed to recognise this conflict as the main reason for the difficulties he experiences with his parents.

In summary, a lack of understanding may lead to negative experiences such as not feeling listened to and stigma. These experiences and fear of them can have a significant impact and affect how much an individual engages with others, leading to social isolation. A lack of understanding from people who do not have experiences of psychosis may result in them treating people with psychosis differently. It also means that service users may not turn to them for support, as they do not feel that they are able to fully empathise with them. It is possible that the fear of stigma from others may contribute to why people with psychosis may withdraw from others.

### **Relationships are vulnerable to change**

Robert and Henry spoke about being on the unit and how this prevented them from seeing their nephews. George seemed concerned about the impact of his psychosis on his brother and this may have influenced how much he shared with his brother. Therese spoke about the change in her relationship with her daughter whilst she had been on the unit.

Hughes, Hayward and Finlay (2009) found that half of their participants felt that their relationships had been significantly affected when they became an inpatient. Unfortunately in the study there was no offer of an explanation as to why some people felt their relationships were affected whilst others did not. If a family is very supportive then this can strengthen the bond rather than have a negative impact (Brown, 2011), thus this may be a factor in determining the level of impact of a separation. This may relate to George's relationship with his brother; although George's brother seemed to struggle to understand psychosis, the support that he offered seemed to strengthen their relationship. In addition, it is possible that Philip may not feel his relationships have been negatively affected because his friends and family have been very supportive.

It seems that participants felt that in order to avoid too much disruption to their relationships it was important to remain connected and to continue to maintain their relationships despite the difference in circumstances. Philip spoke at length about the importance of having regular contact with family and friends and offered this as an explanation as to why the relationships were positive. Wood, Price, Morrison and Haddock (2010) found that participants felt it was important to rebuild relationships that may have broken down in order to assist their recovery. This may relate to the importance of maintaining his roots as suggested by Philip.

Despite various changes, many individuals try to maintain as much involvement as possible (Nicholson, Sweeney & Geller, 1998). Maintaining relationships may enable service users to remain connected with the outside world. George and Therese also spoke about having regular contact with their important others. Robert described how

he wanted to continue to do the same things with his nephews as he had done before he was in hospital. Therese spoke about being a parent and the impact of being separated from her daughter.

There appears to be a limited amount of research on parents with psychosis, with much of the research tending to focus on the prevalence of parents with psychosis (e.g. Thomas & Evelyn, 2004) or the impact for the child (Devlin & O'Brien, 1999). Few studies have looked at the experiences of parents with psychosis. Some research has found that some mothers experience difficulty managing their child's behaviour and this can cause stress and frustration (Nicholson, Sweeney & Geller, 1998; Venkataraman & Ackerson, 2008). Therese also spoke about difficulties managing her daughter's behaviour. However, a limitation of these studies is that it is not clear why these difficulties occur; the assumption seems to be that it has something to do with the parents' unusual experiences. Despite this, Plant et al. (2002) found that the majority of parents with psychosis feel that they are effective parents. Instead, the difficulties some parents with psychosis may be experiencing may not differ significantly from the challenges experienced by most parents.

It is possible, however, that having psychosis may have an indirect impact on parenting; for example, Campbell et al. (2012) found that a significant proportion of parents with psychosis live in poverty and are socially isolated. Or, as seemed to be the case for Therese, having psychosis may result in the parent and child being separated. Evenson et al. (2008) found that some fathers refused to allow their children to see them in hospital as a way to protect the child, but perhaps also because they were ashamed. It seems that this was similar for Henry who refused to allow his nephew to visit him. Thus it may be the separation rather than the psychosis specifically, which has an impact on the relationship. Separation can also result in the child acting differently amongst different relatives (Nicholson, Biebel, Hinden, Henry & Stier, 2001).

The fact that participants seem concerned about being separated from important others and emphasised the importance of maintaining contact seems to contradict the assumption that psychosis is necessarily associated with social isolation. It is possible that individuals with psychosis may withdraw from relationships that may be harmful,

for example, due to stigma, but strive to continue with relationships that are helpful and supportive.

In general, there was a recognition that being on the unit had resulted in a change in their relationships; this was regardless of whether contact was limited or not.

Participants were concerned that they were not able to continue the relationship, as they would have done if they were not on the unit. Despite this, in order to maintain some positive experiences, participants strived to maintain regular contact and to continue their usual roles wherever possible.

### **Difficulty establishing new relationships**

As a result of their negative experiences some participants changed how they viewed relationships. They seemed to recognise this as a way of protecting themselves, but also saw it as a barrier to developing new relationships. George felt that he could no longer trust others; his experiences had taught him that people would react badly if they found out about the psychosis. Henry also spoke about difficulty trusting others and how this resulted in him secluding himself from others. Despite this, he also recognised it as a barrier and suggested that he needed to learn how to trust others. Robert also spoke about avoiding social gatherings and how he needed encouragement and support from his brother to go out. Despite this, he noted that when he did go out he enjoyed it.

Other studies have also found that people with experiences of psychosis describe a change in their relationships, resulting in anxiety about developing new relationships (Hirschfield, Smith, Trower & Griffin, 2005). Negative experiences are likely to make people hesitant about telling new people about their diagnosis due to fear of stigma and judgement (Harris, Collinson & das Nahir, 2012; Pitt et al. 2009). Although this may not lead to a lack of relationships it can affect the quality of relationships (Woodside, Krupa and Pocock, 2007). It is possible that it is this change in how they view relationships that has resulted in research findings suggesting that people with psychosis socially withdraw from others.

Hirschfeld et al. (2005) explored the meaning of experiences of psychosis in young men. All of the men interviewed described how their relationships had changed following their experiences. This left them feeling lonely and reduced their sense of belonging to a peer group. As a result some described feeling anxious about developing new relationships and being able to trust others. Pitt et al. (2009) found that due to the negative response they received from their friends, many were hesitant about telling new people about their diagnosis due to a fear of stigma and discrimination. In addition, Harris et al. (2012) found that participants' experiences of other people's judgements and response to their psychosis influence how much they were willing to talk about their experiences with others.

Despite this, given their experiences it seems understandable and adaptive that individuals would be more careful about whom they trust and relate to. It may even result in them having better and more positive relationships. Macdonald et al. (2005) found that in regards to developing new relationships participants began to reassess their values, this included whom they chose to trust and depend on. Similarly, Woodside, Krupa and Pocock (2008) found that participants sought new sets of friends, for example, ending abusive relationships, avoiding friends who were a bad influence and also avoiding people they did not trust. It is possible that the negative experiences may have helped participants make better sense of what positive and healthy relationships might be like. Both George and Henry, for example, spoke about the importance of being cautious in future relationships in order to avoid getting hurt.

In the present study there was very little discussion about romantic relationships. Robert stressed that he did not want to discuss them, whilst George and Philip did not mention them. Therese spoke about her marriage. Henry, however, did talk about his romantic relationships and he suggested that being on the unit and not having a job and a home would make it difficult for him to establish a romantic relationship. Redmond et al. (2010) found that participants also spoke about the lack of resources such as finances that may act as a barrier to romantic relationships. They also felt that people would not understand their experiences of psychosis.

The study by Redmond et al. (2010) was with young people, therefore some of the findings might not relate to all the participants in the present study. As young people,



many of them had never had romantic relationships before and this in itself was a barrier. Young adulthood is a particularly important period for seeking romantic relationships and disruption during this period is likely to have an impact on their future (Redmond et al., 2010).

This may explain why Therese and Henry have experienced some positive romantic relationships whilst Robert most likely has not. As a young person who had first contact with services when he was sixteen, Robert may have similar feelings to the young people in the study by Redmond et al. (2010). Henry, however, described having many romantic relationships prior to being in hospital and it is likely that this means that he felt more able to have future romantic relationships. Similarly, Therese also met and married her husband before her first contact with services.

In summary, participants noted that their experiences meant that they had begun to think about how they formed relationships with others. There was a belief that they needed to protect themselves and be cautious of whom to trust in order to avoid getting hurt. However, they seemed to recognise that it is important to get the right balance and that they needed to learn how to trust others. There was little discussion about romantic relationships, perhaps because it is a more sensitive topic. In addition, the older age at which some of the participants had their first contact with services may mean that they did not have difficulties establishing romantic relationships.

## **Theory of Mind**

The concept of Theory of Mind did not emerge as a theme in the experiences described by participants. However, discussions during The Hinting Task regarding the participants' thoughts about the task emphasise the importance of this concept with regard to relationships. Much of the literature, which has focused on social functioning in individuals with experiences of psychosis, has suggested that a cognitive deficit such as a Theory of Mind (ToM) deficit may be to blame (e.g. Kosmidis et al. 2011; Sullivan et al. 2013b). However, some research has found no association (Sullivan et al. 2014) or have found that other factors are involved, such as age of onset (Smeets-Jansen et al. 2013), the types of symptoms experienced (Scherzer et al. 2012) and the method used to measure ToM (Sullivan et al. 2013b).

In relation to exploring how individuals make sense of their relationships and any difficulties they experienced, the present study was also interested in whether individuals felt that they had difficulties understanding others. Therefore, all of the participants completed The Hinting Task (Corcoran et al. 1995), a task developed specifically to assess ToM in individuals with psychosis. Individuals with psychosis tend to perform poorly on the task (Scherzer et al. 2012) with an average of 15.6 compared to controls with 18.3 out of twenty (Corcoran et al. 1995).

In the present study three of the participants (George, Robert and Henry) scored 18 or above, which is similar to those without psychosis. Of the other two participants, one scored 15 (Therese), which is close to the average of those with psychosis, and the other scored 10 (Philip), which is notably lower than that average and suggests a significant difficulty. This variation in scores further demonstrates that the association between ToM and psychosis is not simple and that there may be other factors other than experiencing psychosis per se involved.

The qualitative nature of this study meant that participants were asked to briefly talk about how they found the task and whether it related to their everyday experiences. The things they spoke about are more meaningful than the scores in isolation and tell us a lot more about how they make sense of other peoples' intentions. Interestingly, the three who performed well on the task, suggesting that they may not have an impairment, still spoke about some struggles they have understanding others. They seemed to feel that using hints was a form of deception and that they needed to be hypervigilant in order to protect themselves. This was to the extent that one of them felt that he often looked for hints that were not there. This suggests that they may have some difficulty with understanding others, but The Hinting Task did not pick up this difficulty.

According to Frith (2004), it may be inaccurate to suggest that people with psychosis lack a ToM. It seems that they are able to make predictions about other's intentions; however, the difficulty seems to be the types of predictions they make. Frith (2004) criticises many ToM tasks for failing to distinguish between undermentalizing and overmentalizing. Individuals with a ToM deficit are unable to appreciate others'

intentions and thus undermentalize. On the other hand, some individuals are able to understand that people have intentions, but they overmentalize and make excessive attributions.

It is therefore possible that the three who performed well on the task did so because they appreciate that other people have intentions. However, in reality they overmentalize and may make erroneous attributions. Fretland et al. (2015) found a significant albeit small-moderate correlation between positive symptoms and overmentalizing. All three of the participants spoke about the deceitful nature of others, thus it is possible that this suspiciousness may cause them to overmentalize.

The two participants who performed less well did not seem to view the concept of using hints as deceitful or dishonest and throughout their interviews they did not speak about being suspicious of others. This may suggest that they would have, therefore, no inclination to overmentalize. Although Therese, who scored 15, struggled with the task, she recognised that people do use hints but she finds them difficult to recognise. This suggests that she does have a concept of ToM. Philip, on the other hand, who scored the lowest score of 10, said that he was not aware of people using hints, suggesting that he may undermentalize other people's intentions.

Some have now started to argue that the common belief that ToM is either absent or present is too simplistic (Fretland et al. 2015). Abu-Akel and Bailey (2000) argue that ToM impairment may be better viewed as being on a continuum and propose a hyper-theory of mind. On the lower end of the continuum are individuals who lack a ToM and are thus unable to represent and understand others' mental states. Some may have representational understanding but are unable to apply this, for example, if they have a reality bias. Others, however, also have a representational understanding but over attribute mental states.

Although strong conclusions cannot be made about whether these scores have implications for each participant's ability to interact with others, it is interesting that Philip, who scored the lowest, reported the most positive experiences with others. It is possible that undermentalizing may be protective in some way. For example, both Henry and Robert described experiences when they overmentalize and this seems to

have impacted on their relationships. It affected Henry's relationship with the police and Robert's relationship with his family. In addition, the fact that Philip was not concerned about his ability to understand others may mean that he is less likely to avoid social interactions than someone like Robert who was concerned.

Garety, Kuipers, Fowler, Freeman and Bebbington (2001) emphasise the importance of social factors in understanding how people make sense of others' intentions. The different experiences described by the participants may help to understand how they have come to understand others. For example, if Philip has had positive interactions with others and has found no reason to mistrust them then it is unlikely that he will be hypervigilant and overmentalize others' intentions. However, Henry experienced a lot of disruption in his childhood and described being let down frequently. Therefore, it seems adaptable and necessary given his experiences, that he should be more hypervigilant.

In summary, it seems that ToM ability lies on a continuum as opposed to being an ability that is either present or absent. There seemed to be a distinction between participants who undermentalize and those who overmentalize. It is possible that this difference in making sense of others' intentions may be affected by social factors, particularly past experiences. It is possible that ToM ability may affect social functioning in two ways. First, an individual who overmentalizes may have more negative experiences with others. Second, an individual who is worried about their ability to understand others may be more likely to avoid social interactions.

## **Research methodology: strengths and limitations**

### **Qualitative research and Interpretative Phenomenological Analysis**

The main advantage of using qualitative methodology is that it allows for the exploration of phenomena that cannot be easily quantified (Barker, Pistrang & Elliot, 2002). Much of the literature on social relationships in people with experiences of psychosis has been quantitative. The main rationale for the present study is that it was felt that this approach was too reductionist and that it was necessary to explore the experiential nature of relationships for this group. Thus a qualitative approach was chosen as the most fitting method for the rationale of this study.

