Constructing Stories of the Self

Following the First-Psychotic Episode and Substance Misuse

Justine Attard

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List of Abbreviations

FEP – First-episode Psychosis

EIP – Early intervention in Psychosis

PTG – Post-traumatic growth

Declaration of Authenticity

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Student's Code 19MPSY002

Student's Name & Surname Justine Attard

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Abstract

This study aimed to explore the narratives of patients who have experienced a first-episode psychosis with a known history of substance misuse. Therefore, the overarching aim of this study was that of gleaning the constructed life story of the participants. It is expected that this study increases the healthcare professionals' and policy makers' awareness over the patients' subjective experiences. It aimed to examine the manner in which persons who suffered a first episode psychosis experience their selfhood and to identify any changes in their life script occurring after such an episode. For the purpose of this study, a qualitative approach was adopted. Following a minimum period of one year in remission of psychotic symptoms, five males participated in a semi—structured interview. Interviews were transcribed verbatim and analysed through a narrative analysis. Following Vetere and Dallos (2016) model, the analysis was divided into three parts: thematic, structure, and process analysis. Three dominant narratives were elicited: Losing the Grip; Me, Us, and Them and The Self. Participants' narrative structures were analysed and possible 'frozen narratives' were identified, in line with Vetere and Dallos' method of Narrative Analysis. Moreover, process analysis was conducted in order to analyse how the story was being narrated and how it was experienced by the participant and the researcher. Findings suggest that participants struggled on realising that their perceptions were not shared by the people around them. The difficulties they encountered to reach-out and to take on the patient's role are evidenced Changes in their relationships with others, perceptions of life, and sense of self were highlighted. The need for continuity of care, improvement of setting and environment in the services and early intervention for psychosis were recommended.

Keywords: first-psychotic episode, substances, meaning, narratives, self.

Dedication

To all who suffer in silence.

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Chapter One – Introduction

"It's the most soul-wrenching experience
anyone can go through. Use every resource to get through
it and then turn around to help those coming
up the mountain after you. They need your help."
-A person who experienced the first-psychotic episode (NAMI, 2011).

Preamble

The above quote taken from the results of the *National Alliance on Mental Illness* survey on the first-episode psychosis (FEP), conducted in the USA in 2011 highlights the immense suffering of a patient who has experienced the FEP. The same survey outlined striking results about the respondents' most helpful person during the early stages of their FEP - mostly "no one" (22.2%).

In my role as a psychology assistant in the mental health services, I was entrusted with endless stories that highlighted patients' suffering and emotional distress. I believe that the discipline of psychology has come a long way to combat mental health stigma, especially for psychological challenges, such as anxiety and depression, while not as much for other mental health difficulties, particularly, psychosis. This may impact patients' and their relatives' willingness to seek help if they recognise any signs of unusual beliefs, thoughts, or altered states (Martin, Pescosolido, & Tuch, 2000).

As part of a multidisciplinary team, attending weekly ward-rounds highlighted the importance given to diagnostic labels and psychiatric treatment; especially with people who experienced psychotic episodes. Such a dominant medical model gives rise to the negative view of mental challenges as a "one-way street" from which recovery is not possible (Campbell as cited in Bracken & Thomas, 2005). Consequently, little importance is given to the subjective narratives of patients experiencing psychosis (Bracken & Thomas, 2005).

In the last two years I witnessed an increase in young adults' first admission to the psychiatric hospital who were experiencing their FEP and would have admitted to having used substances, particularly cannabis and synthetic drugs. Listening to their stories has given me an understanding that goes beyond diagnoses and medication. Therefore, my research will facilitate my professional development as the primary focus will be given to the patients' idiosyncratic experiences as narrated from their point of view with their choice of words.

Aim of the study – Rationale, Issues to be Investigated and Research Question

Pursuing a career in a psychiatric hospital brought about challenges, yet priceless satisfaction for supporting patients who were caught up in their world, sometimes with no-one supporting them. Restoring the sense of self to the conceptualisation of psychosis underlies my motivation to conduct the current study.

Karl Jaspers (1997) differentiated between descriptive and phenomenological psychopathology; the former refers to a categorical meaning of unusual experiences as recounted by the patient, whereas the latter refers to a more detailed observation of the patients' subjective experience. In phenomenological psychopathology, the patients' distressing experiences are elicited from the patient's language and reformulated in psychiatric terminology. Bracken and Thomas (2005) argued that phenomenology needs to be seen as something that allows the psychiatrist a neutral, scientific view of the patient's subjective world.

Following Jaspers' phenomenological inquiry, my work will aim to elicit the idiosyncratic, phenomenological narratives of patients who have experienced a FEP with a known history of substance misuse. The overarching aim of this study will, therefore, be that of gleaning the constructed life story of the participants; to gain a more in-depth perspective on how the person experiences his selfhood and to attempt to gain a deeper understanding of

any changes to the life script that occurs following a FEP. Hence, the research question will be answered through the gathering of the participants' idiosyncratic narratives.

Theoretical framework and positioning of the researcher

Willig (2001) explained that there are “knowledges” rather than one “knowledge”; therefore, the same phenomenon can be described in different ways. As a researcher, I position myself between critical realism and social constructionism on the epistemological – ontological continuum. Coming from a clinical background where the medical model dominated our thinking and interventions, I agree that having an objective truth about mental challenges via diagnosis is needed. However, the patient’s subjective truth and experience carry meaning which cannot be overlooked.

Diagnosis plays a critical role in clinical practice since it can guide professionals through a logical decision-making process in situations for which more than one intervention is available (Craddock & Mynors-Wallis, 2014). It can also prove helpful for patients themselves since diagnosis can provide reassurance that their situation is not mysterious or unexplainable (Craddock, Kerr, & Thapar, 2010). I also recognise Foucault’s (1977) move from the understanding of power as something negative to power as knowledge; thus, diagnosis could be seen not only as a classification of symptoms but also as a productive agent that gives the individual a new identity.

Behind every diagnosis is a collection of biographical details about the individual’s identity, independent of the symptoms. This brought about the idea of individualisation (Foucault, 1977 as cited in Bracken & Thomas, 2005). Foucault (1977 as cited in Bracken & Thomas, 2005) claimed that power is often exercised through “regimes of truth”; expert discourses. Such discourses have their experts; in this case, diagnoses given by psychiatrists. Essentially, individuals who have been diagnosed live their lives through such discourses that

formulate values and priorities in terms that are given to them. Such discourses being "regimes of truth" (Bracken & Thomas, 2005 p95), they provide a backdrop to ethical debates through which it becomes possible to utter the "truth". Therefore, individuals are given both a diagnostic label and a way of understanding themselves (Bracken and Thomas, 2005, p95).

Clarification of the terminology used

Patient vs client.

Throughout my dissertation, I will be using the term "patient" without intending any disrespect. The words "patient" and "client" are derived from Latin; *patior*; meaning *'to suffer'* whereas *clinar* means 'to learn' (Wing, 1997). Although the word "patient" conjures up negative connotations such as passivity and an unequal relationship with the healthcare professional (Neuberger, 1999), research outlined that people using mental health services themselves opted for such term (Wing, 1997; Deber, et al, 2005). Moreover, the word "patient" conforms to my critical-realist position.

Self.

I will be using the term "self" as an "array of self-relevant knowledge, the tool we use to make sense of our experiences, and the processes that construct, defend, and maintain this knowledge" (Epstein, 1973; Higgins, 1996 as cited in Oyserman, 2012 pp. 500). The self-concept functions as a reservoir of autobiographical memories, as an emotional buffer, a motivational resource, and an organiser of experiences (Markus & Wurf, 1987).

Psychosis.

The British Psychological Society (BPS, 2017) described psychosis as an experience that often includes:

i. Hallucinations: hearing voices, seeing, smelling, tasting, or feeling things, that others do not.
ii. Delusions: beliefs that are not shared by people around them
iii. Thought disorder: manifested through thinking and concentration difficulties
iv. Feelings of helplessness, demotivation, and withdrawal (BPS, 2017).

The BPS (2015) moved from using diagnostic labels based on medical terms to using terminology that is consistent with a functional diagnosis; therefore, describing the behaviour and experience. Hence, the term "psychosis" is replaced by "unusual experience". I will be using both terms interchangeably, reflecting my positioning as a researcher and the participants' terminology.

First-episode psychosis.

The term 'psychosis' is used to describe a group of conditions in which severe symptoms of mental illness, such as, delusions and hallucinations are accompanied by an inability to distinguish between reality and subjective experiences (NICE, 2009). FEP refers to the first time a person presents with psychotic symptoms. However, it could include individuals who have been treated for many years without remission as well as others who had psychosis and have not yet received treatment (NICE, 2009). Literature establishes that substance misuse, such as cannabis, increases the risk of onset for a FEP (Peters et al., 2004). It is also found to be one of the contributing factors for psychotic relapse (Fallon, Dursun, & Deakin, 2012).

Clinical relevance and expected contribution to the field

In my experience working within mental health services, weight was given to the regular assessment of psychotic features and consequently administering and altering anti-psychotic medication, if symptoms persist. It is expected that this study increases healthcare

professionals' and policy makers' awareness over patients' subjective experiences beyond diagnosis and medication. Such a qualitative study is considered to give a voice to participants whose voices are seldom heard (Steffen, 2014).

Studies on the patients' experience of the FEP seem to be more focused on their perception of inpatient services rather than on their phenomenological experience (Koivisto, Janhonen, & Vaisanen, 2003; Tidefors & Olin, 2011). Moreover, there seems to be a gap in research on the possible impact on patients' sense of self following a FEP. Understanding the participants' phenomenological experience can shed light on their needs and may suggest tailor-made interventions and set-up adequate services.

Overview of the dissertation

The introductory chapter has provided a general outline of the researcher's motivations for the study, aims and research question, researcher's theoretical framework and positioning, a clarification of the terminology, and expected contributions of the study. Chapter Two shall be outlining a review of the literature and Chapter Three will present the methodology adopted for the research. The results shall be presented in Chapter Four and discussed in Chapter Five. The concluding chapter will illustrate the strengths and limitations of the study, recommendations for further research, practice, and policy-making.

Conclusion

In this chapter, I have presented an overview of my research, including my motivation to conduct this research, the aim of the study, and the research question. I have illustrated the adopted theoretical framework, my positioning as a researcher, and the key terminology used throughout the study. The expected contributions of the research were outlined. In the following chapter I shall present a review and critical analysis of the existing literature, highlighting the lacuna on the patient's subjective experiences.