There were various themes which emerged from the data in this study, more so than would have been generated from a quantitative study. The qualitative approach allowed me to offer explanations that are missing from quantitative research. This included explanations as to why individuals may withdraw from their social circles and be reluctant to develop further relationships. In addition, qualitative research can lead to the generation of further hypotheses and future research (Barker et al. 2002). I feel that following this study the research could be taken further in various ways.

However, bias is a significant issue in qualitative research (Mehra, 2002) and thus there may be doubts about the significance of the findings if the interpretations are coming from just one researcher (Pringle, Drummond, McLafferty & Henry, 2011). From the start of the study and throughout the process I have been committed to acknowledging and being explicit about my expectations, thoughts and biases. As a result I hope that this means that the way I have interpreted the results is more transparent. Despite this, I can appreciate that someone different to myself may have interviewed the same participants about the same topic area, but experienced the interview differently and emerged with different results.

Another rationale for this study was that I wanted to explore individuals' personal experiences. Again this was motivated by my response to the quantitative literature that seemed to suggest that most individuals with psychosis were similar in their experiences. The focus on in depth individual accounts can be seen as a strength as it provides a detailed account of individual experiences. However, this can also be seen as a weakness because it limits the generalizability of the results to the wider population (Pringle et al. 2011). The accounts of five individuals cannot be generalised in the same way that quantitative data can be. Despite this, I would argue that no experience can be generalised, no matter how many people you interview. Five participants took part in the study, and although there were common themes there was a lot of variation in terms of their relationships and experiences. In addition, many of their experiences related to the literature including quantitative research, and they provide a richer understanding of some of the experiences of people with psychosis.

In addition, the participants who took part were those who were able to engage with me in an interview. This was a necessary requirement of the study, however it is likely that these participants differ considerably from service users who would not have been able to engage in an interview.

## **Interviews**

Many qualitative studies involve asking individuals about their experiences and how they make sense of them. Inevitably this involves talking about personal experiences, some of which may be difficult or upsetting. I was aware that by asking participants to talk about their relationships with other people and how they make sense of difficult experiences, I was asking them to talk about a potentially sensitive area. Except for one, I met all of the participants for the first time just before we started the interview. Thus I can appreciate that it must have been difficult to talk about their relationships with someone they have just met. It is possible that there may have been other relationships that could have been discussed but participants chose not to because they did not know me well enough to share this with me.

I considered doing two interviews with each participant. The first would have been to focus on engaging with them and getting to know them. The second would then carry on from the first with the hope that they would feel more comfortable in sharing their experiences with me. I decided against this, as I was concerned that recruitment with this client group might be difficult and I did not want to dissuade people from taking part by requesting two interviews. However, one of the participants offered to take part in a further interview, suggesting that doing two interviews may have been a feasible approach, at least for some people.

My confidence in undertaking the semi-structured interviews increased with every interview; as a result there may be differences between how I conducted the first interview and final interview. During the first interview I was more tentative with the use of prompts as I was not sure how the participant would respond to the nature of the interview. However, once I got to the final interview, I was more confident with my questions and my approach. Thus it is possible that if I were to do the first interview again, I may have elicited more about the participant's relationships.

I chose to do a semi-structured interview as I hoped it would be empowering for the participant to have some flexibility over what they chose to discuss. However, some of the participants may not have experienced it in this way. At times they found it difficult to know what to say and were more reliant on me prompting them than I anticipated. A limitation of semi-structured interviews is that the non-standard approach can result in there being a lot of variation between the interviews (Sociological Research Skills, 2015). In addition, the researcher decides where to prompt and what further questions to ask (Sociological Research Skills, 2015) and this can result in some experiences being privileged over others.

I considered whether it would be more appropriate to do The Hinting Task at the beginning or end of the interview. I felt that participants would feel more comfortable doing it at the end and that the first interview question asking them about the important people in their life would be a better way of engaging them and building a rapport. However, a limitation of this is that because The Hinting Task was left to the end, it often felt rushed. I was conscious that the participants had been speaking at length about some difficult topics and I did not want to prolong the interview unnecessarily. Although all of the participants were offered a break before doing the task, they all chose to continue without a break in order to 'get it over with'. After completing the task I asked them a few questions about how they found it and how it related to their everyday experiences. However, because it was at the end and it felt necessary to finish the interview I did not use many prompts to elicit more responses from the client. I therefore, think that I could have obtained more information from The Hinting Task if I had allowed more time for it.

It could be argued that The Hinting Task, although it is perhaps more realistic than other ToM tasks, does not represent the complexity of real life social experiences. This was emphasised by one of the participants who suggested that they found the task easier, compared to real life situations, because they were aware that they were meant to be looking for hints. However, asking the participants to do the task was beneficial to the present study as it provided a sense of what their ToM ability might be like. However, more importantly, it also facilitated a general discussion about their ability to understand others.

### **Sample and recruitment**

Although I met with the rehabilitation staff and advised them about the study's inclusion and exclusion criteria, recruitment relied heavily upon staff and I ultimately saw whomever they suggested. I had limited control over how they suggested the research to the service users and even whom they decided to approach. For ethical reasons it would not have been appropriate for me to approach service users. However, it is possible that staff may have approached the service users who they spend more time with or those who they felt would have been more interested in the study. It is also possible that staff may have approached service users who had more current relationships, thinking that they would have had more to say than someone who may have been socially isolated.

In addition, the present study consisted of a sample of relatively young individuals, who had spent time on inpatient units. Their experiences may not be representative of individuals who have received support for their experiences in the community. They also may not be representative of individuals who have had experiences of psychosis for many years.



## **CLINICAL IMPLICATIONS AND RECOMMENDATIONS**

### **Strengthening the staff-service user relationship**

Along with previous research and recommendations (e.g. The Francis Report, Francis 2013), the results from this study highlight the importance of the staff-service user relationship and its role in recovery. It appears that the expected qualities of a supportive relationship such as empathy and feeling listened to are fundamental. This is important for individuals with psychosis, particularly as they may have had experiences where people have been less understanding and supportive. Thus it seems vital that staff spend time building a collaborative and supportive relationship with service users.

The findings from the present study also suggest that service users want staff who are authentic and genuine, staff who connect with them on a social level and treat them as individuals, not different because of their unusual experiences. Although there are issues around maintaining professional boundaries; it is implicit that the staff-service user relationship does not just focus on the service user's treatment but on building a trusting and supportive relationship as would be expected in any other relationship. This seems pertinent given that some service users may have had bad experiences with others particularly prior to entering the service.

Although participants valued the support staff gave them, there was some recognition that staff did not fully understand or appreciate what it is like to have experiences of psychosis. In this case the staff-service user relationship may be strengthened if the staff member moves away from the expert role and trying to 'treat' the service user but instead takes the time to hear the service user and gain some insight into the personal and subjective experiences of psychosis. In addition to feeling listened to this may also empower the service user. Roberts and Wolfson (2004) recommend recovery-oriented practice and suggest that staff should not be viewed as the expert but as a coach who treats the service user as an 'expert by experience'.

## **Facilitating family members' understanding of individual experiences of psychosis**

Family work with individuals with psychosis is important as it can improve the family dynamic and reduce disruptions to their relationships (Addington, McCleery, Collins & Addington, 2007). However, as families may struggle to understand psychosis it has been suggested that psychoeducation may be important (Vikovic, Jankovic-Gajic, Popovic, Markovic-Zigic & Markovic, 2008). However, there are some caveats to this, first, historically there has been an assumption that family dysfunction causes psychosis (McFarlane, Dixon, Lukens & Luckstead, 2003). Thus it is important that any family intervention does not reinforce this belief. In addition, an intervention focusing simply on psychoeducation reinforces the perception that the problem is the individual's unusual experiences.

Second, although it may be helpful to provide family members with general information about psychosis, the present study suggests that what would be more helpful is to encourage conversation and thus awareness about the impact the experiences have had on the individual. For example, it may be helpful for services to encourage and facilitate interventions where the service user is able to share the impact that having psychosis has had on them. This may help family members to develop more empathy for the service user. In addition, if family members are better able to understand the impact that the psychosis has had on the individual they may be less blaming and critical of that person.

Separation from others, particularly family members, seemed to be a reason for difficulties or changes in relationships. Family interventions may also encourage more involvement and thus reduce the sense of loss associated with being an inpatient. In addition, support for young people returning to their family after experiences of psychosis may be beneficial to help them adapt to living at home again.

The importance of supportive staff and involving the family in the service user's care seems to fit with the Open Dialogue approach adopted in Western Finland. The aim is to create an open dialogue between the service user and their support team (Razzaque & Wood, 2015) in order for all parties to feel validated and respected (Olson, Seikkula & Ziedonis, 2014). The service user and their network are encouraged

to form their own narrative in order to describe their experiences of mental health difficulties (Seikkula & Olsen, 2003). Involving the family and members of the service user's social network from the beginning increases the chances of them being involved in the service user's care throughout the process (Olson et al. 2014).

The concept of Open Dialogue is emerging in the United Kingdom with trials being held in Leeds (Jackson, 2015), Somerset (Burchach, Sheldrake & Rapsey, 2015) and Nottingham (Coles, Park, Hendy & Collinson, 2013). Razzaque and Wood (2015) found that NHS staff and service users hold favourable views about Open Dialogue as an NHS intervention. Despite this, the medical approach currently adopted within the NHS means that introducing Open Dialogue may be a challenge. In addition, NHS stakeholders may be concerned about financial and staff resources required to implement such an approach (Razzaque & Wood, 2015).

### **Encouraging peer support from current and previous service users**

An important implication seems to be the role of other service users. Although staff and relatives are important for recovery, the role of other service users in providing empathy and support seems unique. Peer support programmes have been found to increase social opportunities (Davidson et al., 2006; Stain et al., 2012) and quality of life (Castelein et al., 2008). However, peer support groups for psychosis are rarely available despite them being cost effective (Stant et al., 2011).

Peer support may be a beneficial intervention for the participants from this study for several reasons. First, it would give them the opportunity to talk to others about their experiences and learn different ways of coping. Second, it might be helpful if the peer support comes from previous service users who are back in the community. This might help reduce internal stigma and help service users recognise that they can achieve a good quality of life once they leave the unit. Finally, Mead & MacNeal (2015) argue that peer support within mental health is important not only for the shared experience of having a mental health difficulty, but also because there is a shared experience in how people have responded to this difficulty. Thus, providing a space for people to talk about negative experiences such as stigma and relationship breakdowns.

### **Individual interventions tailored towards the social needs of the service user**

Research which has suggested that social difficulties in individuals with psychosis is a result of a cognitive deficit or bias have tended to promote social cognition training as an appropriate intervention (Roberts & Penn, 2009). Although these interventions have been shown to have promising outcomes (Combs et al. 2007), they may be more effective if they are tailored better to the individual and their personal experiences. Rather than using an intervention which focuses more on a perceived deficit that an individual has it might be more helpful if the individual is encouraged to explore how their past experiences relating to and interacting with others may have an impact on their current and future relationships. For example, recognising how their past experiences of being let down by others may affect how much they trust others. This may be more validating for the individual as it demonstrates that their way of relating to others is not a deficit but is perhaps a reasonable and adaptive response given their past experiences. This may also reduce the stigma of the social cognition research that may imply that the service user is to blame for their interpersonal problems.

In summary, it may be helpful for services to continue to focus on the staff-service user relationship. The relationship seems to be important as it aids recovery, but also seems to maintain a sense of normality for the service user. This is particularly important for service users who may have become socially isolated. However, it is important that this relationship is collaborative and the service user is regarded as an expert by experience. Family interventions may be helpful if they focus not only on psychoeducation, but also on facilitating discussions within the system. Open dialogue is an intervention which can allow members of the family or system to share their stories. Peer support is suggested as a beneficial intervention as it could reduce stigma and provide service users with a sense of belonging. Finally, individualized interventions aimed at improving social functioning in people with experiences of psychosis may help service users understand how past experiences impact on their current relationships.

## **FUTURE RESEARCH**

One of the limitations of the present study is that there was not much exploration of the participants' response to The Hinting Task. Some of the participants, particularly those who were suspicious, seemed to suggest that overmentalizing can be problematic for their relationships. A further qualitative study could explore this in more detail.

Participants could be asked about their experiences of making sense of other people's intentions. This could include asking them about why they feel they look for hints that may not be there and the impact that this has on them and their relationships.

Much of the qualitative literature cited has tended to involve individuals with FEP. Thus many of the findings may only relate to a population with emerging psychosis. Although this study did not involve individuals with FEP, it involved individuals who were still in contact with mental health services. One of the themes that emerged was difficulty and anxiety about establishing future relationships. A further qualitative study could explore the meaning and experience of relationships among individuals who have had past experiences of psychosis and now have limited or no contact with services. It might be interesting to explore how they may have re-evaluated their relationships since their experiences of psychosis.

Findings from the present study suggest that a more individualised intervention to improve social relationships may be more beneficial than standardised social cognition training. If any intervention is developed it could be compared to an intervention such as SCIT in a randomised controlled trial.

## **CLOSING REFLECTIONS**

An important part of good qualitative research is to be explicit about one's theoretical stance (Elliot et al. 1999) and to adopt reflexive positioning (Newton et al. 2011). Therefore, I think it is important to summarise how my thoughts changed throughout the study. A transcript of all my reflections throughout the study can be viewed in Appendix X.

When I first proposed the study my expectation seemed to be that the participants would talk about predominantly negative experiences of interacting with others or speak of a lack of important relationships. Although I eventually began to think about the more systemic factors and how responses from others may have an impact on these relationships, I did not consider whether participants would talk about positive experiences with others. Initially, I feel that this bias was fuelled by the literature that I had been reading about people with psychosis and their relationships, it was this bias that likely informed my second research question. However, I also feel that it is a result of my clinical work with people with psychosis. As I have been working with people experiencing distress regarding their experiences of psychosis this has perhaps tainted my view of any positive experiences they might have.

Whilst doing the interviews some of the things I was expecting emerged, for example, issues around stigma and avoiding others in order to remain safe. However, I was struck by the amount of positive experiences discussed, particularly in regards to receiving support from others. I then came to realise that people with psychosis have a variety of relationships like others without clinical experiences of psychosis and that there is a commonality in human experience. Rather than merely determining why people with experiences of psychosis might experience difficulties, it also became apparent that it was interesting to explore why certain aspects common to most relationships may be particularly highlighted as important.

Once I stopped limiting my thoughts to relationships among people with experiences of psychosis I began to think about relationships in general. I queried the definition of an

important relationship. Is it defined as important because it is meaningful or helpful? I also queried what it means to have difficult experiences with others. I came to realise that everyone has difficult interactions with others at some point, so I began to wonder how difficult experiences might differ for people with psychosis.

When I began to analyse the data I began to think in depth about my role within this piece of research. I was initially attracted by the double hermeneutic concept of IPA, and although I found it interesting I did not anticipate how challenging I would find it and the implications it would raise. I wanted to use a qualitative approach because I was responding to the quantitative literature I had read and I wanted to give a voice to the participants. However, as Larkin et al. (2006) point out it is not possible to give the participant's account without including the researcher's interpretations. I began to feel uncomfortable when making interpretations about participants' thoughts and experiences. I worried about whether they would agree with this story and whether my voice was being heard more than theirs. I also became aware of how much power I had in this process. Although I had some standard questions to ask the participants, it was up to me to choose when to prompt them for further responses. In this sense I worried that my own biases and interests may have resulted in me privileging some topics over others.

Overall, my hopes were to do a study that was meaningful and provided an additional perspective to the literature that is already available. I expected that my assumptions would change and that I would get results that I was not expecting. I am pleased that it was the positive experiences that took me by surprise and I hope that these findings provide an alternative narrative about people with psychosis and their experience of relationships with others.

## CONCLUSIONS

In response to the existing literature, the present study aimed to explore the meaning and experience of relationships for people with experiences of psychosis. Interpretative Phenomenological Analysis was used to analyse the data from the semi-structured interviews of five participants with experiences of psychosis from a mental health rehabilitation service. An individual analysis was done for each participant, as it felt important to evidence that each person had a range of experiences. I also undertook a group analysis. Three superordinate themes emerged from the group analysis: 'feeling connected to important others', 'having psychosis can get in the way of relationships' and 'being cautious around others'.

Overall, participants seemed to make sense of their relationships in two ways. First, they emphasised the value of important relationships for providing support and recovery; this included relationships with staff members but also family members. Second, they highlighted the importance of belonging to a group who shared their experiences and understanding. This was predominantly with other service users who also had experiences of psychosis. A range of negative experiences were described; however, there appeared to be a sense that these were largely driven by people's lack of understanding of psychosis. In addition, these negative experiences seemed to have a lasting impact in that they affected how the participants viewed and considered future relationships. It seems too simplistic to suggest that individuals with experiences of psychosis may have difficulties with relationships due to a Theory of Mind impairment. However, it is possible that, for example, overmentalizing and looking for hints that are not there may have a negative impact on relationships.

Although the importance of the staff-service user relationships has already been highlighted, the present study suggests that this relationship could be further strengthened if service users are empowered and encouraged to educate staff about the impact of their experiences of psychosis. Similarly family interventions, rather than focusing on psychoeducation, could also involve encouraging the service user to share with their family members their personal experiences of psychosis. The importance of belonging to a group and receiving support from others with similar experiences suggests that service users may benefit from support groups provided by other service



users with experiences of psychosis. Finally, the participants described a range of experiences and spoke about the impact that these experiences had on their current and future relationships. Therefore, it seems that interventions aimed at improving social functioning should be individualised in order to incorporate the experiences of each individual.

Future research could explore in more depth participants experiences of overmentalizing and the impact this has on their relationships. It might also be interesting to explore how people make sense of and re-evaluate their relationships after an experience of psychosis. Finally, a Randomised Controlled Trial could be used to compare standard social cognition training interventions with a more individualised intervention aimed at understanding and improving the quality of social relationships.

## REFERENCES

- Abba, N., Chadwick, P., & Stevenson, C. (2008). Responding mindfully to distressing psychosis: A grounded theory analysis. *Psychotherapy Research, 18*(1), 77-87.
- Abu-Akel, A., & Bailey, A. L. (2000). Letter. *Psychological Medicine, 30*(03), 735-738.
- Addington, J., McCleery, A., Collins, A., & Addington, D. (2007). Family work in early psychosis. *Journal of Family Psychotherapy, 17*(3-4), 137-153.
- Ainsworth, M. D.S., Blehar, M.C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5<sup>th</sup> ed.). Washington, DC: American Psychiatric Publishing.
- Andersen, K., Fuhrer, R. & Malla, A.K. (2013). 'There are too many steps before you get to where you need to be': Help-seeking by patients with first-episode psychosis. *Journal of Mental Health, 22*(4), 384-395.
- Andres-Roqueta, C., Adrian, J.E., Clemente, R.A., & Katsos, N. (2013). Which are the best predictors of theory of mind delay in children with specific language impairment. *International Journal of Language & Communication disorders, 48*(6), 726-737.
- Barker, C., Pistrang, N., & Elliot, R. (2002). *Research methods in clinical psychology. An introduction for students and practitioners*. West Sussex: John Wiley & Sons, LTD
- Baron-Cohen, S., Leslie, A.M., & Frith, U. (1985). Does the autistic child have a "theory of mind"? *Cognition, 21*, 37-46.
- Baron-Cohen, S. (1997). Hey! It was just a joke! Understanding propositions and propositional attitudes by normally developing children with autism. *Israel Journal of Psychiatry, 34*, 174-178.
- Baron-Cohen, S., Jolliffe, T., Mortimore, C., & Robertson, M. (1997). Another advanced test of theory of mind: evidence from very high functioning adults with autism or asperger syndrome. *Journal of Child Psychology and Psychiatry, 38*, 813-822.
- Baron-Cohen, S., Wheelwright, S., Hill, J., Raste, Y., & Plumb, I. (2001). The "Reading the Mind in the Eyes" Test revised version: a study with normal adults, and adults with Asperger syndrome or high-functioning autism. *The Journal of Child Psychology and Psychiatry, 42*, 241-251.
- Bartholomeusz, C.F., Allot, K., Killackey, E., Liu, P., Wood, S.J., & Thompson, A. (2013). Social cognition as an intervention for improving functional outcome in first episode psychosis: a feasibility study. *Early Intervention in Psychiatry, 7*(4), 421-426.

- Bassett, J., Lloyd, C., & Bassett, H. (2001). Work issues for young people with psychosis: barriers to employment. *The British Journal of Occupational Therapy*, 64(2), 66-72.
- Baumeister, R. F., & Leary, M.R. (1995). The need to belong: desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin*, 117(3), 497-529.
- Bellack, A.S., Green, M.F., Cook, J.A., Fenton, W., Harvey, P.D., Heaton, R.K., . . . Wykes, T. (2007). Assessment of community functioning in people with schizophrenia and other severe mental illnesses: A white paper based on an NIMH -Sponsored workshop. *Schizophrenia Bulletin*, 33(3), 805-822.
- Ben-David, S., Birnbaum, M.L., Eilenberg, M.E., DeVylder, J.E., Gill, K.E., Schienle, J., . . . Corcoran, C.M. (2014). The Subjective Experience of Youths at Clinically High Risk of Psychosis: A Qualitative Study. *Psychiatric Services*, 65(12), 1499-1501.
- Bentall, R. (2003). *Madness explained psychosis and human nature*. London: Penguin Books.
- Berry, K., Barrowclough, C., & Wearden, A. (2007). A review of the role of adult attachment style in psychosis: unexplored issues and questions for further research. *Clinical Psychology Review*, 27(4), 458-475.
- Berry, K., Barrowclough, C., & Wearden, A. (2008). Attachment theory: a framework for understanding symptoms and interpersonal relationships in psychosis. *Behaviour Research and Therapy*, 46, 1275-1282.
- Birchwood, M., Trower, P., Brunet, K., Gilbert, P., Iqbal, Z., & Jackson, C. (2007). Social anxiety and the shame of psychosis: a study in first episode psychosis. *Behaviour Research and Therapy*, 45(5), 1025-1037.
- Bora, E., Yucel, M., & Pantelis, C. (2009). Theory of Mind impairment in schizophrenia: meta analysis. *Schizophrenia Research*, 109(1-3), 109.
- Borg, M., & Kristiansen, K. (2004). Recovery-oriented professionals: Helping relationships in mental health services. *Journal of Mental Health*, 13(5), 493-505.
- Bosco, F.M., Colle, L., Fazio, S.D., Bono, A., Ruberti, S., & Tirassa, M. (2009). Th.o.m.a.s.: An exploratory assessment of Theory of Mind in schizophrenic subjects. *Consciousness and Cognition*, 18, 306-319.
- Bowlby, J. (1983). *Attachment: Attachment and Loss Volume One* (2nd ed.). New York: Basic Books.
- Boydell, K.M., Gladstone, B.M., & Volpe, T. (2006). Understanding help seeking delay in the prodrome to first episode psychosis: a secondary analysis of the perspectives of young people. *Psychiatric Rehabilitation Journal*, 30(1), 54-60.
- Bratlien, U., Oie, M., Lien, L., Agartz, I., Romm, K.L., Vaskinn, A., . . . Melle, I. (2013). Social dysfunction in first-episode psychosis and relations to neurocognition, duration of untreated psychosis and clinical symptoms. *Psychiatry Research*, 207(1), 33-39.
- Brennan, K.A., Clark, C.L. & Shaver, P.R. (1998). Self-report measurement of adult romantic attachment: An integrative overview. In J.A. Simpson & W.S. Rholes

- (Eds.), *Attachment theory and close relationships* (pp. 46-76). New York: Guildford Press.
- Brown, J.A. (2011). Talking about life after early psychosis: The impact on occupational performance. *Canadian Journal of Occupational Therapy, 78*(3), 156-163.
- Brune, M. (2005a). Emotion recognition, 'theory of mind', and social behaviour in schizophrenia. *Psychiatry Research, 133*, 135-147.
- Brune, M. (2005b). 'Theory of Mind' in schizophrenia: a review of the literature. *Schizophrenia Bulletin, 31*, 21-42.
- Burbach, F., Sheldrake, C., & Rapsey, E. (2015). Open dialogue in Somerset? *Context, 138*, 17-19
- Burden, R. (1987). Feuerstein's Instrumental Enrichment Programme: Important issues in research and evaluation *European Journal of Psychology of Education, 11*(1), 3-16.
- Camic, P., Rhodes, J.E., & Yardley, L. (2003). *Qualitative research in psychology: Expanding perspectives in methodology and design*. Washington DC: American Psychological Association.
- Campbell, M.L.C., & Morrison, A.P. (2007). The subjective experience of paranoia: Comparing the experiences of patients with psychosis and individuals with no psychiatric history. *Clinical Psychology & Psychotherapy, 14*(1), 63-77.
- Campbell, L.E., Hanlon, M-C., Poon, A.W.C., Paolini, S., Stone, M., Galletly, C., . . . Cohen, M. (2012). The experiences of Australian parents with psychosis: The second Australian national survey of psychosis. *Australian and New Zealand Journal of Psychiatry, 46*(9), 890-900.
- Castelein, S., Bruggeman, R., Van Busschbach, J.T., Van Der Gaag, M., Stant, A.D., Knegtering, H., & Wiersma, D. (2008). The effectiveness of peer support groups in psychosis: a randomized controlled trial. *Acta Psychiatrica Scandinavica, 118*(1), 64-72.
- Chan, K.K., & Chen, E.Y.H. (2011). Theory of mind and paranoia in schizophrenia: A game theoretical investigation framework. *Cognitive Neuropsychiatry, 16*(6), 505-529.
- Coles, S., Park, B., Hendy, C., & Collinson, C. (2013). *Discussion and strategy document on Open Dialogue. The key principles and development of Open Dialogue in Nottinghamshire Healthcare NHS Trust Adult Mental Health Services*. Retrieved from [developingopendialogue.com/wp-content/uploads/2015/04/Notts-Healthcare-Trust-discussion-document.pdf](http://developingopendialogue.com/wp-content/uploads/2015/04/Notts-Healthcare-Trust-discussion-document.pdf)
- Colle, L., Baron-Cohen, S., & Hill, J. (2007). Do children with autism have a theory of mind? A non-verbal test of autism vs specific language impairment. *Journal of Autism and Developmental Disorders, 37*(4), 716-723.
- Collip, D., Wigman, J.T.W., Lin, A., Nelson, B., Oorschot, M., Vollerbergh, W.A.M., . . . Yung, A.R. (2011). Dynamic association between interpersonal functioning & positive symptom dimensions of psychosis over time: A longitudinal study of healthy adults. *Schizophrenia Bulletin*.
- Combs, D., Adams, S.D., Penn, D.L., Roberts, D.L., Tiegreen, J., & Stem, P. (2007). Social Cognition and Interaction training (SCIT) for inpatients with

schizophrenia spectrum disorders: preliminary findings. *Schizophrenia Research*, 97, 112-116.