Chapter Two – Literature Review

Introduction

The overarching aim of this study was that of gleaning the constructed life story of individuals who experienced a FEP following substance misuse, with specific focus on their subsequent experience of selfhood. The literature presented in this chapter underscores the lack of research on patients' phenomenological experience of a FEP and its potential influence on their sense of self.

A brief historical background of the central figures in the history of psychosis, influence of the antipsychiatry movement on mainstream psychiatry and diagnosis in the 1960s can be found in *Appendix K*. These were deemed significant due to their conceptualization of mental illness as socially constructed. The primary diagnostic classification systems, namely the Diagnostic Statistical Manual DSM-V (American Psychiatric Association, 2013) and the International Classification of Diseases ICD-10 (WHO, 1992) are also discussed. I then discuss phenomenology and descriptive psychopathology, followed by the relationship between psychotic symptoms and the individual's life experience with reference to the notion of the 'nugget of truth' in psychosis (Benning, 2007).

Since this research is aimed at gathering narratives of participants who have experienced a FEP following substance misuse, I draw on several studies as a means of understanding the implications of substance misuse, particularly cannabis, and its relationship to the development of psychosis. In the last part of the chapter, pharmacological and therapeutic interventions for psychosis will be discussed. Lastly, I will discuss the notion of the self.

Research strategy

To my knowledge to date, local research about FEP is limited. Therefore, most of the literature cited in this chapter was based on international studies conducted between the 1950s and 2018. The following keywords were used; first-episode psychosis, meaning, self, substances, treatment, and diagnosis. Most of the articles were retrieved from HyDi from the University of Malta Library, Sage, and the US National Library of Medicine: National Institute of Health. Other studies were retrieved from Google Scholar and Google Books. Printed books were purchased from Book Depository.

Diagnosis

The Diagnostic and Statistical Manual-V (DSM-V) classification.

In contrast to earlier versions, in the DSM-V psychosis is explained as a significant feature in schizophrenia spectrum disorders, a possible but variable feature in mood and substance use disorders, and also highly prevalent in various developmental, medical, neuro-degenerative, and acquired conditions (Arciniegas, 2015). A common characteristic between the DSM-V and the ICD-10 on the conceptualisation of psychosis is that both require the presence of hallucinations and/or delusions without insight (APA, 2013; WHO, 1992).

In earlier publications of the DSM, the term ‘psychotic’ was less developed. In the DSM-II, it was used to describe individuals whose “mental functioning is sufficiently impaired to interfere grossly with their capacity to meet the ordinary demands of life”, without necessarily implying impaired reality testing (APA, 1980, p.368). The DSM-III incorporated the impairment of reality testing as a fundamental feature of psychosis (APA, 1980).

Diagnostic criteria for substance/medication-induced psychotic disorder.

There are five diagnostic criteria for such disorder in the DSM-V. Criterion A specifies the presence of delusions and/or hallucinations which developed during or soon after substance intoxication, withdrawal, or exposure to a medication. Criterion B requires evidence-based findings that such substances/medication can cause these symptoms. Criterion C specifies that the disturbance cannot be better explained by another primary psychotic disorder. Criterion D states that the disturbance does not have to occur only within the course of delirium. Criterion E requires that the disturbance has to cause clinically significant distress or impairment in social, occupational, or other significant areas of functioning (APA, 2013).

Similarly, in the ICD-10, psychoactive substance-induced psychotic disorders, may present with varying symptoms. These variations depend on the substances taken by the individual and his/her personality (WHO, 2018). When the individual's experiences of perceptual distortions or hallucinatory experiences are possibly related to a substance that can produce hallucinogenic effects such as LSD and cannabis, acute intoxication may be a more accurate diagnosis (WHO, 2018).

The classification systems discussed above do not make any reference to the patients' experience and their phenomenological relevance on the patients' sense of self and identity. For this purpose, the below sections on phenomenology and descriptive psychopathology were considered pivotal for the overarching aim of the study.

Phenomenology and descriptive psychopathology

Psychopathology.

Psychopathology is the scientific study of mental health disorders which incorporate abnormal psychological behaviours, cognitions and experiences. Femi Oyebode defined

psychopathology as “the preeminent foundation for rational practice of clinical psychiatry” (Oyebode, 2008). It includes both explanatory and descriptive psychopathology. Explanatory psychopathology refers to pre-set explanations based on theoretical constructs which aim to arrive at a cause-and-effect, whereas descriptive psychopathology aims to arrive at a descriptive and categorical meaning of abnormal experiences as recounted by the patient (Gogoi, 2016). The latter can be divided into two main views;

i. The continuity view – psychologists and clinicians who predominantly regarded the pathology phenomena as quantitative variations on normal mental functions
ii. The discontinuity view – psychiatrists who considered specific symptoms as too bizarre to have a function in ‘normal behaviour' (Berrois, 1996).

Phenomenology.

Edmund Husserl (1931), the founder of phenomenology, defined phenomenology as a descriptive analysis of the essence of pure consciousness (Zahavi, 2003). He distinguished between phenomenology as a science of pure consciousness and psychology as a science of empirical facts. Husserl was interested in finding a means by which one might identify the *essential* qualities of their experiences (Smith, Flowers & Larkin, 2009).

Other philosophers like Heidegger, Merleau-Ponty, and Sartre developed the idea of viewing the person as embedded and immersed in a world of objects and relationships, language and culture, projects and concerns (Smith et al., 2009). They focused on understanding perspectival directedness of the involvement in the lived world – something which is personal to each individual (Smith et al., 2009).

Phenomenological psychopathology.

Karl Jaspers introduced the biographical method in psychiatry that reflects the importance of one's illness as part of his life history (Jaspers, 1993). In his book *General Psychopathology*, Karl Jaspers encouraged practitioners to look for a detailed account of the phenomena:

> "We expect to account for every psychic phenomenon. In no circumstances should we rest satisfied with a general impression or a set of details collected ad hoc" (Jaspers, 1993 pp.56).

Jaspers adopted Husserl's ideas to his phenomenological approach to interviewing psychiatric patients. He came up with two methods which connected the patient's life experiences to the development of mental illness; *Erklären* – explanation, and *Verstehen* – understanding (Nardi et al., 2013). These referred to causal relatedness and the demonstration of a mental disorder that could have emerged from a conflict between one's life experiences and its emotional consequences (Jaspers, 1997; Kirkbright, 2004).

Jaspers laid the ground for phenomenological psychopathology which he defined as a detailed study of facts observed in the individual patient (Jaspers, 1997). Experiences creating distress to the patient are therefore elicited from the patient's language and reformulated in psychiatric terminology. Phenomenology needs to be seen as something that allows the psychiatrist a neutral, scientific view of the subjective world of the patient (Bracken & Thomas, 2005).

The nugget of truth in psychosis.

Various studies highlight psychosis as reflecting the individual's real-life experiences (Benning, 2007). Rhodes and Jakes (2000) conducted a study which indicated that the content of the patient's delusions was either their real biographical life experiences or linked to their anxieties.

In his book, *Madness Explained – Psychosis and Human Nature,* Richard Bentall (2003), emphasised on 'the nugget of truth' in psychosis. He described a case example of a distressed lady having paranoid delusions whereby the lady was describing how something horrible would happen if she does not leave the island. Diagnosed with a psychotic disorder, sometime later she was able to recall a series of threatening phone calls she was getting from a stranger; thus, her life was indeed threatened (Bentall, 2003).

As evidence in favour of the nugget of truth, Bentall cited the work conducted by the American psychoanalyst, William Niederland, on the famous case of Daniel Schreber (Bentall, 2003). Niederland investigated Schreber's family following Freud's insights that Schreber's delusions had to do something with his father, finding that the delusions contained a nugget of truth when understood according to the patient's upbringing.

On the other hand, hallucinations have been widely reported with non-psychotic disorders and in non-clinical populations, such as in post-bereavement and solitude (Benning, 2007). Bentall and Slade (1992) found that 15.4% of a sample population of hundred and fifty males responded positively to a statement indicating that they have heard a voice of someone who was not present. Another quantitative study conducted with professionals working in the mental health sector, particularly psychiatric nurses, found an 84% prevalence rate for auditory hallucinations (Millham & Easton, 1998). The data being gathered through a self-report questionnaire, one needs to look further into the validity and reliability of the study.

The above findings bridge the boundary and the stigma that distinguishes "normal" from "pathological" populations (Benning, 2007). In *Paradoxes of Delusions* (1994), American psychologist Louis Sass argued that individuals who experienced delusions were not incognisant of their reality as they might be perceived to be (Sass, 1994).

Emotions in psychosis may appear to be unnatural, absent, unsatisfying, or somehow inappropriate (Sass & Parnas, 2003). Experiences that are associated with the primary symptoms of psychosis reported by non-clinical populations are remarkably similar to experiences occurring in individuals who experience anxiety or those who are diagnosed with a personality disorder (Huppert & Smith, 2005). These individuals commonly adopt an abnormal kind of detached, introspective stance toward their own bodily experience (Angyal 1936). These findings gave rise to the continuum model of psychosis which seems to be less stigmatising and alienating the "insane" from the "sane" population (Benning, 2007).

Substance misuse and the first psychotic episode

Literature suggests a high correlation between substance misuse and FEP, with cannabis having the highest prevalence rate (Van Mastrigt et al., 2004; Archie et al., 2007). Cannabis and alcohol are found to be the two most common substances used by individuals with a psychotic disorder (Margolese et al., 2004). Milton et al. (2001) found that male patients who have had FEP and a history of cannabis misuse reported a higher incidence of aggression.

Various studies have found that cannabis is an implicated risk factor for developing psychosis (Van Mastrigt et al., 2004; Veen et al., 2004; Barnes et al., 2006). Substance misuse was also found to be a perpetuating factor for psychotic symptoms; with reduction in substance use associated with a reduction of symptoms and a lower rate of hospital admissions (Lambert et al., 2005).

Abusing cannabis was also found to be related to prognosis and increases the risk of relapse in young people who have already experienced their FEP (Archie et al., 2007). When compared to non-abusers, patients with FEP abusing cannabis did not benefit much from

early intervention services designed as a treatment option for FEP patients (Rosenbaum et al., 2005).

Treating psychosis

Pharmacological treatment.

Chlorpromazine was discovered in 1952 by a French surgeon who was experimenting with antihistamines to reduce surgical shock and unexpectedly found that there were significant improvements on the patients' mental states following its administration (Kane & Correll, 2010). At that time psychiatrist Pierre Denker tried chlorpromazine with some of the most challenging cases and claimed that the results were remarkable. By 1964, around fifty million people were treated by chlorpromazine for psychotic disorders (Kane & Correll, 2010). Its calming effect on patients with psychotic symptoms is considered one of the most significant advances in medicine in the twentieth century.

In 1964, there was a series of studies which compared the use of first generation antipsychotics; chlorpromazine, fluphenazine and thioridazine with a placebo (Cole as cited in Kane & Correll, 2010). All the drugs were found to be equally valid and more effective than the placebo. First generation antipsychotics; typical antipsychotics, neuroleptics and dopamine antagonists have different properties which are targeted to treat different aspects of the psychotic features. Neuroleptics can cause psychomotor slowing and create an affective indifference (Stahl, 2008). Dopamine antagonists differ significantly between first-generation antipsychotics and second-generation anti-psychotics which are known as dopamine-serotonin antagonists and are found to have less adverse reactions (Sadock et al., 2009).Typical antipsychotics such as haloperidol and mesoridazine were part of the first-generation anti-psychotics which produced common side-effects such as weight gain and extrapyramidal symptoms (Grunder et al., 2009).

Electroconvulsive therapy (ECT) was developed by a Swiss physician who administered camphor by mouth to produce convulsions and cure lunacy (Abrams, 2002). The idea of treating patients with schizophrenia using ECT came from *neuropathological* studies that suggested a lack of glial cell growth in the brain of such patients (Abrams, 2002). In the 1950s, ECTs became less popular due to the administrations of psychotropic drugs; however, they were reconsidered in the 1970s due to the limitations in efficacy and adverse reactions of such medication (Fink & Sackeim, 1996).

Non-adherence to treatment.

Non-adherence to treatment is a well-known factor in psychotic disorders and is the principal reason for hospitalisation, relapse, and poor outcomes (Valenstein et al., 2002; Weiden et al., 2004). Three main factors behind non-adherence to antipsychotics are: illness-related variables such as level of insight and the severity of symptoms, treatment-related variables such as length of treatment and side-effects, and patient-related variables such as the patient's attitude towards the illness, treatment and possible alcohol or substance misuse (Novick et al, 2010). A poor patient-clinician therapeutic alliance was found to be a pivotal contributor to non-adherence in patients with schizophrenia (Olfson et al., 2000).

National Institute for Health and Care Excellence (NICE).

In *Psychosis and Schizophrenia in Adults: Prevention and Management* (NICE, 2014), psychosis and its management are divided in following phases:

i. **Prodromal -** precedes psychosis and is often characterised by some functional deterioration, such as, concentration difficulties, disturbed affect, and unusual ideas. People tend to not seek help and endure symptoms for a discrete time that can last between a few days up to two years (NICE, 2014).

ii. **Untreated psychosis**; the psychotic episode emerges and leads the individual to treatment. Individuals in this phase would have contemplated suicide and 25% would have already made one suicide attempt before seeking treatment (NICE, 2009).

iii. **Acute psychotic treatment -** characterised by hallucination, delusions, behavioural disturbances and psychological distress (NICE, 2014).

iv. **Post-psychotic recovery -** considered as highly distressing to patients since they would experience difficulties related to a possible neurocognitive deficit (NICE, 2009) and are at high risk of suicide (Hunt et al., 2009; Heila et al., 1999).

v. **Early phase of relapse.** Patients achieve remission from their symptoms within approximately six months. Relapse rates are high following disengagement from psychiatric and psychological services (NICE, 2009).

Early intervention in psychosis (EIP).

NICE (2014) recommends EIP services to people of all age groups who experience an FEP and who might be diagnosed with schizophrenia, schizo-affective disorder, and/or bipolar disorder. NHS (2016) also recommends EIP to people experiencing an FEP following substance misuse such as cannabis. Such services are not available in the local context.

EIPs are highly structured and they do not allow for the client's phenomenological experience. EIP services are made up of multidisciplinary teams to whom clients are referred by their general practitioner or any other professional or mental health services (NHS, 2016). When clients have complex needs, EIP services adopt a care-programme-approach which provides ongoing support to clients. Depending on the specific programme for EIP, clients who have experienced a psychotic episode would benefit from CBT and their relatives could also be given support through family interventions (NHS, 2016).

Research shows that EIP has proven to be beneficial in FEP since it improved symptoms, reduced substance abuse (Addington & Addington, 2001), improved the patient's quality of life (Malla et al., 2001), and reduced the rates for hospitalisation (DeHaan et al., 2003). Although there is not much research conducted by means of randomised controlled studies that compare EIP to other forms of treatment, one study found that as opposed to regular treatments, EIP reduced helplessness in patients (Nordentoft et al., 2002) and improved their adherence to other forms of treatment (Jorgensen et al., 2000; Larsen et al., 2001).

While some studies found that EIP can be beneficial with FEP (Addington & Addington, 2001), other studies found no benefits with clients who experienced FEP with a history of substance misuse (Rosenbaum et al., 2005).

A cognitive model of psychosis.

Garety, et al, (2001) believe that there are two possible routes for the development of the positive symptoms of psychosis: the first proceeds through cognitive and affective changes and the second through affective disturbances alone. Hemsley (1993) explains automatic cognitive disturbances as:

> "a weakening of the influences of stored memories of regularities of previous input on current perception, which leads to ambiguous, unstructured sensory input and the subsequent intrusion into consciousness of unintended material from memory" (Hemsley, 1993 as cited in Garety et al., 2001 p189).

Frith (1992) offers an alternative way to explain the same concept:

> "[…] the basic cognitive dysfunction may be recently developed difficulties with the self-monitoring of intentions and actions, which would lead to individuals' own intentions to act not being recognized and therefore being experienced as alien (Frith, 1992 as cited in Garety et al., 2001 p190).

The common understanding between them is that cognitive disturbances lead to exceptional conscious experiences such as racing thoughts, thoughts experienced as voices and unconnected events appearing as causally linked (Garety et al., 2001). Subsequently, emotional disturbances occur as a response to the external triggering event or situation. The individual would then try to attribute meaning to the experience and emotional changes (Maher, 1988). Research found empirical evidence linking cognitive biases with individual cognitive styles such as tendencies to jump into conclusions and deficits in understanding social situations and the intentions of others (Garety & Freeman, 1999). Other studies suggest that early adverse experiences might instil a persistent cognitive vulnerability characterised by negative schematic models of the world (Agid et al., 1999). In a study of over 7000 participants screened for psychiatric symptoms over a three-year follow-up period, participants who experienced psychosis were more likely to have low self-esteem and depressive schemas (Birchwood et al., 2000).

The Stress-Vulnerability Model.

As illustrated in figure 1, the stress-vulnerability model is a fundamental aspect in the CBTp because while it provides an illustrated explanation which normalises the client's experience, it clarifies the relationship between stressful events and their impact on the development of symptomology (Zubin & Spring, 1977).

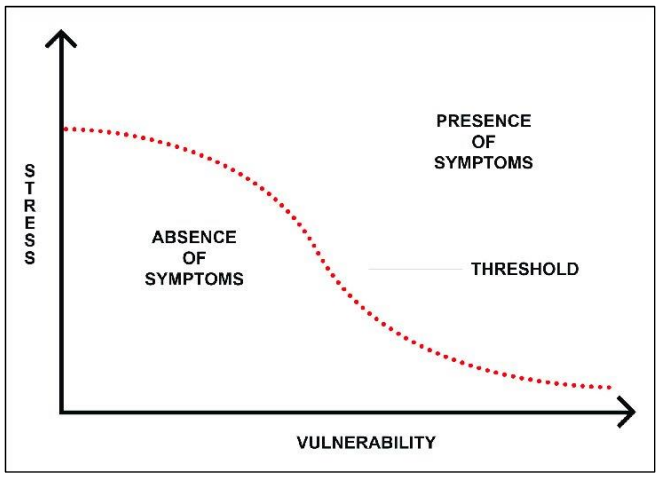

Figure 1: The Stress Vulnerability Model (Adapted from Zubin & Spring 1977)

The stress-vulnerability model incorporates multiple factors such as the psychotic experience itself, biological stressors, childhood traumas, and other predisposing factors which can heighten stress levels. Therefore, CBTp aims to minimise the psychotic symptomology and alter the patient's interpretations and beliefs about the nature and consequence of psychotic symptoms (Zubin & Spring, 1977).

Psychoanalytic theories of psychotic breakdown

Psychoanalytic theories debate about the role organic factors play in psychosis and the continuum perspective to neurosis and psychosis. There seems to be concordance that failures in early psychological development beginning with the mother-infant relationship may predispose an individual to develop schizophrenia later on in life (Jackson as cited in Williams, 2001). Deficits in ego functions can be the result of an under-developed capacity to regulate emotions in infancy, to differentiate between object and self, and to form a secure sense of identity (Jackson, 2001).

Contemporary psychoanalysts, including Klein, Winnicott and Bion, stated that mother-baby interactions establish the internal object in the inner world through processes of introjections and projections (Jackson as cited in Williams, 2001). These processes ensure a basis for stability of mental life and the capacity to develop reflective thinking. Impairments

in such processes render the individual vulnerable to develop psychosis later in life. Grotstein (1977) attributed the psychological vulnerability to the unresolved overwhelming destructive feelings in part-object relations stemming from the mother-infant relationship. A psychotic breakdown can thus be understood as the patient's defensive response to a crisis when s/he is psychologically and perhaps biologically vulnerable. Jackson (2001) argued that deficits in ego functions trigger a regressive process when the individual is faced with psychological stressors whereby earlier modes of mental functioning are reactivated, impacting the capacity for rational thoughts and distorted perceptions. Essentially,

> "object relationships may be replaced by identifications, and the capacity to differentiate from inner and outer reality is compromised. Space-cantered thinking undermines the subject's sense of time, and this leads to memories experienced as immediate perceptions. Wishes and fears assume hallucinatory and delusional qualities and may be experienced as present realities, and rational thinking is distorted by dream-like primary process thinking (Jackson as cited in Williams, 2001 p43-44).