- Combs, D., Kenneth, E., Penn, D.L., Tiegreen, J., Nelson, A., Ledet, S.N., & Basso, M.R. (2009). Stability and generalization of social cognition and interaction training (SCIT) for schizophrenia: six month follow-up results. *Schizophrenia Research*, 112(1-3), 196-197.
- Corcoran, R., Mercer, G., & Frith, C.D. (1995). Schizophrenia, symptomatology and social inference: Investigating "theory of mind" in people with schizophrenia. *Schizophrenia Research*, 17, 5-13.
- Cornblatt, Barbara A, Carrión, Ricardo E, Addington, Jean, Seidman, Larry, Walker, Elaine F, Cannon, Tyrone D, . . . Tsuang, Ming T. (2011). Risk factors for psychosis: impaired social and role functioning. *Schizophrenia Bulletin*, sbr136.
- Corrigan, P.W., Buican, B., & Toomey, R. (1996). Construct validity of two tests of social cognition in schizophrenia. *Psychiatry Research*, 63, 77-82.
- Corsun, D.L., & Enz, C.A. (1999). Predicting psychological empowerment among service workers: The effect of support-based relationships. *Human Relations*, 52(2), 205-224.
- Couture, S.M., Lemcomte, T., & Leclerc, C. (2007). Personality characteristics and attachment in first episode psychosis; Impact on social functioning. *Journal of Nervous & Mental Disease*, 195(8), 631-639.
- Couture, S.M., Penn, D.L., & Roberts, D.L. (2006). The functional significance of social cognition in schizophrenia: A review. *Schizophrenia Bulletin*, 32(51), S44-S63.
- Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Tebes, Jacob K. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice*, 6(2), 165-187.
- Day, J.C., Bentall, R.P., Roberts, C., Randall, F., Rogers, A., Cattell, D., . . . Power, C. (2005). Attitudes toward antipsychotic medication: the impact of clinical variables and relationships with health professionals. *Archives of General Psychiatry*, 62(7), 717-724.
- Dean, K., & Murray, R.M. (2005). Environmental risk factors for psychosis. *Dialogues in Clinical Neuroscience*, 7(1), 69-80.
- DeRosse, P., & Karlsgodt, K.H. (2015). Examining the Psychosis Continuum. *Current Behavioral Neuroscience Reports*, 1-10.
- Devlin, J.M. & O'Brien, L.M. (1999). Children of parents with mental illness. I: An overview from a nursing perspective. *Australian and New Zealand Journal of Mental Health Nursing*, 8(1), 19-29.
- Dilks, S., Tasker, F., & Wren, B. (2010). Managing the impact of psychosis: a grounded theory exploration of recovery processes in psychosis. *British Journal of Clinical Psychology*, 49, 87-107.
- Dinos, S., Stevens, S., Serfaty, M., Weich, S., & King, M. (2004). Stigma: the feelings and experiences of 46 people with mental illness Qualitative study. *The British Journal of Psychiatry*, 184(2), 176-181.

- Dixon, L., Adams, C., & Lucksted, A. (2000). Update on family psychoeducation for schizophrenia. *Schizophrenia Bulletin*, 26(1), 5.
- Drayton, M., Birchwood, M., & Trower, P. (1998). Early attachment experience and recovery from psychosis. *British Journal of Clinical Psychology*, 37(269-284).
- Drury, V.M., Robinson, E.J., & Birchwood, M. (1998). 'Theory of mind' skills during an acute episode of psychosis and following recovery. *Psychological Medicine*, 28, 1101-1112.
- Duxbury, J. (2002). An evaluation of staff and patient views of and strategies employed to manage inpatient aggression and violence on one mental health unit: a pluralistic design. *Journal of Psychiatric and Mental Health Nursing*, 9(3), 325-337.
- Elliott, R., Fischer, C.T., & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.
- Erlenmeyer-Kimling, L, Rock, Donald, Roberts, Simone A, Janal, Malvin, Kestenbaum, Clarice, Cornblatt, Barbara, . . . Gottesman, Irving I. (2000). Attention, memory, and motor skills as childhood predictors of schizophrenia-related psychoses: the New York High-Risk Project. *American Journal of Psychiatry*, 157(9), 1416-1422.
- Evenson, E., Rhodes, J.E., Feigenbaum, J., & Solly, A. (2008). The experiences of fathers with psychosis. *Journal of Mental Health*, 17(6), 629-642.
- Feeney, J.A. (1994). Attachment style, communication patterns, and satisfaction across the life cycle of marriage. *Personal Relationships*, 1(4), 333-348.
- Feeney, J.A., & Noller, P. (1990). Attachment style as a predictor of adult romantic relationships. *Journal of Personality and Social Psychology*, 58(2), 281-291.
- Feuerstein, R. (1980). *Instrumental Enrichment*. Baltimore: University Park Press.
- Field, T., Diego, M., & Sanders, C. (2002). Adolescents' parent and peer relationships. *Adolescence*, 36, 121-130.
- Fish, S.C. (2009). *Pupillary response measures of processing resource allocation during theory of mind task performance in schizophrenia*. (Doctor of Philosophy in Clinical Psychology). University of California.
- Fizdon, J.M., Fanning, J.R., Johannesen, J.K., & Bell, M.D. (2013). Social cognition deficits in schizophrenia and the relationship to clinical and functional status. *Psychiatry Research*, 205, 25-29.
- Florian, V., Mikulincer, M., & Bucholtz, I. (1994). Effect of adult attachment style on the perception and search for social support. *The Journal of Psychology: Interdisciplinary and Applied*, 129(6), 665-676.
- Fossatti, A. (2012). Adult attachment in the clinical management of borderline personality disorder. *Journal of Psychiatric Practice*, 18(3), 159-171.
- Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive summary. Retrieved from [www.midstaffpublicinquiry.com/sites/default/files/report/Executive%20summary.pdf](http://www.midstaffpublicinquiry.com/sites/default/files/report/Executive%20summary.pdf)

- Franz, L., Carter, T., Leiner, A.S., Bergner, E., Thompson, N.J., & Compton, M.T. (2010). Stigma and treatment delay in first-episode psychosis: a grounded theory study. *Early Intervention in Psychiatry*, 4(1), 47-56.
- Freeman, D. & Fowler, D. (2009). Routes to psychotic symptoms: trauma, anxiety and psychosis-like experiences. *Psychiatry Research*, 169(2), 107-112.
- Fretland, R.A., Andersson, S., Sundet, K., Andreassen, O.A., Melle, I., & Vaskinn, A. (2015). Theory of mind in schizophrenia: Error types and associations with symptoms. *Schizophrenia Research*, 162(1-3), 42-46.
- Frith, C.D. (1992). *The cognitive neuropsychology of schizophrenia*. Hove, UK: Lawrence Erlbaum Associates.
- Frith, C.D. (2004). Schizophrenia and theory of mind. *Psychological Medicine*, 34(03), 385-389.
- Frith, C.D., & Frith, U. (2007). Social cognition in humans. *Current Biology*, 17, R724-R732.
- Garety, P.A., Kuipers, E., Fowler, D., Freeman, D., & Bebbington, P.E. (2001). A cognitive model of the positive symptoms of psychosis. *Psychological Medicine*, 31, 189-195.
- Garety, P.A., & Freeman, D. (2013). The past and future of delusions research: from the inexplicable to the treatable. *The British Journal of Psychiatry*, 203(5), 327-333.
- Garman, A, N., Corrigan, P.W., & Morris, S. (2002). Staff burnout and patient satisfaction: Evidence of relationships at the care unit level. *Journal of Occupational Health Psychology*, 7(3), 235-241.
- Gilbert, H., Rose, D. & Slade, M. (2008). The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Services Research*, 8(92), 1-12.
- Glaser, B.G., & Strauss, A. (1967). *Discovery of Grounded theory: Strategies for Qualitative Research*. Mill Valley, CA: Sociology press.
- Grealish, A., Tai, S., Hunter, A. & Morrison, A..P. (2013). Qualitative exploration of empowerment from the perspective of young people with psychosis. *Clinical Psychology & Psychotherapy*, 20(2), 136-148.
- Green, M.F., Penn, D.L., Bentall, R.P., Carpenter, W.T., Gaebel, W., Gur, R.C., . . . Heinssen, R. (2008). Social cognition in schizophrenia: An NIMH workshop on definitions, assessment, and research opportunities. *Schizophrenia Bulletin*, 34(6), 1211-1220.
- Grieg, T.C., Bryson, G.J., & Bell, M.D. (2004). Theory of mind performance in schizophrenia: Diagnostic, symptom, and neuropsychological correlates. *Journal of Nervous and Mental Disease*, 192, 12-18.
- Gumley, A.I., Schwannauer, M., Macbeth, A., Fisher, R., Clark, S., Rattrie, L., . . . Davidson, K. (2014). Insight, duration of untreated psychosis and attachment in first-episode psychosis: prospective study of psychiatric recovery over 12-month follow-up. *The British Journal of Psychiatry*, 205(1), 60-67.

- Gumley, A.I., Taylor, H.E.F., Schwannauer, M., & MacBeth, A. (2014). A systematic review of attachment and psychosis: measurement, construct validity and outcomes. *Acta Psychiatrica Scandinavica*, 129(4), 257-274.
- Gyllensten, K. & Palmer, S. (2007). The coaching relationship: An interpretative phenomenological approach. *International Coaching Psychology Review*, 2(2), 168-177.
- Hansson, L., Bjorkman, T., & Berglund, I. (1993). What is important in psychiatric inpatient care? Quality of care from the patient's perspective. *International Journal for Quality in Health Care*, 5(1), 41-48.
- Happe, F.G.E. (1994). An advanced test of theory of mind: understanding of story characters' thoughts and feelings by able autistic, mentally handicapped and normal children and adults. *Journal of Autism and Developmental Disorders*, 24, 129-154.
- Happe, F., Brownell, H., & Winner, E. (1999). Acquired 'theory of mind' impairments following stroke. *Cognition*, 70(5), 211-240.
- Harder, S. (2014). attachment in Schizophrenia-implications for research, prevention, and Treatment. *Schizophrenia Bulletin*, 40(6), 1189-1193.
- Harrington, L., Siegert, R.J., & McClure, J. (2005). Theory of mind in schizophrenia: a critical review. *Cognitive Neuropsychiatry*, 10, 249-286.
- Harris, K., Collinson, C., & das Nair, R. (2012). Service-users' experiences of an early intervention in psychosis service: An interpretative phenomenological analysis. *Psychology and Psychotherapy: Theory, Research and Practice*, 85(4), 456-469.
- Harrison, G., Hopper, K., Craig, T., Laska, E., Siegel, C., Wanderling, J., . . . Wiersma, D. (2001). Recovery from psychotic illness: a 15- and 25-year international follow-up study. *British Journal of Psychiatry*, 178, 506-517.
- Harrop, C., & Trower, P. (2001). Why does schizophrenia develop at late adolescence? *Clinical Psychology Review*, 21(2), 241-265.
- Henderson, S., & Malhi, G, S. (2014). Swan song for schizophrenia? *Australian and New Zealand Journal of Psychiatry*, 48(4), 302-305.
- Hesse, E. & Main, M. (2000). Disorganized infant, child and adult attachment: collapse in behavioural and attentional strategies. *Journal of the American Psychoanalytic Association*, 48, 1097-1127.
- Hirschfeld, R., Smith, J., Trower, P., & Griffin, C. (2005). What do psychotic experiences mean for young men? A qualitative investigation. *Psychology and Psychotherapy: Theory, Research and Practice*, 78(2), 249-270.
- Holma, J., & Aalonen, J. (1995). The self-narrative and acute psychosis. *Contemporary Family Therapy*, 17(3), 307-316.
- Horan, W.P., Kern, R.S., Shokat-Fadai, K., Sergi, M.J., Wynn, J.K., & Green, M.F. (2009). Social cognitive skills training in schizophrenia: an initial efficacy study of stabilized outpatients. *Schizophrenia Research*, 107, 47-54.



- Howgego, I. M., Yellowlees, P., Owen, C., Meldrum, L., & Dark, F. (2003). The therapeutic alliance: The key to effective patient outcome? A descriptive review of the evidence in community mental health case management. *Australian and New Zealand Journal of Psychiatry*, 37(2), 169-183.
- Hughes, R., Hayward, M., & Finlay, W.M.L. (2009). Patients' perceptions of the impact of involuntary inpatient care on self, relationships and recovery. *Journal of Mental Health*, 18(2), 152-160.
- Hughes, S., Jaremka, L.M., Alfano, C.M., Glaser, R., Povoski, S.P., Lipari, A.M., . . . Carson, W.E. (2014). Social support predicts inflammation, pain, and depressive symptoms: Longitudinal relationships among breast cancer survivors. *Psychoneuroendocrinology*, 42, 38-44.
- Husserl, E. (1927). Phenomenology. *Journal of the British Society for Phenomenology* 2, 77-90.
- Jackson, V. (2015). Getting on with it: The Early Network Response trial in Leeds. *Context*, 15-16.
- Jang, J.H., Shin, N.Y., Shim, G., Park, H.Y., Kim, E., Jang, G.E., . . . Kwon, J.S. (2011). Longitudinal patterns of social functioning and conversion to psychosis in subjects at ultra-high risk. *Australian & New Zealand Journal of Psychiatry*, 45(9), 763-770.
- Janssen, I., Krabbendam, L., Jolles, J., & van Os, J. (2003). Alterations in theory of mind in patients with schizophrenia and non-psychotic relatives. *Acta Psychiatrica Scandinavica*, 108, 110-117.
- Johns, L.C. & van Os, J. (2001). The continuity of psychotic experiences in the general population. *Clinical Psychology Review*, 21(8), 1125-1141.
- Judge, A. M., Estroff, S.E., Perkins, D.O., & Penn, D.L. (2008). Recognizing and responding to early psychosis: a qualitative analysis of individual narratives. *Psychiatric Services*, 59, 96-99.
- Kennedy, D.P., & Aldophs, R. (2012). Perceptions of emotion from facial expressions in high-functioning adults with autism. *Neuropsychologia*, 50(14), 3313-3319.
- Kilkku, N., Munnukka, T., & Lehtinen, K. (2003). From information to knowledge: the meaning of information-giving to patients who had experienced first-episode psychosis. *Journal of Psychiatric and Mental Health Nursing*, 10(1), 57-64.
- Klem, A.M., & Connell, J.P. (2004). Relationships matter: Linking teacher support to student engagement and achievement. *Journal of School Health*, 74(7), 262-273.
- Knight, M.T.D., Wykes, T., & Hayward, P. (2003). 'People don't understand': An investigation of stigma in schizophrenia using Interpretative Phenomenological Analysis (IPA). *Journal of Mental Health*, 12(3), 209-222.
- Korver-Nieberg, N., Fett, A-K.J., Meijer, C.J., Koeter, M.W.J., Shergill, S.S., Haan, L.D., & Krabbendam, L. (2013). Theory of mind, insecure attachment and paranoia in adolescents with early psychosis and healthy controls. *Australian & New Zealand Journal of Psychiatry*, 00(0), 1-9.
- Kosmidis, M.H., Giannakou, M., Garyfallos, G., Kiosseoglou, G., & Bozikas, V.P. (2011). The impact of impaired "Theory of Mind" on social interactions in