Psychosis as the creation of a new reality.

The term 'reality' in psychodynamic practice implies both the external world and changes in the processing of psychic-emotional reality (Martindale & Summers, 2013). One of the mind's core tasks is to integrate different aspects of reality, tolerate conflicts between them, and to manage and compromise such different realities at any one time. The psychodynamic approach focuses on clarifying experiences of reality that were unmanageable to the patient based on the premise that through psychotic symptoms these experiences were altered rather than contained. After the disintegration, emotional pain, and anxieties underlying the psychosis are understood, the psychosis may be found to have a developmental or self-preservative function (Martindale & Summers, 2013).

Psychotic defences.

Defence mechanisms are fundamental to psychodynamic practice since they are an integral way of mental processing of the individual's everyday life. One of the central defence mechanisms in psychosis is denial. This may feature as denial of one's internal reality which may be represented in denying aspects of oneself such as aggression and sexuality (Hingley as cited in Johannessen, Martindale, & Cullberg, 2006). Projective identification, another defence mechanism, can be understood in two ways; someone projecting unacknowledged attributes of oneself is convinced that the recipient is acting similarly with these attributes which might lead to delusions of persecution or paranoia, and secondly, the recipient would experience something similar to what has been unconsciously projected onto them (Migone, 1995). Martindale and Summers (2013) spoke about how manic-defence, a third defence mechanism, can feature in psychotic manifestations. This includes difficult feelings and attributes of oneself which the patient finds challenging to bear, such as low self-esteem and shame. During a psychotic phase, these same attributes are turned into opposite characteristics; grandiose ideas, superiority or contempt.

One of the most influential concepts within psychodynamic theory is the concept of the self. Self-Psychology was developed by Kohut (1971; 1977; 1984) and consists of a developmental model and a model for therapy and consultation. At the centre of Kohut's theory lies the self that is "conceptualised as a mental system that organises a person's subjective experience in relation to a set of developmental needs" (Wolf, 1988 as cited in Banai, Mikulincer & Shaver, 2005 p.224). The self emerges from the ego and is the core of one's psychological being that is made up of thoughts, sensations, feelings, and attitudes towards oneself and the world (Kohut, 1977).

Since the notion of the self is pertinent to the research question, a brief conceptualisation of the self was deemed necessary.

The notion of the self

The self is an active agent which is continuously seeking competence, resolution of internal and external conflicts, and mastery in the real world (Brown, 1998). The self is a social product moulded and shaped by early relationships and experiences (Mikulincer, 1998; Frome & Eccles, 1998). It is constructed by developmental changes in cognitive abilities and the requirements of specific life-events that are embedded in specific times and spaces (Moretti, Higgins & Simon, 1990). Thus, others' norms, values, and behaviours play a significant role (Oyserman, 2012). What one remembers, how one remembers it, and the sense one makes out of one's experiences are shaped by one's self-concept (Oyserman, 2012).

The self-concept shapes experiences and motivates action; hence it has been referred to as the 'theory of self' since it represents and organises current self-knowledge and guides how new self-knowledge is perceived (Epstein, 1973). This does not necessarily reflect one's abilities, competences, and self-worth (Oyserman, 2012). Additionally, the self-concept provides and maintains a cognitive anchor; a way of making sense of who one is and, therefore, what to expect from oneself and others (Oyserman, 2012).

Conclusion

The literature discussed above provided a timeline perspective on the history of the understanding of psychosis; the first theories proposed by central figures, the radical shift of the antipsychiatry movement, and the move to a deeper understanding of the patients' phenomenological experience and how it moulded their sense of self and identity.

It is clinically relevant to glean a deeper understanding of the FEP because there is evidence that the earlier the intervention the better the prognosis, the less familial disruption, and distress together with decreased need for hospitalisation (CAMH, 2015). Giving a voice

to the patients' phenomenological meaning of their stories behind their experience of the FEP serves to better understand and meet their needs. Ambiguities often characterise patients' stories; a combination of doubts about their fears and abilities, and their feelings of being underestimated and unvalued by professionals who failed to hear their chaotic stories (Abma, 1998).

The literature review was aimed to serve as a conceptual framework for conducting my research and a backdrop against which results can be considered. The succeeding chapter will provide a detailed explanation of the methodology employed.

Chapter Three – Methodology

Introduction

In this chapter I will be presenting a detailed description of the methodology employed in this research. I will outline the research question and the main aim of the research. Subsequently, I will discuss the rationale behind using a qualitative research method and the reasons for using a narrative analysis. Furthermore, I will be stating my position as a researcher.

In part two, I shall outline the research process, including recruitment procedures followed, access to participants, and inclusion criteria. I shall explain the process of data collection and analysis, ethical considerations, credibility and trustworthiness of the study, and the invaluable role of researcher reflexivity.

Part One - Methodology

The research question, aims and objectives

The diagnostic process is often conducted at the expense of gathering the subjective experience of individuals. Following Jaspers' phenomenological inquiry which was discussed in the previous chapter, my research will aim to elicit the idiosyncratic, phenomenological understanding of individuals who have experienced the FEP with a history of substance misuse and who are presently free of psychotic symptoms.

The overarching aim of the study will be that of gleaning the constructed life story of the participants and to detect any changes in the life script or selfhood of the individual that may have occurred as a result of a FEP with a history of substance misuse.

Research in the area of FEP seems to be mostly focused on symptomology, diagnosis, and treatment. Literature on the clients' experience of the FEP seems to be more focused on their perception on inpatient services (Koivisto, Janhonen, & Vaisanen, 2003; Tidefors &

Olin, 2011).Other studies have focused on the relationship between the FEP and substance misuse, particularly cannabis, claiming that there seems to be evidence for both an increased risk and poor prognosis (Archie et al., 2007; Van Mastrigt et al., 2004; Margolese et al., 2004). There seems to be a research lacuna with respect to the impact on the individual's life story and selfhood following a FEP.

Research shows that admission to a mental health hospital is often the first psychiatric contact for an individual with a FEP (Whitehorn, Richard & Kopala, 2004). Hospitalisation is established as being a vital intervention for many reasons, including the provision of care where medication can be easily administered, a respite from various stressors and as a source of escapism from society where their behaviour could create friction (Fuller Torrey, 2001). This research aims to address the gap in the literature by focusing on the participants' phenomenological narratives that will be elicited from their language and therefore understood from their subjective world-view (Bracken & Thomas, 2005).

The qualitative approach

My primary interest in this research is the subjective narrative of individuals who have experienced a FEP with a known history of substance misuse. I shall analyse the process and content of the individual's life stories, their coherent and ‘frozen’ narratives, as they recount their idiosyncratic experience of their FEP (Dallos & Vetere, 2016). A qualitative approach to this research is thus necessary since it gives the researcher a deeper understanding of a complex, idiosyncratic phenomenon (Dallos & Vetere, 2005).

Qualitative research methods share the common fundamental assumption that there are no universal truths or one objective reality (Lyons, 2007). Hawking and Mlodinow (2010) argued that what one determines as his reality is a subjectively constructed model that has

been formulated through a process of interpretations of events. Such an understanding of a subjective reality goes back to William Thomas's pioneering work in 1928. He argued that:

> "If men [sic] define situations as real, they are real in their consequences." (Thomas & Thomas, 1928, p. 572).

Qualitative researchers believe that knowledge itself and the production of knowledge is context-specific. Qualitative methods in research are focused on the interpretation of a phenomenon in its natural setting and are aimed to make sense in terms of the meaning individuals attribute to such setting (Denzin & Lincoln, 2007). Moreover, researchers have an active role since together with their participants, and any other related individuals, groups, ideologies, and social structures are dynamic and fundamental parts of the context of the phenomenon under investigation (Dallos & Draper, 2010). As Willig (2013) noted, the qualitative researcher aims to understand "what it is like" for the participants to experience particular situations and subsequently, how they manage such situations (pp. 8).

Rationale for using narrative analysis.

The overarching aim of my research is to glean the participants' constructed life story through how they experience their selfhood and any possible changes to their life-script following their FEP. Quantitative methods, although useful in studying aggregates, do not permit a deeper understanding of one's sense of selfhood, meaning, intention, and experiences (Heron, 1992). Although different methodologies were considered for this study, such as interpretative phenomenological analysis (IPA), narrative analysis seemed to be the most appropriate. Ricoeur (1989), stated that there is no other way for us to describe a lived time other than through narrative. Apart from describing events that have occurred, narratives can also depict imagined potential futures (Sammut, Foster & Andrisano-Ruggieri, 2016). Narrative analysis is thus adequate to answer the research question because apart from

understanding the meaning participants attributed to a lived time, it looks at the construction of stories and any possible changes to their life "script" (Byng-Hall, 1995).

Clandinin and Connelly (2000) explained that stories allow for an understanding of the subjective meaning, and as the story unfolds, the sense of self and identity are negotiated. They stated that stories facilitate the researcher to outline intricate patterns, descriptions of identity construction and reconstruction, and evidence of social discourses. These factors are considered to be significant for individuals as they impact on their creation of knowledge based on specific cultural perspectives. It was therefore considered that narrative analysis seemed most suited to address the research question and to reach the aims and objectives of this study. Furthermore, as outlined in the previous chapter, diagnosis being a productive agent in giving the individual a new sense of identity, narrative analysis is in line with such conceptualisation since it aims to better understand the manner in which participants construct their selves through their stories.

Epistemological reflexivity.

Epistemology is concerned with questions about how reality can be known, the interdependent relationship between the knower and what is known, the process of knowing and the process of gathering findings that are laden into specific principles, assumptions and beliefs. Consequently, epistemology is concerned with the possibility of such complete process being shared and repeated by someone else to assess the quality of the study and the reliability of same findings (Vasilachis de Gialdino, 2011).

In contrast to epistemology, epistemological reflexivity is neither a normative nor finalised discipline (Miller & Fredericks, 2002). Epistemological reflexivity poses questions that elicit the researcher's reflexive process on issues such as, how could the research question possibly defined and limited the findings; hence, the process through which the

design and method of analysis chosen for the sturdy constructed the data. It encourages the researcher to reflect upon whether the research question could have been investigated differently and if so, whether different approaches of investigation could have yielded a different understanding of the phenomenon under research (Willig, 2013). Specifically, epistemological reflexivity encourages the researcher to:

> "reflect upon the assumptions (about the world, about knowledge) that we have made in the course of the research, and it helps us to think about the implications of such assumptions for the research and its findings" (Willig, 2013 p. 10).