- schizophrenia. *Journal of the International Neuropsychological Society*, 17(3), 511-521.
- Langdon, R., Davies, M., & Coltheart, M. (2002). Understanding minds and understanding communicated meanings in schizophrenia. *Mind and Language*, 17(68-104).
- Langdon, R., Siegert, R.J., McClure, J., & Harrington, L. (2005). Schizophrenia, theory of mind, and persecutory delusions. *Cognitive Neuropsychiatry*, 10(2), 87-100.
- Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3, 102-120.
- Lasalvia, A., Bonetto, C., Tansella, M., Stefani, B., & Ruggeri, M. (2008). Does staff-patient agreement on needs for care predict a better mental health outcome? A 4-year follow-up in a community service. *Psychological Medicine*, 38(01), 123-133.
- Lasalvia, A., Penta, E., Sartorius, N., & Henderson, S. (2015). Should the label "schizophrenia" be abandoned? *Schizophrenia Research*, 162(1), 276-284.
- Lucksted, A., McFarlane, W., Downing, D., & Dixon, L. (2012). Recent developments in family psychoeducation as an evidence-based practice. *Journal of Marital and Family Therapy*, 38(1), 101-121.
- Luhrmann, T.M., Padmavati, R., Tharoor, H., & Osei, A. (2015). Differences in voice-hearing experiences of people with psychosis in the USA, India and Ghana: interview-based study. *The British Journal of Psychiatry*, 206(1), 41-44.
- Maat, A., Fett, A.K., & Derks, E. (2012). Social cognition and quality of life in schizophrenia. *Schizophrenia Research*, 137(1-3), 212-218.
- MacDonald, E., Sauer, K., Howie, L., & Albiston, D. (2005). What happens to social relationships in early psychosis? A phenomenological study of young people's experiences. *Journal of Mental Health*, 14(2), 129-143.
- MacDonald, S., Flanagan, S., Rollins, J., & Kinch, J. (2008). TASIT: a new clinical tool for assessing social perception after traumatic brain injury. *Journal of Head Trauma Rehabilitation*, 18, 219-238.
- Mackrell, L., & Lavender, T. (2004). Peer relationships in adolescents experiencing a first episode of psychosis. *Journal of Mental Health*, 13(5), 467-479.
- Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. . In I. Bretherton & E. Waters (Eds.), *Growing points of attachment theory and research. Monographs of the society for research in child development* (Vol. 50, pp. 66-104).
- Main, M. (1991). Metacognitive knowledge, metacognitive monitoring, and singular (coherent) vs. multiple (incoherent) model of attachment. In C.M. Parkes, J. Stevenson-Hinde & P. Marris (Eds.), *Attachment across the life cycle* (pp. 127-159). London: Routledge.
- Mawson, A., Berry, K., Murray, C., & Hayward, M. (2011). Voice hearing within the context of hearers' social worlds: An interpretative phenomenological analysis. *Psychology and Psychotherapy: Theory, Research and Practice*, 84(3), 256-272.

- Mazza, M., Lucci, G., Pacitti, F., Pino, M.C., Mariano, M., Casacchia, M., & Roncone, R. (2010). Could schizophrenic subjects improve their social cognition abilities only with observation and imitation of social situations? *Neuropsychological Rehabilitation, 20*(5), 675-703.
- Mazza, M., Pollice, R., Pacitti, F., Pino, M.C., Mariano, M., Tripaldi, S., . . . Roncone, R. (2012). New evidence in theory of mind deficits in subjects with chronic schizophrenia and first episode: correlation with symptoms, neurocognition and social function. *Rivista di Psichiatria, 47*(4), 327-336.
- McCallum, C. & McLaren, S. (2010). Sense of belonging and depressive symptoms among GLB adolescents. *Journal of Homosexuality, 58*(1), 83-96.
- McCann, T.V., & Baker, H. (2001). Mutual relating: developing interpersonal relationships in the community. *Journal of Advanced Nursing, 34*(4), 530-537.
- McFarlane, W.R., Dixon, L., Lukens, E., & Lucksted, A. (2003). Family psychoeducation and schizophrenia: a review of the literature. *Journal of Marital and Family Therapy, 29*(2), 223-245.
- McLaren, S. (2009). Sense of belonging to the general and lesbian communities as predictors of depression among lesbians. *Journal of Homosexuality, 56*(1), 1-13.
- Mead, S. & MacNeal, C. (2015). Peer support: what makes it unique? Retrieved from <http://www.intentionalpeersupport.org/wp-content/uploads/2014/04/Peer-Support-What-Makes-It-Unique.pdf>
- Mehra, B. (2002). Bias in qualitative research: voices from an online classroom. *The Qualitative Report, 7*(1), Retrieved from <http://www.nova.edu/ssss/QR/QR7-1/mehra.html>
- Montemayor, R. (1983). Parents and adolescents in conflict: All families some of the time and some families most of the time. *Journal of Early Adolescence, 3*(1-2), 83-103.
- Moore, T.H.M, Zammit, S., Lingford-Hughes, A., Barnes, T.R.E., Jones, P.B, Burke, M., & Lewis, G. (2007). Cannabis use and risk of psychotic or affective mental health outcomes: a systematic review. *The Lancet, 370*(9584), 319-328.
- Moreau, N., Viallet, F., & Champagne-Lavau, M. (2013). Using memories to understand others: The role of episodic memory in theory of mind impairment in Alzheimer disease. *Ageing Research Reviews, 12*(4), 833-839.
- Moriarty, A., Jolley, S., Callanan, M.M., Garety, P. (2012). Understanding reduced activity in psychosis: the roles of stigma and illness appraisals. *Social Psychiatry and Psychiatric Epidemiology, 47*(10), 1685-1693.
- Moritz, S., & Woodward, T.S. (2007). Metacognitive training in schizophrenia: From basic research to knowledge translation and intervention. *Current Opinion in Psychiatry, 20*(6), 619-625.
- Mossakowski, K.N. (2003). Coping with perceived discrimination: does ethnic identity protect mental health? *Journal of Health and Social Behavior, 44*(3), 318-331.
- Muela, A., Torres, B., & Ballverka, N. (2012). Attachment style and psychopathology in adolescent victims of child maltreatment. *Infancia Y Aprendizaje, 35*(4), 451-469.

- Murphy, B., & Bates, G.W. (1997). Adult attachment style and vulnerability to depression. *Personality and Individual Differences*, 22(6), 835-844.
- Newman, B.M., Lohman, B.J., & Newman, P.R. (2007). Peer group membership and a sense of belonging: their relationship to adolescent behavior problems. *Adolescence*, 42(166), 241-263.
- Newton, B.J., Rothlingova, Z., Gutteridge, R., LeMarchand, K., & Raphael, J.H. (2011). No room for reflexivity? Critical reflections following a systematic review of qualitative research. *Journal of Health Psychology*, 17, 866-885.
- Newton, E., Larkin, M., Melhuish, R., & Wykes, T. (2007). More than just a place to talk: Young people's experiences of group psychological therapy as an early intervention for auditory hallucinations. *Psychology and Psychotherapy: Theory, Research and Practice*, 80(1), 127-149.
- Nicholson, J., Sweeney, E.M., & Geller, J.L. (1998). Focus on women: mothers with mental illness: I. The competing demands of parenting and living with mental illness. *Psychiatric Services*, 49(5), 635-642.
- Nicholson, J., Biebel, K., Hinden, B.R., Henry, A.D. & Stier, L. (2001). Critical issues for parents with mental illness and their families. Retrieved from [escholarship.umassmed.edu](http://escholarship.umassmed.edu)
- (NIH), National Institute of Health. (2012). *Psychosis*. Retrieved from <http://www.nlm.nih.gov/medlineplus/ency/article/001553.htm>
- Nithsdale, V., Davies, J., & Croucher, P. (2008). Psychosis and the experience of employment. *Journal of Occupational Rehabilitation*, 18(2), 175-182.
- Nuevo, R., Chatterji, S., Verdes, E., Naidoo, N., Arango, C. & Ayuso-Mateos, J.L. (2012). The continuum of psychotic symptoms in the general population: A cross-national study. *Schizophrenia Bulletin*, 38(3), 473-485.
- Olson, M., Seikkula, J., & Ziedonis, D. (2014). *The key elements of dialogic practice in open dialogue: fidelity criteria*. The University of Massachusetts Medical School. Worcester, MA.
- Parks, M.R. & Floyd, K. (1996). Meanings of closeness and intimacy in friendship. *Journal of Social and Personal Relationships*, 13(1), 85-107.
- Perry, B.M, Taylor, D. & Shaw, S.K. (2007). "You've got to have a positive state of mind": An interpretative phenomenological analysis of hope and first episode psychosis. *Journal of Mental Health*, 16(6), 781-793.
- Philpot, A.L., Rinehart, N.J., Gray, K.M., Howlin, P., & Cornish, K. (2013). Understanding of mental states in late childhood: an investigation of theory of mind in autism spectrum disorder and typical development with a novel task. *International Journal of Developmental Disability*, 59(2), 108-117.
- Pickering, L., Simpson, J., & Bentall, R.P. (2008). Insecure attachment predicts proneness to paranoia but not hallucinations. *Personality and Individual Differences*, 44(5), 1212-1224.
- Pinkham, A.E., & Penn, D.L. (2006). Neurocognitive and social cognitive predictors of interpersonal skill in schizophrenia. *Psychiatry Research*, 143, 167-178.

- Pinkham, A.E., Penn, D.L., Perkins, D.O., & Lieberman, J. (2014). Implications for the neural basis of social cognition for the study of schizophrenia. *The American Journal of Psychiatry*, 160(5), 815-824.
- Pitt, L., Kilbride, M., Nothard, S., Welford, M. & Morrison, A.P. (2007). Researching recovery from psychosis: a user-led project. *Psychiatric Bulletin*, 31(2), 55-60.
- Pitt, L., Kilbride, M., Welford, M., Nothard, S. & Morrison, A.P. (2009). Impact of a diagnosis of psychosis: user-led qualitative study. *Psychiatric Bulletin*, 33(11), 419-423.
- Plant, K., Byrne, L., Barkla, J., McLean, D., Hearle, J., & McGrath, J. (2002). Parents with psychosis: a pilot study examining self-report measures related to family functioning. *Australian e-journal for the Advancement of Mental Health*, 1(1), 38-48.
- Pos, K., Bartels-Velthuis, A.A., Simons, C.J.P., Korver-Nieberg, N., Meijer, C.J., de Haan, L., . . . Myin-Germeys, I. (2014). Theory of Mind and attachment styles in people with psychotic disorders, their siblings, and controls. *Australian and New Zealand Journal of Psychiatry*, 1-10.
- Premack, D., & Woodruff, G. (1978). Does the chimpanzee have a 'theory of mind'? *Behavioral and Brain Sciences*, 4, 515-526.
- Pringle, J., Drummond, J., McLafferty, E. & Hendry, C. (2011). Interpretative phenomenological analysis: a discussion and critique. *Nursing Research*, 18(3), 20-24.
- Razzaque, R. & Wood, L. (2015). Open Dialogue and its relevance to the NHS: Opinions of NHS staff and service users. *Community Mental Health Journal*.
- Redmond, C., Larkin, M., & Harrop, C. (2010). The personal meaning of romantic relationships for young people with psychosis. *Clinical Child Psychology and Psychiatry*.
- Rhodes, J.E., & Jakes, S. (2000). Correspondence between delusions and personal goals: A qualitative analysis. *British Journal of Medical psychology*, 73, 211-225.
- Riessman, C.K. (2002). Narrative analysis. In M. Huberman & M.B. Miles (Eds.), *The Qualitative Researcher's companion*. California: SAGE.
- Roberts, D.L., & Penn, D.L. (2009). Social cognition and interaction training (SCIT) for outpatients with schizophrenia: A preliminary study. *Psychiatry Research*, 166(2-3), 141-147.
- Roberts, G., & Wolfson, P. (2004). The rediscovery of recovery: open to all. *Advances in Psychiatric Treatment*, 10(1), 37-48.
- Roe, D., Hasson-Ohayon, I., Kravetz, S., Yanos, P.T., & Lysaker, P.H. (2008). Call it a monster for lack of anything else: Narrative insight in psychosis. *Journal of Nervous and Mental Disease*, 196(12), 859-865.
- Roe, D., & Kravetz, S. (2003). Different ways of being aware of a psychiatric disability: A multifunctional narrative approach to insight into mental disorder. *The Journal of Nervous and Mental Disease*, 191(7), 417-424.
- Romme, M. & Escher, S. (1997). Foreword in R. Coleman & M. Smith (2005). *Working with voices II victim to victor*. Dundee: P&P Press Ltd.