Social constructionism underpins the narrative approach. It underscores the fact that perception and any other human experience are grounded in history, culture and linguistics (Willig, 2013). Therefore, one's perceptions and experiences do not reflect direct environmental conditions but have to be understood as a specific reading of such conditions. Moreover, social constructionism is grounded in the idea that there are 'knowledges' rather than 'knowledge'. Language is considered to be pivotal for socially constructed knowledge; hence, the relevance to narrative analysis. The same phenomenon or event can be described by different narratives, which consequently give rise to different ways of understanding and perceiving, yet no narrative is right or wrong (Willig, 2013).

In narrative analysis, the researcher tends to adopt a phenomenological approach since his/her primary interest is to elicit knowledge about the subjective experience of the participants. Even though the researcher captures something that exists in the real world, mainly the participants' perceptions, feelings, thoughts, and lived experiences, s/he does not make any judgment over the cause and effect of these factors that constitute the participants" experiences (Willig, 2013). The researcher would be gathering phenomenological knowledge; knowledge of the quality and the texture of the experience itself.

In line with the above, it is pertinent to mention that Field Theory, which was developed from Phenomenology in Gestalt therapy, informs my understanding of the world and consequently, my research. Field theory in Gestalt therapy is a method of exploring which describes the field as a whole and subsequent events as part of the current field that they are happening in (Simkin, 1981). Parts in the field are in an immediate relationship and responsive to each other; therefore, what goes on in the field influences the parts interdependently (Yontef, 2005). Individuals are considered to constitute a field in their life space at any given time. Yontef (1993) described the field approach as descriptive rather than speculative with ultimate emphasis on observing, describing, and explicating the exact structure of what is being studied. Hence, as a Gestalt therapist, I believe that everything that happens in the field is relational, and this belief has inevitably permeated my approach to the study, my choice of research question, my choice of approach, and consequently the process of data collection which is a relational process in itself.

Axiology – the wold view of the researcher.

In research, axiology refers to "what the researcher believes is valuable and ethical" (Killam, 2013 p. 6). Ethical beliefs are grounded in the research paradigm itself and guide the researcher's decision-making process. Throughout the research process an axiological inquiry needs to balance what the researcher values with other ethical considerations (Killam, 2013).

Based on my beliefs and views about the world, I trust that narrative analysis fits my belief system; thus, guiding my positioning as a researcher. Being a gestalt psychotherapist, I adhere to the fundamental therapeutic stance of being fully present with the clients, moment-by-moment, with whatever emerge and suspend ideas or judgement about what they should bring up or impose on the direction therapy should take (Hycner, 1991). I believe that my psychotherapeutic background and being a clinical psychology trainee mirrors my critical-realist position as a researcher.

In line with this approach, narrative analysis can be conducted through a single-question-interview which allows the participant to unveil experiences and recount them in any manner they chose themselves; hence, freely decide what is essential to recount or not (Flick, 1998; Boyatzis, 1998). In gestalt therapy, the therapist adopts a 'confirmation' stance which involves the willingness and the capacity of the therapist to listen and attend to what the client brings as to understand his/her uniqueness and experience (Clarkson, 2014).

I also adhere to the phenomenological stance in Humanistic-Existential therapies, primarily Gestalt, which is grounded in the ideology that the experiences of others can only be understood if one approaches them with an "open mind and genuine curiosity, where nothing matters except the discovery of their personal experience" (Joyce & Sills, 2010 p. 20).

Nonetheless, I believe that the researcher's values and belief system cannot be entirely omitted from the research process. This idea is core to constructivists-interpretivists who argue that the researcher needs to acknowledge, describe and bracket his/her values and beliefs but cannot eliminate them (Ponteretto, 2005). The epistemology behind the constructivist approach consists of an in-depth, prolonged interpersonal contact with the participants to support their construction of a 'lived experience' (Ponteretto, 2005).

Husserl's notion of bracketing referred to the suspension of presuppositions, assumptions, judgments, and interpretations which allow the researcher full awareness of what is actually before him (Willig, 2001). Heidegger moved away from Husserl's descriptive commitments and transcendental interests towards a more wordily and interpretative position focusing on understanding perspectival directedness of the researcher's involvement in the lived world; something which is personal to each one of us (Smith et al,

2009). Therefore, I believe that my cognitive processes and interpretations have a large bearing on the work.

Given the above, I can state that narrative analysis fits both my views about reality and the world and also my beliefs on how I can gain the knowledge I am seeking through this study.

Narrative research

Todorov (1979) defined a narrative as divided into two parts; it begins with:

> "equilibrium, where everything is balanced, progresses as something comes along to disrupt that equilibrium, and finally reaches a resolution, when equilibrium is restored" (p. 138).

He continued by stating that the shift between the first and the second part of the narrative is represented through the different instabilities, changes, and the new equilibrium is reached in the second part. In contrast, Bruner (2002) defined the structure of a narrative as having a sequence of events, mental states, and involves human beings as characters or actors. He added that every individual was born with a unique set of predispositions to think and interpret the world in a specific manner; hence, one acts upon those interpretations. Such interpretations are of fundamental relevance to the researcher whose primary interest is to gather narratives as recounted through the voice of their participants (Bruner, 2002).

Narrative research was defined as a way of understanding experiences through a collaborative process between the participants and the researcher in a specific time, place, social interactions, and social environment (Clandinin & Connely 2000). Narrative inquiry can be summarised as embracing narratives as both their method and phenomena of the research study (Pinnegar & Daynes, 2007).

Philosophical roots and influences of narrative research

Narrative analysis has its roots and influences in various theories and philosophies. In parts of the literature, narrative analysis was defined as an extension of literary theory while in other articles it was explained as an extension of ethnography or even as stemming from psychoanalysis (Mitchell & Egudo, 2013). Gergen (1998) explained that the basis for application and understanding of narrative methodology is rooted in postmodernist thinking and social constructionism.

Postmodernism.

As a philosophical way of thinking, postmodernism came into use during the late twentieth century and started to question the predecessor modernist philosophy which was formulated around the assumption of rationality and universal truth (Engholm, 2001). Postmodernism called for an ideological critique of foundational knowledge and privileged discourses and questioned the notions of truth, certainty, and objective reality. Ferrier (1998) outlined the following seven major emphases of the postmodernist philosophy:

(i) contextual construction of meaning in that multiple perspectives are valid,

(ii) the construction of knowledge by individuals or groups of individuals,

(iii) reality is multiperspectival,

(iv) truth is grounded in everyday life and social relations,

(v) life is a text, but thinking is an interpretative act,

(vi) values and facts are inseparable, and

(vii) science and any other form of human activity are value-laden.

Such philosophical principles have been put into practice since narratives are a source of identity construction (Czarniawska, 1997). Other studies have shown that stories contribute to sense-making and act as a foundation for a better understanding of a lived phenomenon

(Gabriel, 1998). Moreover, stories can become instrumental in constructing and communicating meaning and impart knowledge. Stories that are shared within their cultural context could contribute to the construction of an individual identity or the concept of a community (Mitchell & Egudo, 2013).

Social constructionism.

Social constructionism adopts a critical stance toward 'taken-for-granted' knowledge, ways of understanding the world and ourselves, criticising the notion that "our observations of the world unproblematically yield its nature to us" (Burr, 2015 p. 2).Social constructionists believe that one's ways of understanding are products of that same culture and history which are interdependent to specific social and economic situations that prevailed in that culture at that specific time (Burr, 2015). It postulates that knowledge is sustained by social processes which in themselves bring about various possible social constructions of events, inviting people to take different kinds of actions (Gergen, 1998).

Narrative analysis is conducted through the way the researcher understands "how the protagonists interpret things" (Bruner, 1990 p. 51). It is appropriate to study the participants' sense of identity and subjectivity since it is grounded in the foundations of imagination and the human involvement in the construction of the story itself (Mitchell & Egudo, 2013). Similar to the social constructionists' position, Rosenwald and Ochberg (1992) explained that through one's story and the way of narrating, the researcher could analyse how the narrator's values, issues, and beliefs are culturally and historically contingent.

Literature outlined other philosophical roots and influences of narrative research. Some of which are Dewey's theory of experience (1938), literary theory, and influences from the history of psychology. These are presented in *Appendix L*.

Historically it seems that there was a pendulum swing away from Freud's case study approach toward quantitative studies and again, toward ideographic studies. Quantitative studies, although generalizable, did not adequately study ideographic phenomena. Salvatore and Valsiner (2010) argued that scientific knowledge could be pursued through the individuality of social and psychological phenomena; highlighting that generalisation is conceived through uniqueness (as cited in Catania & Darmanin Kissaun, 2016). Valsiner (2007) coined the term *idiographicnomothetic* indicating that idiographic methods seek generalised knowledge through the study of a single, unique specimen in their specific dynamic contexts (Ponterotto, 2005 as cited in Catania & Darmanin Kissaun, 2016).

Part Two – Methods

The research process.

Recruitment of participants.

Inclusion criteria. I took several measures to ensure that the inclusion criteria would safeguard the participants' safety and psychological well-being. Participation was open to any gender between the age of eighteen and thirty-five. By the time of the interview participants were to have experienced one psychotic episode with a known history of substance misuse. Participants were eligible to participate if their psychotic symptoms were fully remitted for a minimum period of one year. In order to minimize the possibility of risk or harm to the participants, as far as this was possible, participants with a co-morbid diagnosis were excluded

Access to participants. Following the approval from several organisations and mental health services, participants were recruited from OASi Foundation, Richmond Foundation, and Mental Health Services. The recruitment letter (Appendix A) was sent to the respective organisation's gatekeeper; a psychiatrist or a psychologist, who ensured that the potential participants fit the inclusion criteria. Gatekeepers assessed whether participants were

cognitively intact, articulate, and able to withstand the interview without experiencing undue distress.

The initial contact was made through gatekeepers who were not members of the team that I form part of at MCH. They assured the potential participants that their participation was entirely voluntary in order to reduce the risk of coercion. During our initial telephone conversation, I provided the participants with a detailed description of the study and a brief overview of the interview. I also addressed any concerns they had. The table below illustrates the demographic details of the five participants. In order to protect the participants' anonymity, pseudonyms were given.

Table 1: Table of Participants

Name	Age	Gender	Occupation	Relationship status
Bobby	21	Male	Factory worker	In a relationship
Mario	35	Male	Chef	In a relationship
Sam	23	Male	Student	Single
Frank	22	Male	Family business	Long-distance relationship
Brandon	25	Male	Student	In a relationship

Constructing the interview guide.

The interview guide was adapted from *The Thought Disorder Questionnaire* (Waring, Neufeld, & Schaefer, 2003) & *The First Episode: Psychosis NAMI Survey* (The National Alliance on Mental Illness, 2011). Most of the questions were adjusted in order to focus on the participants' idiosyncratic experience. Participants were asked to bring two photographs: one which was taken recently and another which was taken some time ago. Three of the participants did not bring any photographs.

The interview guide (Appendix G) was based on two fundamental factors. First, the semi-structure interview was based on Wengraf's Single Question aimed at inducing a Narrative (SQUIN). Such method allows the participants to generate stories and stimulates them to speak without being interrupted (Wengraf, 2001). Secondly, both the attitude adopted during the interview and the questions themselves were based on the BPS (2014) principle that in relation to functional psychiatric presentations, one should avoid the use of diagnostic language.

Data collection and analysis

Following the participants' written consent (Appendix E), data was gathered through a one-hour one-to-one semi-structured interview, which was audio-recorded and transcribed verbatim. Participants were offered the possibility of holding the interviews on the premises of the service from which they were recruited in order to prioritise their safety and to help them feel at ease. Participants opted for this arrangement.

I went through both the transcripts and the audio-recordings for several times as to remain faithful to the participants' narrative. As explained in Part One of the methodology, a narrative analysis was adopted for each interview. This was done by following the method proposed by Vetere and Dallos (2016) whereby the narrative method is divided into three major parts: thematic analysis, structural analysis, and process analysis. They proposed that incoherent memories, lack of detail, verbal connection, and clarity are responses to unprocessed trauma. Therefore "frozen narratives" are explained as trauma memories in which the individual is in a traumatised state of mind (Dallos &Vetere, 2005).

I thus elicited dominant narratives and subsequent narrative themes (Vetere & Dallos, 2016). In structural analysis, narratives were summarised in terms of structure. This process included considering, for example, coherence and clarity of the story and details about the

timing of the events within the narrative (Vetere & Dallos, 2016). The absence of these characteristics is indicative of a frozen narrative. I also considered whether the story was directed towards ideas of how to manage current difficulties and anticipate future issues, a process which, as Vetere & Dallos (2016) stated, requires the researcher to look into resolution.

Process analysis as proposed by Vetere and Dallos (2016) for systemic therapy includes an analysis of how, for example, family members interact, how they clarify their intentions, and how they get their point across. Being a gestalt psychotherapist, I have adjusted the above method to a phenomenological frame that is based on careful attention to the participants' idiosyncratic experience, including how the researcher experiences it within their co-created process; and what is happening in the in-between from the participants' and researcher's perspective (Yontef, 1993).

Ethical considerations.

Various measures were taken to safeguard the participants' safety, anonymity and emotional well-being. Interviews were conducted after obtaining UREC's approval and other necessary permissions from the respective organisations. As explained above, participants were identified by a professional who ensured that they were in a position of recounting their experiences and able to understand the implications of their consent. Participants' emotional well-being was a priority to ensure that no harm would be done to participants; hence, the specificity of the inclusion criteria.

Brinkmann and Kvale (2008) spoke about the danger of semi-therapeutic relationships in qualitative research. They explained that the researcher could not engage in a therapeutic relationship to encourage participants to elaborate further on the information they provide. However, through their therapeutic approach, they can delve deeper in an ethically

appropriate manner. Using therapeutic skills, such as empathic reflections can have significant benefits when researching sensitive issues (Coyle & Wright, 1996). As a result of my training in psychotherapy, I was careful to retain an empathic, neutral, and non-judgemental stance. Moreover, I deemed it necessary to remind the participants of their right to skip any question or even withdraw from the study at any point without the need to justify themselves.

Participants had the opportunity to go through the recruitment letter and discuss any concerns. They were asked to sign a consent form, which gave them the reassurance of anonymity and also the right to withdraw from this study at any point. This was done after we went through an adapted version of The Older Adults' Capacity to Consent to Research scale (OACCR) (Appendix C) as a screening tool to substantiate ethical consideration (Lee, 2010).

Audio-recordings will be destroyed following the dissertation assessment purposes. Following each interview, participants were asked to choose a pseudonym; a fictitious name that was only shared between the researcher and participant. In this way confidentiality was ensured throughout the research.

Reflexivity.

Denzin and Lincoln (1994) argued that in social sciences, the researcher could not help engaging in interpretation, as nothing speaks for itself. They explained that researchers learn about the research method through their reflections about how they make sense of their lives. This applies to qualitative research since the researcher is the primary research instrument (Vetere & Dallos, 2016). It is necessary for the researcher to make a critical evaluation of, for example, the co-constructed process during the interview, the cultural context in which the story was being narrated and took place, the purpose of the story and why it was narrated in that manner (Vetere & Dallos, 2016).

Throughout the research process I kept a research journal to log and reflect on my process as a researcher and write any reflections following each interview. Though the research topic was close to heart since I had been working with clinical populations, I am aware that due to unforeseen circumstances, my enthusiasm for the study was challenged. My motivation and determination were rekindled as soon as I started meeting the participants who trusted me with sensitive narratives about their life-story.

I struggled to maintain my empathic responses without intervening therapeutically and had to remind myself that my role here was merely that of an interviewer. However, I managed to maintain a safe, holding space and ensured that participants did not leave the interview with second thoughts or doubts. Participants voiced their appreciation of the opportunity to tell their stories.

Credibility and trustworthiness of the study.

Guba and Lincoln (1985) divided trustworthiness in qualitative research into four main concepts: credibility, dependability, transferability, and confirmability. Meyrick (2006) came up with his model for trustworthiness, which incorporated aspects from Guba and Lincoln (1985) and also from Yardley's model (2000). For my study, I decided to follow Meyrick's model (2006). The three models differ mainly in the terminology used rather than the method.

Throughout my research, I documented a detailed step-by-step process that allows the reader a clear pathway to follow through. Most of such process was outlined in the methods chapter. Such process included the aims and objectives of the study, theoretical framework, and the researcher's positioning. Moreover, readers can judge for themselves whether the narrative analysis was the appropriate methodology for my research. Moreover, Meyrick’s model refers to systematicity, what Guba and Lincoln (1985) refer to as credibility. Although

I have used a well-established method by Vetere and Dallos (2016), I did not engage in independent audit and respondent validation. However, some participants requested a confirmation of the excerpts used from their transcripts, which I provided.

Sensitivity to context was crucial since the study was conducted with a potentially vulnerable population. Mental health challenges often evoke negative emotional reactions such as, fear and pity; hence, mental health stigma remains the greatest obstacle to future progress mental health (Hinshaw, 2007). Moreover, one had to keep in mind how mental health challenges are conceptualised in Malta; a highly dense population where multiple relationships are more possible (O'Reilly Mizzi, 1994). Therefore, participants' anonymity was fundamental. I believe that my research was sufficiently sensitive to context (Meyrick, 2006).

Essentially, I was sensitive to all the participants' stories, maintained confidentiality, provided a safe space and pseudonyms were chosen by the participants as to preserve their identity. I used several verbatim quotes to ensure the participants' voice and remain faithful to their experience. Given that the data gathered was complex and profound, it allows the reader to determine whether the results could be transferable to other persons in a similar context.

I feel that the criterion of coherence, which Meyrick (2006) also believes contributes to strengthening trustworthiness, was fulfilled. This is as the philosophical perspectives underlying the methodology are consonant with the aims of the research question – namely that of uncovering the participants' phenomenological experience. Moreover, my positioning on the epistemological-ontological continuum is in line with the frameworks that inform my thinking – namely the phenomenological, dialogical, and field theory perspectives described above.

Conclusion

The chapter above provided a thorough presentation of the research process. In part one; I outlined the research question, rationale for using a qualitative method: specifically, narrative analysis, and my positioning as a researcher. Part two outlined the research process; access and recruitment of participants, constructing the interview guide, data collection and analysis, ethical considerations, reflexivity, and credibility and trustworthiness of the study.

In the following chapter, I shall present the results obtained from all the five semi-structured interviews.

Chapter Four – Results

Introduction

In this chapter, I shall present the raw data elicited from the interviews. I shall start with presenting a brief story about each participant and proceed with thematic, structural, and process analysis. In line with the method proposed by Dallos and Vetere (2016), thematic analysis is structured under three dominant narratives, each having three themes. Structure and process analysis shall be presented through an individual narrative for each participant.

Bobby.

Bobby is a twenty-one-year-old Maltese factory worker. He resides with his mother, step-father, and younger brother. Bobby has been in a relationship for three years and described his girlfriend as very supportive. Although he described himself as a reserved person, he seemed to be gregarious and engaged easily in the interviewing process. His sense of humour was prominent throughout the interview.

Brandon.

Brandon is a twenty-five-year-old undergraduate student. He is in a relationship and is expecting his first child. Together with his girlfriend, he resides with his mother and younger sister. Brandon's smile was captivating. One of the dominant themes during his interview was about self-image and identity; a theme which he seems to be working on at present. Brandon was articulate and reflexive throughout the interview.

Frank.

Frank is a twenty-two-year-old Maltese artist who leads a busy life. He holds two jobs; full-time employment in a family-run business and a part-time job in the catering industry. Frank lives with his mother, step-father, older sister, and two younger brothers. He

has been in a long-distance relationship for the past five years. He described himself as a joyful person who tries to balance work with leisure.

Mario.

Mario is a thirty-five-year-old Italian man who has been living in Malta for years. He has been in a relationship for the past ten years and has a one-year-old son whom Mario described as his primary source of motivation. Mario has led an independent life since he was sixteen years old. Recently his parents and his brother moved to Malta. Mario is employed in the catering industry but has tried his luck at running his own business more than once.

Sam.

Sam is a twenty-three-year-old postgraduate student who described himself as determined and hard-working. He is single and currently resides with his family of origin. Sam appeared to be intelligent and well-read. Despite the fact that one of the dominant themes within his story revolved around self-consciousness, he allowed me to witness his intriguing life-story. One of his greatest qualities seemed to be his perseverance in furthering his self-development.