- Ronccone, R., Falloon, I.R.H., Mazza, M., De Risio, A., Pollice, R., Necozone, S., . . . Cassacchia, M. (2002). Is theory of mind in schizophrenia more strongly associated with clinical and social functioning than with neurocognitive deficits? *Psychopathology*, *35*, 280-288.
- Ronccone, R., Mazza, M., Frangou, I., De Risio, A., Ussorio, D., Tozzini, C., & Casacchia, M. (2004). Rehabilitation of theory of mind deficit in schizophrenia: a pilot study of metacognitive strategies in group treatment. *Neuropsychological Rehabilitation*, *14*(4), 421-435.
- Rubio, J.L., Ruiz-Veguilla, M., Hernandez, L., Barrigon, M.L., Salcedo, M.D., Moreno, J.M., . . . Ferrin, M. (2011). Jumping to conclusions in psychosis: A faulty appraisal. *Schizophrenia Research*, *133*(1-3), 199-204.
- Scherzer, P., Leveille, E., Achini, A., Boisseau, E., & Stip, E. (2012). A study of theory of mind in paranoid schizophrenia: a theory or many theories? *Frontiers in Psychology*, *3*(432), 1-11.
- Seikkula, J., & Olsen, M. (2003). The open dialogue approach to acute psychosis: Its poetics and micropolitics. *Family Processes*, *42*(3), 403-418.
- Shattell, M. M., McAllister, S., Hogan, B., & Thomas, S.P. (2006). "She took the time to make sure she understood": Mental health patients' experiences of being understood. *Archives of Psychiatric Nursing*, *20*(5), 234-241.
- Sinclair, J., & Milner, D. (2005). On being Jewish: A qualitative study of identity among British Jews in emerging adulthood. *Journal of Adolescent Research*, *20*(1), 91-117.
- Smeets-Janssen, M.M.J., Meesters, P.D., Comijs, H.C., Eikelenboom, P., Smit, J.H., de Haan, L., . . . Stek, M.L. (2013). Theory of Mind differences in order patients with early-onset and late-onset paranoid schizophrenia. *International Journal of Geriatric Psychiatry*, *28*(11), 1141-1146.
- Smith, G. (1998). Ethnicity, religious belonging, and inter faith encounter: Some survey findings from East London. *Journal of Contemporary Religion*, *13*(3), 333-351.
- Smith, J.A. (1996). Beyond the divide between cognition and discourse: Using Interpretative Phenomenological Analysis in health psychology. *Psychology & Health*, *11*(2), 261-271.
- Smith, J.A. (1999). Identity development during the transition to motherhood: An interpretative phenomenological analysis. *Journal of Reproductive and Infant Psychology*, *17*(3), 281-299.
- Smith, J.A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, *1*, 39-54.
- Smith, J.A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, *5*(1), 9-27.
- Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, method and research*. London: SAGE Publications Ltd.
- Smith, J.A., & Osborn, M. (2007). Interpretative Phenomenological Analysis. Retrieved from

[http://xa.yimg.com/kq/groups/70983503/1686788382/name/17418\\_04\\_smith\\_2\\_e\\_ch\\_04.pdf](http://xa.yimg.com/kq/groups/70983503/1686788382/name/17418_04_smith_2_e_ch_04.pdf).

- Sociological Research Skills. (2015). Research methods. Retrieved from [www.sociology.org.uk](http://www.sociology.org.uk)
- Sørensen, Holger J, Nielsen, Philip R, Pedersen, Carsten B, Benros, Michael E, Nordentoft, Merete, & Mortensen, Preben B. (2014). Population impact of familial and environmental risk factors for schizophrenia: A nationwide study. *Schizophrenia Research*, 153(1), 214-219.
- Sprong, M., Schothorst, P., Vos, e., & Hox, J. (2007). Theory of mind in schizophrenia: meta-analysis. *The British Journal of Psychiatry*, 191, 5-13.
- Stain, H.J., Galletly, C.A., Clark, S., Wilson, J., Killen, E.A., Anthes, L., . . . Harvey, C. (2012). Understanding the social costs of psychosis: The experience of adults affected by psychosis identified within the second Australian national survey of psychosis. *Australian and New Zealand Journal of Psychiatry*, 46(9), 879-889.
- Stant, A.D., Castelein, S., Bruggeman, R., van Busschbach, J.T., van der Gaag, M., Knegtering, H., & Wiersma, D. (2011). Economic aspects of peer support groups for psychosis. *Community Mental Health Journal*, 47(1), 99-105.
- Sullivan, P.F., Daly, M.J., & O'Donovan, M. (2012). Genetic architectures of psychiatric disorders: the emerging picture and its implications. *Nature Reviews Genetic*, 13, 537-551.
- Sullivan, S., Lewis, G., Wiles, N., Thompson, A., & Evans, J. (2013a). Psychotic experiences and social functioning: a longitudinal study. *Social Psychiatry and Psychiatric Epidemiology*, 48(7), 1053-1065.
- Sullivan, S., Herzig, D., Mohr, C., Lewis, G., Corcoran, R., Drake, R., & Evans, J. (2013b). Theory of mind and social functioning in first episode psychosis. *Cognitive Neuropsychiatry*, 18(3), 219-242.
- Sullivan, S., Lewis, G., Mohr, C., Herzig, D., Corcoran, R., Drake, R., & Evans, J. (2014). The longitudinal association between social functioning and theory of mind in first-episode psychosis. *Cognitive Neuropsychiatry*, 19(1), 58-80.
- Sundquist, K., Frank, G., & Sundquist, J. (2004). Urbanisation and incidence of psychosis and depression Follow-up study of 4.4 million women and men in Sweden. *The British Journal of Psychiatry*, 184(4), 293-298.
- Tait, L., Birchwood, M., & Trower, P. (2004). Adapting to the challenge of psychosis: personal resilience and the use of sealing-over (avoidant) coping strategies. *British Journal of Psychiatry*, 185, 410-415.
- Tajfel, H. (2010). *Social identity and intergroup relations*. Cambridge: Cambridge University Press.
- Tas, C., Danaci, A.E., Cubukuoglu, Z., & Brune, M. (2012). Impact of family involvement on social cognition training in clinically stable outpatients with schizophrenia: a randomized pilot study. *Psychiatry Research*, 195, 32-38.
- Thomas, C. & Bromet, E.J. (2004). Parents with psychosis. *Annals of Clinical Psychiatry*, 16(1), 35-39.

- Touroni, E., & Coyle, A. (2002). Decision-making in planned lesbian parenting: An interpretative phenomenological analysis. *Journal of Community & Applied Social Psychology, 12*, 194-209.
- van Dam, D.S., Korver-Nieberg, N., Velthorst, E., Meijer, C.J., & de Haan, L. (2014). Childhood maltreatment, adult attachment and psychotic symptomatology: a study in patients, siblings and controls. *Social Psychiatry and Psychiatric Epidemiology, 49*(11), 1759-1767.
- Varese, Filippo, Smeets, Feikje, Drukker, Marjan, Lieveerse, Ritsaert, Lataster, Tineke, Viechtbauer, Wolfgang, . . . Bentall, R.P. (2012). Childhood adversities increase the risk of psychosis: a meta-analysis of patient-control, prospective-and cross-sectional cohort studies. *Schizophrenia Bulletin, 38*(4), 661-671.
- Venkataraman, M., & Ackerson, B.J. (2008). Parenting among mothers with bipolar disorder: strengths, challenges, and service needs. *Journal of Family Social Work, 11*(4), 389-408.
- Vest, B.M., Kahn, L.S., Danzo, A., Tumiel-Berhalter, L., Schuster, R.C., Karl, R., . . . Fox, C.H. (2013). Diabetes self-management in a low-income population: impacts of social support and relationships with the health care system. *Chronic Illness, 0*(0), 1-11.
- Vikovic, B.V., Jankovic-Gajic, J.A., Popovic, B.V., Markovic-Zigic, D.M., & Markovic, V.A. (2008). The family role in different phases of psychosis. *European Psychiatry, 23*, S350.
- Wahass, S. & Kent, G. (1997). Coping with auditory hallucinations: A cross-cultural comparison between Western (British) and Non-Western (Saudi Arabian) patients. *Journal of Nervous & Mental Disease, 185*(11), 664-668.
- Walling, S.M., Suvak, M.K., Howard, J.M., Taft, C.T., & Murphy, C.M. (2012). Race/ethnicity as a predictor of change in working alliance during cognitive behavioural therapy for intimate partner violence perpetrators. *Psychotherapy, 49*(2), 180-189.
- Werner, S., Malaspina, D. & Rabinowitz, J. (2007). Socioeconomic status at birth is associated with risk of schizophrenia: Population-based multilevel study. *Schizophrenia Bulletin, 33*(6), 1373-1378.
- Wicks, S., Hjern, A., Gunnell, D., Lewis, G., & Dalman, C. (2014). Social adversity in childhood and the risk of developing psychosis: a national cohort study. *American Journal of Psychiatry, 162*, 1652-1657.
- Wimmer, H., & Perner, J. (1983). Beliefs about beliefs: Representation and constraining function of wrong beliefs in young children's understanding of deception. *Cognition, 13*, 103-128.
- Windell, D., & Norman, R.M.G. (2012). A qualitative analysis of influences on recovery following a first episode of psychosis. *International Journal of Social Psychiatry, 59*(5), 493-500.
- Wood, L., Price, J., Morrison, A., & Haddock, G. (2010). Conceptualisation of recovery from psychosis: a service-user perspective. *The Psychiatrist, 34*(11), 465-470.



- Woodside, H., Krupa, T., & Pocock, K. (2007). Early psychosis, activity performance and social participation: A conceptual model to guide rehabilitation and recovery. *Psychiatric Rehabilitation Journal*, 31(2), 125.
- Woodside, H., Krupa, T., & Pocock, K. (2008). How people negotiate for success as psychosis emerges. *Early Intervention in Psychiatry*, 2(1), 50-54.
- Wykes, T., & Reeder, C. (2005). *Cognitive Remediation for Schizophrenia. Theory & Practice*. London: Routledge.

## APPENDIX

### Appendix I: Staff information sheet



UNIVERSITY OF LEEDS  
Doctor of Clinical Psychology Programme  
Staff Information Sheet

#### **A study exploring the personal meaning and experience of relationships and interactions among people experiencing psychosis**

My name is Diane Agoro; I am in my second year of training to be a Clinical Psychologist at the University of Leeds. As part of my course I am completing a research study which is being supervised by Dr Anjula Gupta. I am wondering if you might be interested in the study which I have described below. Thank you for taking the time to read the information.

#### **Aims of the study**

The need for positive relationships and interactions with others is a basic human need, yet this need seems to be a neglected area of research among people with psychosis. This is despite research suggesting that level of social functioning may affect long term outcome. This study is intended to provide people with psychosis with the opportunity to share their personal and individual experiences of interacting with others. It is a qualitative study in which participants will be interviewed about these experiences. The hope is that participants' individual accounts will improve our understanding of their experiences and help us provide better care for service users in the future.

#### **What will taking part involve?**

I would like to interview up to ten people interested in sharing their experiences with me. There will be two parts to the study and altogether it should take approximately an hour (with additional time for breaks when required). The first part will be an interview about experiences of interacting with others. Participants will be asked to talk about the important people in their lives and to give examples about recent interactions they have had with them. They will also be asked to share how they feel about these experiences. This part of the study should last approximately 45 minutes.

The second part involves completing a task called 'The Hinting Task' which will involve me reading out some short stories and asking the participant a question about what the people in the story are thinking or feeling; this should take approximately 10-15 minutes. Afterwards, with the participant's agreement, I would like to ask a staff member to provide me with some brief additional information about the participant. This will include:

- 1) Age
- 2) Ethnicity
- 3) Year of first contact with mental health services

Version 5: 14.04.2014

---

- 4) Length of admission on the rehabilitation and recovery unit
- 5) Current/ most recent diagnosis

Participants will be compensated for their time with a £10 Argos gift voucher.

**Who can take part?**

We would be grateful if staff would give the participant information sheet to people who may meet the following criteria:

*Inclusion criteria:*

- Have the capacity to give informed consent
- Experiences of psychosis across the lifespan
- Are able to engage in an interview about their experiences of interacting with others
- Are fluent in English

*Exclusion criteria:*

- Is at significant risk of becoming distressed if they take part in the study (as assessed by the staff professionals involved in their care)
- Are currently experiencing features of florid psychosis that would make it difficult to engage in an interview

If anyone does express an interest in taking part please contact myself or Dr Anjula.

**Contacts for further information:**

If you would like further information you can contact me or anyone else from the research team:

**Diane Agoro (Psychologist in Clinical Training)**

Dept. of Clinical Psychology,  
Charles Thackrah Building,  
Clarendon Road,  
University of Leeds,  
Leeds LS2 9LJ  
Email: [Diane.Agoro@nhs.net](mailto:Diane.Agoro@nhs.net) Tel : 0113 233 2732

**Dr Anjula Gupta**

Consultant Clinical Psychologist/ Honorary Lecturer (Leeds University)

Version 5: 14.04.2014

Psychology & Psychotherapy Service  
Leeds and York Partnership Foundation NHS Trust  
Blenheim Terrace, Woodhouse Lane  
LS2 9HN

Email: [Anjula.Gupta@nhs.net](mailto:Anjula.Gupta@nhs.net) Tel : 0113 343 1962

**Dr Alastair Cardno**

Senior Lecturer in Psychiatry  
Academic Unit of Psychiatry and Behavioural Sciences  
Leeds Institute of Health Sciences  
University of Leeds  
Charles Thackrah Building  
101 Clarendon road  
Leeds LS2 9LJ  
UK

Email : [A.G.Cardno@leeds.ac.uk](mailto:A.G.Cardno@leeds.ac.uk) Tel : 0113 343 3910

**Dr Sylvie Collins**

Lecturer in Clinical Psychology,  
Dept. of Clinical Psychology,  
LIHS,  
Charles Thackrah Building,  
Clarendon Road,  
University of Leeds,  
Leeds LS2 9LJ

Email : [Sylvie.C.Collins@leeds.ac.uk](mailto:Sylvie.C.Collins@leeds.ac.uk) Tel : 0113 343 3407

**Thank you for spending the time to read and consider this study; any support would be really appreciated**

A study exploring the personal meaning and experience of relationships and interactions among people experiencing psychosis

My name is Diane Agoro; I am in my second year of training to be a Clinical Psychologist at Leeds University. As part of my course I am doing some research, this research aims to find out about people's personal experiences of relationships and interacting with others. You are being invited to take part in this research. It is completely up to you whether you decide to take part; please feel free to read through this information. Talk to others about the study if you wish.

**Thank you for taking the time to read through this information sheet**

***What is the purpose of the study?***

Some studies have looked at the quality of service users' relationships with other people, however very few studies have invited service users to talk in detail about their personal experiences of relationships. This study is about giving you the opportunity to share your own experiences. You might find it helpful to think about things that you find difficult or things that work really well. By learning about the experiences of different service users we may be able to improve our understanding of service user needs, and improve the service.

***Why have I been approached about this study?***

A member of staff may have handed this information sheet to you because you may have experiences of psychosis and they think that you may be interested in taking part in this study and sharing some of your own experiences of interacting with others.

***Do I have to take part?***

It is your decision whether you wish to take part in the study or not. If you decide at any stage that you no longer want to take part, you can withdraw; without having to give any reason for withdrawing. Any information that you might already have given will be destroyed. Withdrawing will not affect the care you receive.

***What happens if I decide to take part?***

If you are interested in participating, a member of staff from your team will ask you whether you agree to me coming to meet with you.

That meeting will take approximately one hour. At any point we can stop for a break or stop the study if you no longer want to continue. Together we will do the four following things:

1. Discuss what the study involves and answer any questions you may have.
2. If you are happy to continue, I will ask you to sign a consent form, stating that you agree to take part.
3. Talk about some of your experiences of being and meeting with other people and how this feels. This will take about 45 minutes and will be audio recorded. I have a few questions to ask you, but more importantly I hope you will be able to talk to me about whatever feels relevant and comfortable.
4. Complete a task called 'The Hinting Task' which will involve me reading out 10 short stories and asking you a question about your views on what the people in the stories might be thinking or feeling. This should take 10-15 minutes.

After we have met, with your agreement, I will ask staff to give me some more information about you. This will include:

- 1) Date of birth
- 2) Ethnicity
- 3) The year you first had contact with mental health services
- 4) Length of admission on the Rehabilitation and Recovery unit
- 5) Your current/most recent diagnosis

You will be compensated for your time with a £10 Argos gift voucher.

***Are there any possible risks or disadvantages of taking part?***

Sometimes people find it difficult or uncomfortable to talk about their relationships. However, if there is anything you do not wish to talk about you do not need to. Also, if there is anything you do talk about that you find upsetting you might find it helpful to talk about this with a member of staff afterwards.

***Are there any possible advantages of taking part?***

You might find it helpful to talk about your experiences, especially if you have not had much opportunity to share them before. The findings of this research may also help the service think about how we can better understand service users' relationships with other people.

***What happens to the information about me?***

All personal information will be kept strictly confidential. The interview will be audio recorded and then it will be transcribed. The transcriber will agree to maintain strict confidentiality according to University policy. After transcription, the audio recording will then be deleted. All information will be anonymised so that no one will be able to tell who you are. The transcripts will be held securely at The University of Leeds for 3 years, but they will not be used for anything else without your permission. Only the research team listed below and I will have access to the transcript.

Dr Anjula Gupta is part of the research team, she is a Clinical Psychologist who has worked on the unit, therefore you may have come into contact with her at some point. She will keep any information collected from you as a result of this research confidential. However, if during the research we become concerned about any risk to you or others I will need to breach confidentiality and share this information with your care team. However, I will normally discuss this with you beforehand.

***What will happen to the results of the study?***

At the end of the study all results will be written up and may be published in peer review articles or presented at conferences and team meetings. Published material may include some of your quotes from the interview, but I will remove any specific information about you so that you will not be identifiable. The results will also be available at the University of Leeds Library in 2016. If you are interested, I will be happy to provide you with a short summary of the results.

**Thank you for considering participation in this study.**

If you require any further information then you can contact me or Anjula Gupta and the rest of the research team using the details on the following page:

**Diane Agoro**

Clinical Psychology Programme  
Leeds Institute of Health Sciences  
University of Leeds  
Charles Thackrah Building  
101 Clarendon Road  
Leeds LS2 9LJ  
Tel: 0113 233 2732

Email : [Diane.Agoro@nhs.net](mailto:Diane.Agoro@nhs.net)

**Dr Alastair Cardno**

Senior Lecturer in Psychiatry

Academic Unit of Psychiatry and  
Behavioural Sciences  
Leeds Institute of Health Sciences  
University of Leeds  
Charles Thackrah Building  
101 Clarendon road  
Leeds LS2 9LJ

Email: [A.G.Cardno@leeds.ac.uk](mailto:A.G.Cardno@leeds.ac.uk)  
Tel : 0113 343 3910

**Dr Anjula Gupta**

Consultant Clinical Psychologist  
Psychology & Psychotherapy  
Service  
Leeds and York Partnership  
Foundation NHS Trust  
Blenheim Terrace, Woodhouse  
Lane, LS2 9HN

Email: [Anjula.Gupta@nhs.net](mailto:Anjula.Gupta@nhs.net)  
Tel : 0113 343 1962

**Dr Sylvie Collins**

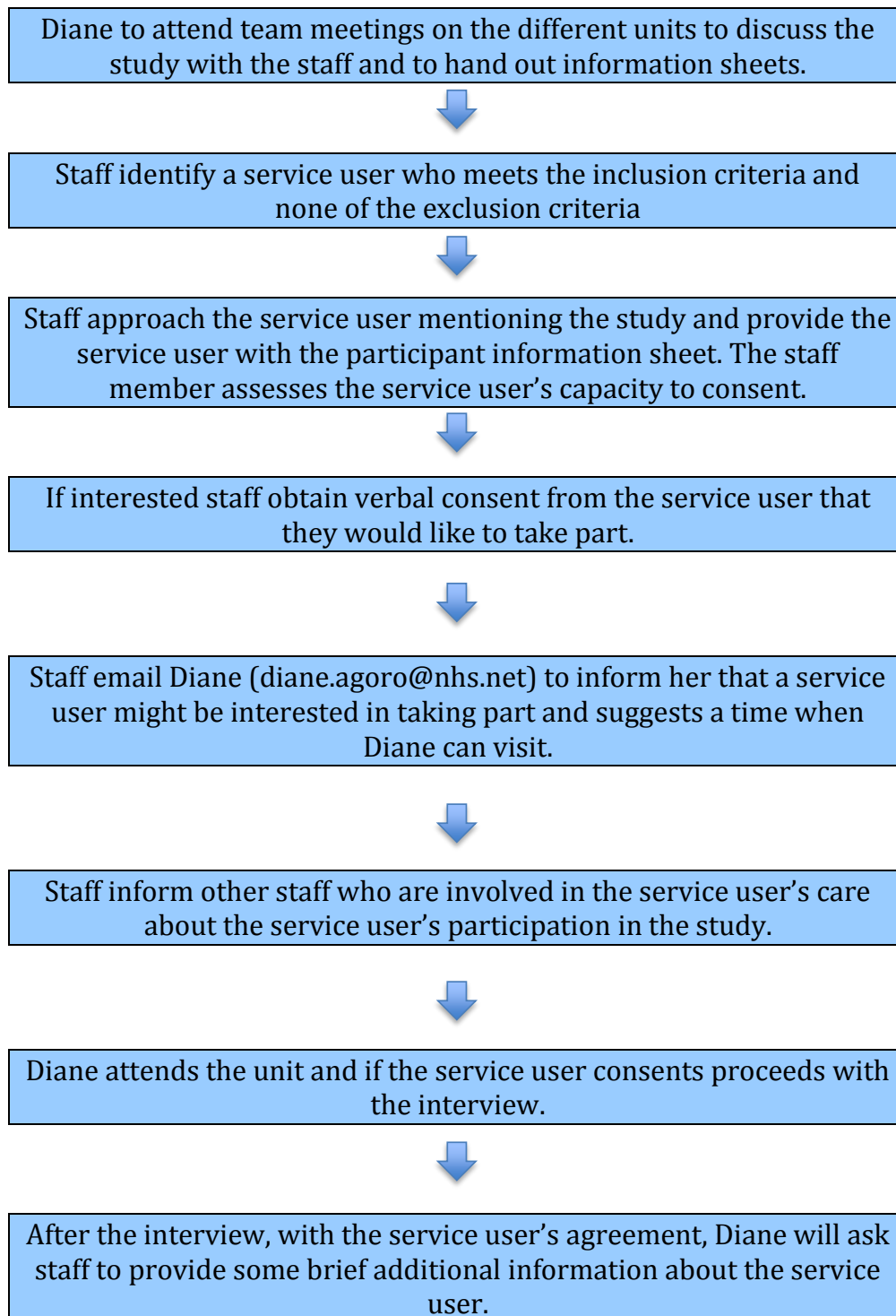
Lecturer in Clinical Psychology,  
Dept. of Clinical Psychology,  
LIHS,  
Charles Thackrah Building,  
Clarendon Road,  
University of Leeds,  
Leeds LS2 9LJ

Email: [Sylvie.C.Collins@leeds.ac.uk](mailto:Sylvie.C.Collins@leeds.ac.uk)  
Tel : 0113 343 3407

Version number 6  
Date of issue: 14/04/2014

## Appendix III: Recruitment procedure

### Recruitment procedure





## Appendix IV: Interview guide

*Note to ethics: This interview schedule is semi-structured and serves as a guide only. The aim is for me to have some core questions of interest, but to be flexible and allow the participant to explore and share their own topics of interest. Therefore, the content and format of this interview is subject to changes throughout the research.*

### **Semi structured interview schedule**

#### *Introduction:*

- Introduce self
- Go through the information sheet and answer any questions
- Explain that I have some questions to ask about their experiences of psychosis<sup>1</sup> and how it has changed/affected their relationships with others
- Will be asking them to tell me about the important people in their life and to give examples of when it has been difficult to be around others and when it has not been so difficult
- Explain that the interview is flexible and they can also share other topics which they feel may be relevant for this interview
- Go through the consent process and obtain informed consent

#### *Core questions:*

- 1) Can you tell me about the important people in your life?
- 2) Can you tell me about a time when it was difficult to be around other people?
- 3) Can you tell me about a time when it was less difficult/positive to be around other people?

#### *Prompts for the core questions:*

- What happened/ Why/ What did you do/Could you tell me a bit more about that?
- What did that mean for you/How did you make sense of it?
- How did you feel/ What impact has that had on you/ How was that for you?
- How did that differ to other times? (More specific to questions 3 and 4)

---

<sup>1</sup> Participants will be asked about the language they prefer to use to describe their experiences and this will be used throughout the interview.

*The Hinting Task:*

- Do the Hinting Task with the participant
- After completing the task ask them for their feedback about how they found it and whether they could relate to any of the stories

*Ending the interview:*

- Check whether there is anything else they want to share/anything that has not been covered
- Ask how they have found the interview and whether there is anything that they shared that they would like omitted from the analysis
- Check for any distress and follow the necessary procedures as agreed by the team/key worker
- Explain how the results will be disseminated

*Obtain additional information from staff:*

- Date of birth
- Ethnicity
- Year of first contact with mental health services
- Length of admission on the rehabilitation and recovery unit
- Current/ most recent diagnosis

*Notes about my initial response to the interview:*

- My reactions/feelings/emotions to the participant and their experiences
- Any observations noticed from the interview, e.g. non-verbal cues, silences and long pauses
- Questions that I should have asked (which could be included in the next interview)
- Questions/prompts which were perhaps unhelpful and may be omitted from the next interview

## Appendix V: The Hinting Task

Hinting Task.

Instructions.

I'm going to read out a set of 10 stories involving two people. Each story ends with one of the characters saying something. When I've read the stories out I'm going to ask you some questions about what the character said.

Here's the first story. Listen carefully to it.

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Quick: \_\_\_\_\_

<b>Story</b>	<b>Verbatim Response 1 and score</b>	<b>Verbatim Response 2 and score</b>
long, hot journey		
dirty bath		
treacle toffees		
creased shirt		
flat broke!		
project at work		
birthday present		
ornaments		
train set		
heavy cases		

Scoring

1) George arrives in Angela's office after a long and hot journey down the motorway. Angela immediately begins to talk about some business ideas. George interrupts Angela saying:

"My, my! It was a long, hot journey down that motorway!"

QUESTION: What does George really mean when he says this?

Answer: George means either "Can I have a drink" and/or "Can I have a few minutes to settle down after my journey before we start talking business". Either of these responses would score 2.

If a correct response is not given for the first hint (eg. the participant just replies something like "He means exactly what he says") then introduce next part of the story / hint.

ADD: George goes on to say:

"I'm parched!"

QUESTION: What does George want Angela to do?

Answer: George wants Angela to get him or offer to get him a drink. This response would score 1. Anything else would be given a score of 0

2) Melissa goes to the bathroom for a shower. Anne has just had a bath. Melissa notices the bath is dirty so she calls upstairs to Anne:

"Couldn't you find the Ajax, Anne?"

QUESTION: What does Melissa really mean when she says this?

Answer: Melissa means "Why didn't you clean out the bath" or "Go and clean out the bath now". This response would be given a score of 2 and next item would be introduced

If the participant fails to give the correct answer at this stage then:

ADD: Melissa goes on to say:

"You're very lazy sometimes, Anne!"

QUESTION: What does Melissa want Anne to do?

Answer: Melissa wants Anne to clean out the bath. This response would score 1. Any other response would be given a score of 0

3) Gordon goes to the supermarket with his mum. They arrive at the sweetie aisle.

Gordon says:

"Cor! Those treacle toffees look delicious."

QUESTION: What does Gordon really mean when he says this?

Answer: Gordon means "Please buy me some sweets, mum"

ADD: Gordon goes on to say:

"I'm hungry, mum."

QUESTION: What does Gordon want his mum to do?

Answer: buy him some sweets

4) Paul has to go to an interview and he's running late. While he is cleaning his shoes, he says to his wife, Jane:

"I want to wear that blue shirt but it's very creased."

QUESTION: What does Paul really mean when he says this?

Answer: Paul means "Will you iron my shirt for me please?"

ADD: Paul goes on to say:

"It's in the ironing basket."

QUESTION: What does Paul want Jane to do?

Answer: Iron his shirt

5) Lucy is broke but she wants to go out in the evening. She knows that David has just been paid. She says to him:

"I'm flat broke! Things are so expensive these days."

QUESTION: What does Lucy really mean when she says this?

Answer: Lucy means "Will you lend me some money David ?" OR "Will you take me out tonight and pay?"

ADD: Lucy goes on to say:

"Oh well, I suppose I'll have to miss my night out."

QUESTION: What does Lucy want David to do?

Answer: She wants David to lend her money or offer to take her out and pay.

6) Donald wants to run a project at work but Richard, his boss, has asked someone else to run it. Donald says:

"What a pity. I'm not too busy at the moment."

QUESTION: What does Donald really mean when he says this?

Answer: Donald means " Please change your mind Richard and give the project to me"

ADD: Donald goes on to say:

"That project is right up my street."

QUESTION: What does Donald want Richard to do?

Answer: change his mind and give the project to him to run

7) Rebecca's birthday is approaching. She says to her Dad:

"I love animals, especially dogs."

QUESTION: What does Rebecca really mean when she says this?

Answer: "Will you buy me a dog for my birthday Dad?"