Part One: Thematic analysis

The table below represents the three dominant narratives that were elicited from the participants' stories. The dominant stories were further divided into three themes.

Table 2: Table of Dominant Narratives

Dominant Narratives	Themes
Losing the grip	A film in graphic detail
	The demon that filled the void
	From illusion to reality
Me, us and them	The family and the outside world
	Road to recovery
	On becoming a patient
The Self	Who I was
	Who I became
	Who I am and wish to be

Losing the grip.

'Losing the grip' was a theme that emerged in the five interviews. Below, I shall present the participants' stories of 'A film in graphic detail', 'The demon that filled the void', and 'From illusion to reality'.

A film in graphic detail.

Most of the interviews were characterised by a detailed description of the participant's unusual experiences. Mario described at length one specific event which happened while he was living in London. He was travelling for three hours to a rave party with intense fear that "people were staring at me. And I was convinced that it was, kind of, a demon that was trying to get my soul". Mario explained how his paranoia made him believe that most of what was happening was part of a plan. He stated that the experience was "very very scary […], and if I think about how it was, it feels real". His fear in the story was intensified "because I am not a huge ten feet tall […] travelling alone in not the safest areas in London".

Frank narrated how although he had experienced his FEP three years ago, it still feels like yesterday. He compared his story with a movie scene *("xi ħaġa tal-films")* that was illustrated by means of elaborate detail.

> "tibda tagħmel ċertu affarjiet li tgħid "imma x`jien nagħmel" […] niftakar kont b`shorts, u ħrigt mill-bieb iġifieri niġri qisu biza' kbira ġo fija li hemm xi ħadd jiġri warajja" (Frank).

> *"you start doing things that you feel like "but what am I doing?" […] I remember that I was wearing shorts, and I went running to the door with an extreme fear that someone was running after me" (Frank).*

Frank explained how he used to speak about his late father; a topic he usually avoided. He explained how he used to share details about him with people who visited him while he was admitted in a psychiatric ward.

Brandon also shared a detailed narrative of visual hallucinations fuelled by an intense fear of being alone, and possibly dying. He explained how, following his FEP, he still gets overwhelming anxiety, sometimes escalating to panic attacks, when he is about to pass wind. Brandon described the experience as "traumatic". He explained how, during his psychosis, he believed that he saw "a spirit" coming out of his cousin's mouth soon after he had passed wind.

Sam's narrative was the most detailed. Despite feeling slightly overwhelmed, he provided a detailed account of his experience. Comparably, Bobby shared minor details about his experience.

> "Kont naħseb li vera madwari qed jiġri dak li qed naħseb. Qisni, ma kontx għadni fir-realta'. Fis-sens, bdejt naħseb affarijiet li mhumiex vera." (Bobby).

> *"I used to think that everything I was thinking was actually happening. It's like I was detached from reality. I mean, I used to think things that weren't true" (Bobby).*

The demon that filled the void.

Participants provided a genuine narrative about substance misuse; including details of the substances and amount consumed. They recognised that cannabis could have been the primary contributing factor to their psychosis.

Bobby explained how he started using cannabis when he was thirteen and how he only managed to stop when he started having paranoid delusions. He stated that his advice to someone who might be going through a similar experience would be to avoid substances since there is nothing good about them *("Sustanzi ma jużax, dawk ma jagħmlu l-ebda ġid").*

Mario spoke freely about his substance and alcohol use as a way of bolstering his confidence. "It used to make me believe that I was a nice man to spend time with". He acknowledged that at one point he used to consume considerable amounts of cannabis. Similar to Bobby's perspective, Mario stated that "whoever tried substances, they will know that, eventually, that kind of event might happen". Similarly, Frank considered cannabis use as the primary "triggering factor" to his FEP.

> "tatni tisbita għal ġol-art u naħseb ħafna aktar l-isfel … dawk l-affarjiet li għamilt qabel ma naħsibx li ħa nerġa' nagħmilhom għax għandi biża' ġo fija li nispiċċa nerġa' ngħaddi minn li għaddejt" (Frank).

> *"A big blow to the floor and even way deeper than that… the things I've done before, I do not think that I will do them again because I have a fear within me that I would end up having to go through the same experience" (Frank).*

In his narrative of substance misuse Brandon frequently associated it with “filling a void”. He spoke at length about his cousin whose dominant sense of identity is smoking cannabis; hence, describing him as an “empty shell”. Brandon developed an overwhelming fear that he “would go back to that situation”, a fear also voiced by Frank. Brandon spoke of periods when he could not tolerate the smell of cannabis and still avoids conversations about substances.

The theme of substance misuse was presented compellingly in Sam's story. He stated that there was a significant increase in cannabis misuse before his “psychotic break”. He explained that “I don't like to point the blame solely on a substance. Because when that happens, it really dehumanises the experience”.

From illusion to reality.

“Losing the grip” was made up of substantial details about the first stages of becoming aware of the participants’ mental state and ultimately realising that their perceptions, thoughts or emotions were unusual. Bobby narrated how he started having second thoughts about his delusions, aided by the fact that his family members had started drawing his attention to them. He explained how at the time their comments were met with hostility (“*dak iż-żmien kont noħodhom ħażin […] ġieli kienet taqbiżli u nargumenta, eżempju nkisser il-mobile*”). He added that his paranoid delusions were the main reason he stopped using marijuana.

Frank’s detailed story of realising that he was not well was followed by an urgent need for help.

> "bdejt naktja vera ħażin, id-dar għajjat u storbju [...] ma nafx kif iġifieri irrealizzajt li kelli bżonn l-għajnuna, u ma nafx kif mort ***[1] hemmek inħabbat għall-għajnuna" (Frank).
>
> *"I started acting really bad, chaos and shouting at home […] I don't know how I realised that I needed help, and I don't know how I went to ***, I went knocking at their door for help" (Frank).*

The 'Losing the grip' narrative dominated Brandon's story. It was quite challenging to decipher whether such parts of the story belonged to his FEP as such or to the anxiety he developed as a result of it. Brandon explained,

> "bdew jiġru affarijiet strambi ħafna, ejja ngħidu hekk. Hallucinations iġifieri" (Brandon).
>
> *"Strange things started to happen, let's put it that way. I mean hallucinations" (Brandon).*

Sam provided a vivid story of how he started to become aware of his delusions. "That point when you start to realise your delusions. It's like everything breaks". He explained that a turning point into becoming aware and realising what was happening to him was "the doctor's note" which he wished he did not read.

Me, us and them.

In the following narrative, I shall present the raw data that has been divided into 'The family and the outside world', 'Road to recovery" and "On becoming a patient".

[1] ** Name of service was removed to safeguard the participants anonymity

The family and the outside world.

In order to capture a visual illustration of the participants' support system and to facilitate such process, I followed Abbey and Dallos (2004) sociograms model; whereby, participants constructed two separate sociograms; one highlighted their significant others who were present at the time when they were ‘losing the grip’ and another one highlighted their life at present. Coins were used to represent their significant others and their perceived proximity as to how closely connected they felt at different points in time (Dallos & Draper, 2010). *Figure 2* represents the data collected from the sociograms. I will present the data gathered from each participant separately as to remain faithful to their experiences. Such results are illustrated in *Figure 3 to 7*.

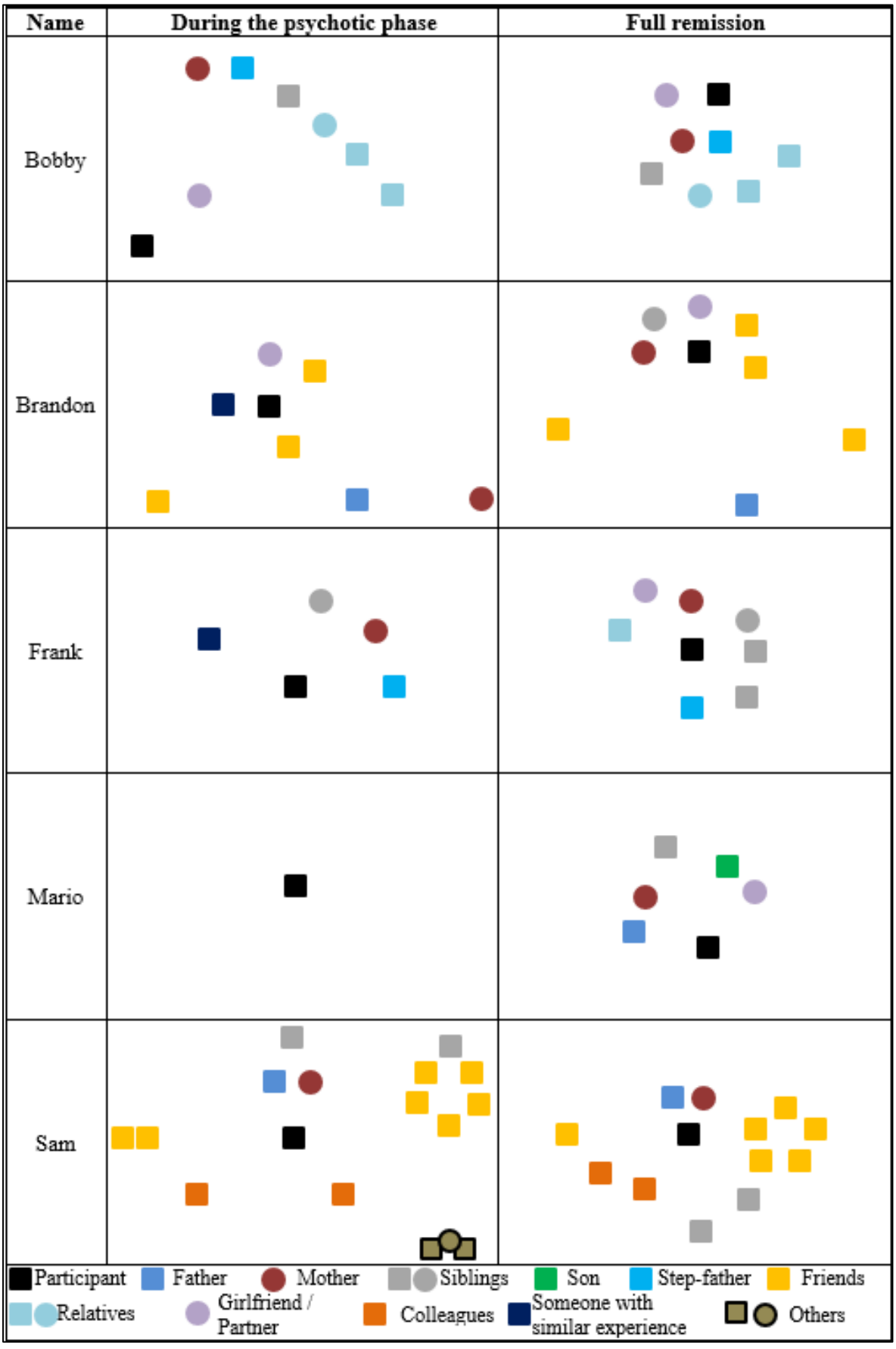

Figure 2: Sociograms

At first glance, *Figure 3* illustrates considerable difference between Bobby's sociograms in how he positioned himself and his significant others. He explained how, during his FEP, he did not feel the need to explain his unusual thoughts to them as he was convinced that they would not understand. Moreover, I could feel his sense of frustration as he explained how his mother used to try to persuade him to disregard his delusions. Bobby's frustration was masked with a sense of helplessness as he tried to communicate the depth of his struggles in fighting his delusions.