ADD: Rebecca goes on to say:

"Will the pet shop be open on my birthday, Dad?"

QUESTION: What does Rebecca want her dad to do?

Answer: Buy her a dog for her birthday

8) Betty and Michael moved into their new house a week ago. Betty has been unpacking some ornaments. She says to Michael:

"Have you unpacked those shelves we bought, Michael?"

QUESTION: What does Betty really mean when she says this?

Answer: Betty means "Will you put those shelves up now please?"

ADD: Betty goes on to say:

"If you want something doing you have to do it yourself!"

QUESTION: What does Betty want Michael to do?

Answer: put the shelves up

9) Jessica and Max are playing with a train set. Jessica has the blue train and Max has the red one. Jessica says to Max

"I don't like this train."

QUESTION: What does Jessica really mean when she says this?

Answer: Jessica means "I want your train and you can have mine."

ADD: Jessica goes on to say:

"Red is my favourite colour."

QUESTION: What does Jessica want Max to do?

Answer: swap trains

10) Patsy is just getting off the train with three heavy cases. John is standing behind her. Patsy says to John:

"Gosh! These cases are a nuisance."

QUESTION: What did Patsy really mean when she said this?

Answer: Patsy means "Would you help me with my luggage please"

ADD: Patsy goes on to say:

"I don't know if I can manage all three."

QUESTION: What does Patsy want John to do?

Answer: help her with her cases.

## Appendix VI: Ethics approval

Letter reissued 7<sup>th</sup> May 2014 to correct document date for Staff PIS



### Health Research Authority

NRES Committee Yorkshire & The Humber - Leeds West

Jarrow REC Centre  
Room 002, Jarrow Business Centre  
Rolling Mill Road  
Jarrow  
NE32 3DT

Tel: 0191 4283548

02 May 2014  
(reissued 07 May 2014)

Mrs Diane Agoro  
University of Leeds  
Clinical Psychology Training Programme  
Leeds Institute of Health Sciences  
Charles Thackrah Building  
101 Clarendon Road  
Leeds  
LS2 9LJ

Dear Mrs Agoro

**Study title:** A study exploring the personal meaning and experience of relationships and interactions among people experiencing psychosis.

**REC reference:** 14/YH/0070

**Amendment number:** Amendment 1

**Amendment date:** 14 April 2014

**IRAS project ID:** 140166

The above amendment was reviewed by the Sub-Committee in correspondence.

#### Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

#### Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Protocol	2	03 April 2014
Semi structured interview schedule	5	07 April 2014
Notice of Substantial Amendment (non-CTIMPs)	Amendment 1	14 April 2014
Participant Information Sheet: Staff	5	14 April 2014
Participant Information Sheet	6	14 April 2014
Recruitment Procedure	2	03 April 2014
Covering Letter	D. Agoro	16 April 2014

Letter reissued 7<sup>th</sup> May 2014 to correct document date for Staff PIS

Participant Consent Form	6	14 April 2014
--------------------------	---	---------------

### Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

### R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

### Statement of compliance

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

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

14/YH/0070:

Please quote this number on all correspondence

Yours sincerely

  
pp

**Dr Rhona Bratt**  
**Chair**

E-mail: [nrescommittee.yorkandhumber-leedswest@nhs.net](mailto:nrescommittee.yorkandhumber-leedswest@nhs.net)

Enclosures:

*List of names and professions of members who took part in the review*

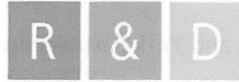
Copy to:

*Sinead Audsley, Leeds Partnerships Foundation Trust*

*Clare Skinner, University of Leeds*



## Appendix VII: R&D approval



Our Ref: 2014/485/L

Leeds and York Partnership **NHS**

NHS Foundation Trust

Research & Development  
North Wing, St Mary's House,  
St Mary's Road  
Leeds LS7 3JX

E-mail: [sinead.audsley@nhs.net](mailto:sinead.audsley@nhs.net)  
Direct Line: 0113 295 2387  
FAX: 0113 2954466

Mrs Diane Agoro  
University of Leeds  
Department of Clinical Psychology  
Fielding House  
St James's University Hospital  
Leeds  
LS9 7TF

08/05/2014

Dear Mrs Agoro

**Project title: A study exploring the personal meaning and experience of relationships and interactions among people experiencing psychosis**

**Amendment number: Amendment 1**

**Date of submission: 14 April 2014**

**REC Reference: 14/YH/0070**

Following the recent review of the amendment to the above project I am pleased to inform you that the amendment complies with Research Governance standards, and has been approved by the relevant Trust management. As such your project may continue within Leeds and York Partnership NHS Foundation Trust.

The final list of amended documents reviewed and approved is as follows:

Document	Version	Date
Protocol	2	03 April 2014
Semi structured interview schedule	5	07 April 2014
Notice of Substantial Amendment (non-CTIMPs)	Amendment 1	14 April 2014
Participant Information Sheet: Staff	5	14 April 2014
Participant Information Sheet	6	14 April 2014
Recruitment Procedure	2	03 April 2014

The amendment may therefore be immediately implemented at this site under the existing NHS Permission dated 03/04/2014. Please note that you may only implement changes that were described in the amendment notice or letter.

If you have any queries during your research please contact us at any time. May I take this opportunity to wish you well with the project.



Yours sincerely

*Sinead Audsley*

Sinead Audsley  
Research Governance Manager

cc: (PI) Dr Anjula Gupta

Leeds and York Partnership NHS Foundation Trust  
Research Governance Department  
Leeds General Infirmary  
Leeds LS2 9PL

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page]*

## Appendix VIII: Protocol to minimize and manage the risk of distress

### Protocol to minimize and manage the risk of distress

At team meetings Diane will advise staff to be mindful of the nature of the interviews and to consider whether the topic may be distressing for some service users.



When a service user is suggested Diane will check with the staff member whether there is the potential for the service user to experience distress and what the best plan of action is.



On the day of the interview Diane will contact the unit beforehand to check whether it is still ok to visit the service user and if there is anything that she should be aware of.



Before the interview Diane will discuss the topic of the interview and check whether the service user would feel comfortable discussing it.



Throughout the interview Diane will check with the service user whether they are ok. Whenever necessary they can have a break or discontinue the interview and reschedule if they want to.

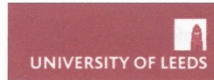


After the interview Diane will ask the service user how they are feeling and whether there was anything about the interview they found difficult.



If service users do become distressed Diane will implement the agreed plan.

## Appendix IX: Consent form



**UNIVERSITY OF LEEDS**

Doctor of Clinical Psychology Programme

Participant Consent Form

Title of Project: A study exploring the personal meaning and experience of relationships and interactions among people experiencing psychosis

Name of Researcher: Diane Agoro

Please initial all boxes below

I confirm that I have read and understand the information sheet dated 14.04.2014 (Version 6) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my care or legal rights being affected.

I understand that the interview will be audio recorded.

I understand that the interview will be transcribed by someone other than the person who interviewed me and that this will be kept confidential.

I understand that if there are any significant concerns, then the information will have to be shared, and confidentiality breached.

I understand that data collected during the study, may be looked at by individuals from the research team, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

Consent form version number: 6  
Consent form date of issue: 14.04.2014

Page 1 of 2

I understand that with my agreement, staff on the unit may be approached by individuals from the research team to obtain some additional information about me.

I understand that the supervisors of the research may read my transcribed anonymised interview.

I agree to take part in this study.

---

Name of Participant	Signature	Date
---------------------	-----------	------

---

Name of researcher obtaining consent	Signature	Date
--------------------------------------	-----------	------

Diane Agoro  
Psychologist in Clinical Training  
Clinical Psychology Programme  
Leeds Institute of Health Sciences  
University of Leeds  
Charles Thackrah Building  
101 Clarendon Road  
Leeds  
LS2 9LJ  
0113 343 0815

## Appendix X: Reflections

### Reflections

Prior to doing the interviews:

- I've noticed that I've been holding the assumption that social interactions tend to be a negative experience or non-existent for people with psychosis. This is particularly demonstrated by the fact that in my ethics application and proposal I've been very concerned about it being a difficult topic to discuss which may cause distress.
- After reading an IPA study about ToM in ASD I thought about any coping strategies that may emerge from my own study and whether I should include a question relating to this.
- How much will my sample reflect the wider society? The people being interviewed are likely to be the ones who have less social difficulties. Maybe I can learn about what helps and this may have implications for the wider society? Transferability?
- Some early assumptions I have noted down: feeling isolated, misunderstood, lonely, angry, loss of control, anxious, avoidant, hopelessness, coping strategies
- My assumptions have changed now that the stance of my study has changed. Previously I was interested in ToM deficits and social dysfunction in psychosis. Now I'm looking at it more broadly and thinking about interactions in general, therefore there may be more room for looking at positive experiences?
- My participants will be those who are willing to take part and discuss their experiences. What about those who are not willing- what does that mean?
- I'm assuming that people want to interact with others, and that these will be positive or negative, what about those who are just not interested in interacting with others? Because they can't or because they won't?
- There may be a parallel between relationships with voices and relationships with others.
- Issues around loss might come up, e.g. loss of the spouse/children they should/could have had?
- Might some people keep their distance because they are afraid others might become aware of their unusual beliefs- i.e. a form of protection, not suspiciousness
- Do interactions with others depend on how the symptoms are experienced and an individual's perception of this? For example, if someone is in denial of their symptoms and wants to show they are ok they might want to keep interacting?
- May be various reasons why people don't interact- avoidance, suspiciousness, not interested, stigma, scared?
- What is the function of their interactions- sign of success? Control? Comfort? Distress?
- People might avoid others if they have command voices to harm others
- What happens if they interact with others and they find out about the voices?
- I've been assuming that people with psychosis might choose not to interact with others. Maybe others no longer want to interact with them because of how they're behaving. Lack of understanding, not knowing what to do.
- Sometimes it might be adaptive to avoid others, especially if they're vulnerable
- What is the impact of psychosis on family and friends?
- Relationships must change, perhaps from being more social to being a carer- how does it go back to being a social relationship?
- Some of the experiences might be traumatic for friends/family
- Perhaps family etc. discourage them from seeing others because they feel ashamed?
- What about relationships/friendships with other service users?
- Maybe there's a need to focus on systemic social interactions rather than the deficit in the individual?

- Social withdrawal in childhood- this is the time when you learn about social relationships and form friendships- maybe people with psychosis have lost the opportunity?
- Haven't thought much about parent-child relationships
- Do friends stop contacting them? What can they do, especially if they're in hospital?
- What would people have to talk about with friends if they're stuck on a ward, bored and not being stimulated?
- Do they feel that lack of contact with the outside world contributes to their difficulty interacting with others?
- Maybe having visitors is too painful, especially when they leave- to avoid this maybe they refuse to see people?
- Maybe their relationship with staff members affects their beliefs about others and thus their relationships with them?
- Any verbal aggression may drive others away?
- Does being sectioned affect their willingness to trust others?
- What about people who disagree that they are experiencing mental health difficulties? Will they also deny they have problems with social interactions?

Whilst doing the interviews:

- All the participant have spoken about such a range of experiences, I'm pleased as this supports why I chose to do qualitative, I wanted to demonstrate that people with psychosis are not just a statistic but have a range of lived experiences. However, what will this mean for the group analysis?
- Although some of the participants have spoken about issues that are unsurprising, as it has come up in the literature already, it has been really insightful to hear each individual's account of their experiences.
- I feel that reading the wealth of quantitative data which merely produces statistics suggesting that people experience stigma etc. has removed the emotional connection for me. Hearing these people's stories has brought me back to the individual experiences of the participants.
- I was pleased to hear that one participant was married and had a child. However, I was disappointed that I was surprised- why should I be surprised that people with psychosis have relationships just like everybody else?
- What does important mean in a relationship- current? Meaningful? Good?
- Difficult is a strong word to use, if I did not use that term but something else would participants describe other negative experiences?
- There are so many times when I want to probe further and ask more questions, but I hesitate, is it too sensitive? Is it any of my business? My clinical side seems to get in the way.
- Looking back at my previous reflections I thought about the loss of relationships they should have had/ could have had. However, this was assuming that they were unable to achieve these relationships. Instead the participants spoke about the loss of current relationships- again demonstrating normal relationships like everyone else.
- All the participants were likeable and pleasant to interview. Generally I have not got a sense that they have had any difficulty understanding me or interacting with me.
- At some points of some of the interviews I felt that I could have been interviewing anyone about their experiences of relationships, not necessarily someone who had experiences of psychosis. Again this made me realise the normality of their experiences.
- Some of the participants complained that using hints is deceptive. I never thought about it like that, but now that they mention it, I think it is true, maybe at times people could be more honest and direct?

- How much did I as a person affect how the participants engaged with me? I wondered whether Henry felt able to fully express his experiences of racism with me because I am also a person of colour? Did Therese feel able to talk to me about her experiences as a mother because I am a woman? Did George feel able to talk to me about his voice hearing because I am a psychologist?

During analysis:

- Relationships don't have to be between one individual and another; it can be between an individual and a structure within society for example, institutions, the government etc.
- It has been difficult managing my clinical side versus my research side. My clinical side is used to making interpretations and tentatively proposing this to the client. However, with this research I feel slightly uncomfortable with the amount of power I have to make interpretations. If the participant read it, would they recognise it as them, would they agree with it?
- There are so many times when I have not prompted further- was this because I did not feel comfortable or because I did not think it was important. This has made me aware of how much I as a researcher have influenced what the participant has said and thus the emergent themes.
- Initially I was only going to do a group analysis, however, I feel really connected to each individual's story, they're unique and full of a range of experiences and emotions. They gave their time to share their story with me and I think it would be a disservice to each and every one of them if I merely summarise their experiences and focus on the group themes. Therefore, I have decided to do an individual analysis with themes for each participant.
- At times I have repeatedly read through a section of a transcript and wished I had asked a different question or prompted more.
- I feel that reading through the transcript has resulted in me having more questions rather than answers
- Sometimes participants have mentioned two interesting points in one sentence. I have asked further questions about one point but neglected the other point. Sometimes I think this was because the other point got lost and I forgot to go back to it. But I also wonder whether I chose to privilege one point over another.