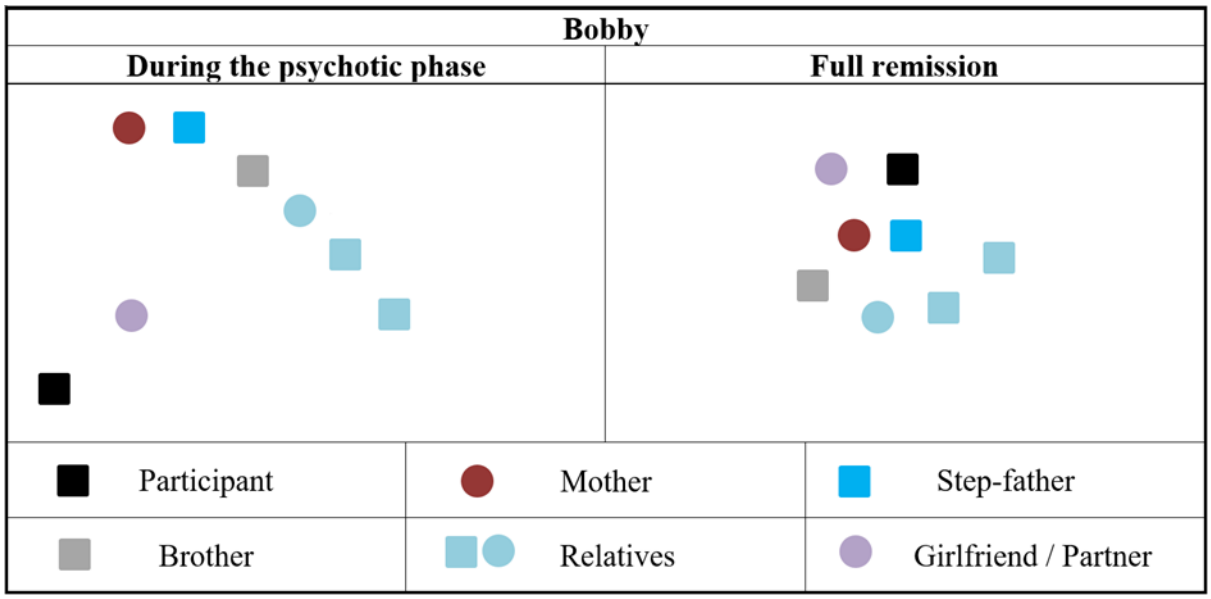

Figure 3: Sociograms – Bobby

There seems to be a substantial shift in the proximity of Bobby's relatives. In the second sociogram, Bobby placed himself at the top centre; a position that allows him some space.

Figure 4 illustrates the substantial changes in Brandon's support network and the level of connectedness with his significant others. He spoke at length about a close friend who also experienced a FEP and whom he described as more like a "son".

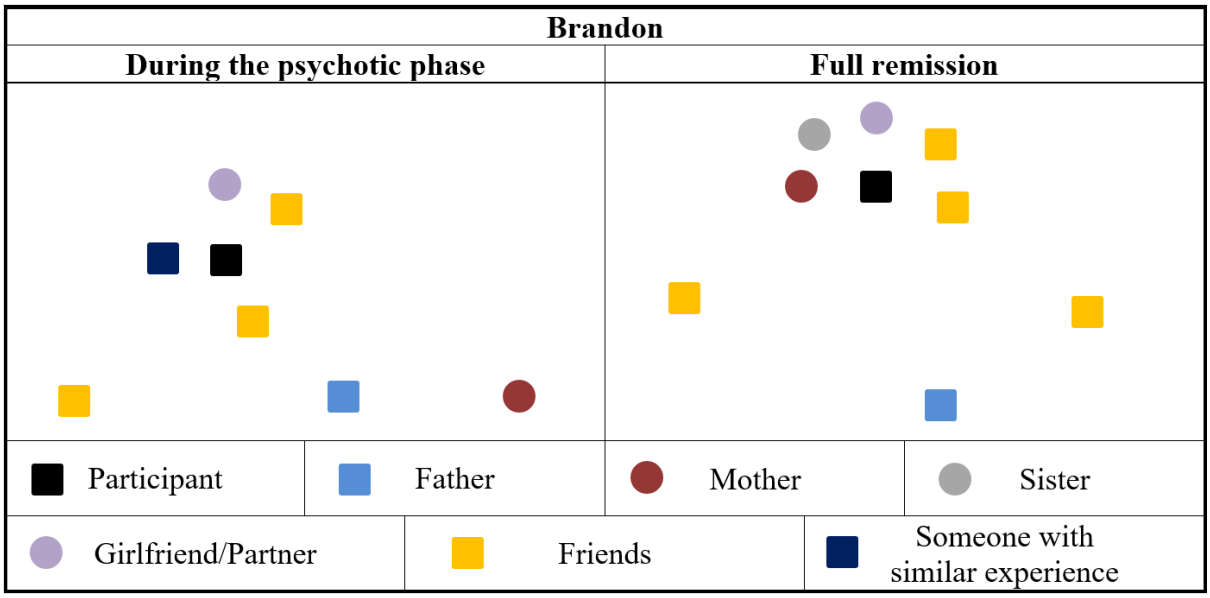

Figure 4: Sociograms - Brandon

Brandon shared several anecdotes about the relationship with his parents. He explained how he placed his mother at the far bottom right since he felt that at the time of his FEP, she pushed him away, and thus, Brandon left home to live with his father. In the second sociogram, while Brandon's mother was moved closer, his father is relatively distant; possibly indicating their “friend-to-friend” relationship.

Frank’s first sociogram illustrated his support network during the time he was admitted to hospital. He explained how the most significant source of support was provided by a friend who went through a similar experience. Furthermore, he highlighted his relative’s challenges and psychological pain in visiting him in a psychiatric ward; hence impacting their connectedness.

As illustrated in *Figure 5*, Frank’s second sociogram illustrates two noteworthy changes: his positioning and increase in support network. As opposed to his first sociogram in which he placed anyone else at a relative distance, in remission, he placed himself in the centre of his family. Frank stated that despite their closeness, he still prefers to face any potential difficulty on his own.

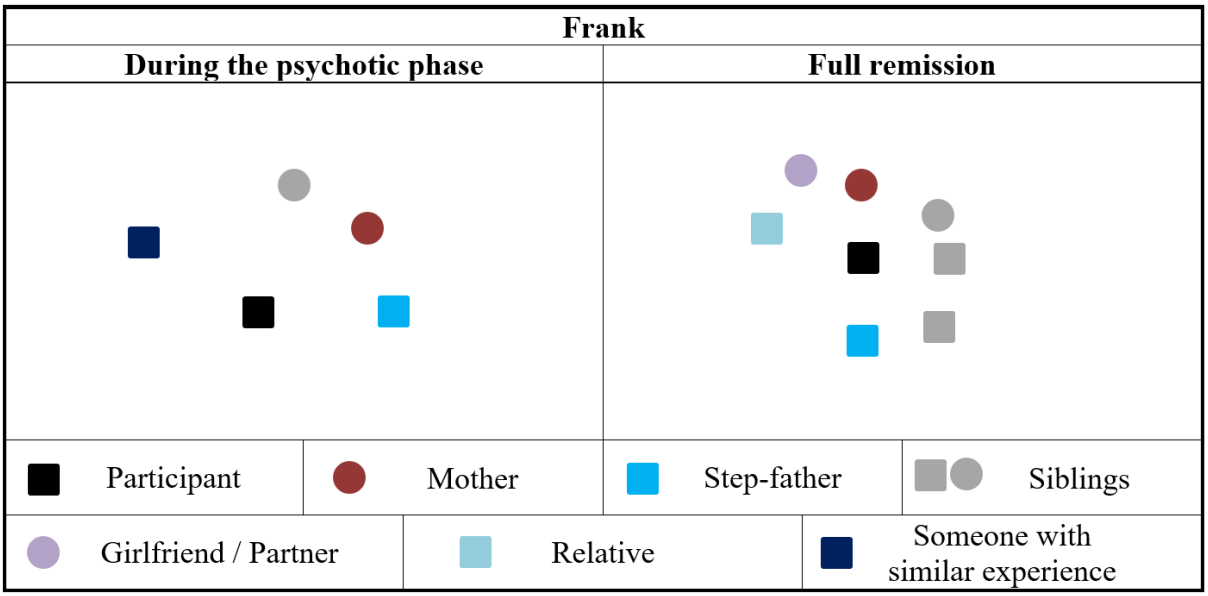

Figure 5: Sociograms - Frank

Figure 6 represents a striking shift between Mario's sociograms. Mario firmly stated that as he went through his FEP, which he described as "very scary", he felt "pretty much alone". Therefore, he did not include anyone in his first sociogram. However, at present, when he is fully recovered, Mario mentioned his parents, brother, partner and his son as his primary sources of support. Mario narrated how growing up alone could have contributed to his struggle in forming close relationships. Hypothetically, his positioning in the second sociogram could be indicative of the "wall" he had built between himself and his world around him.

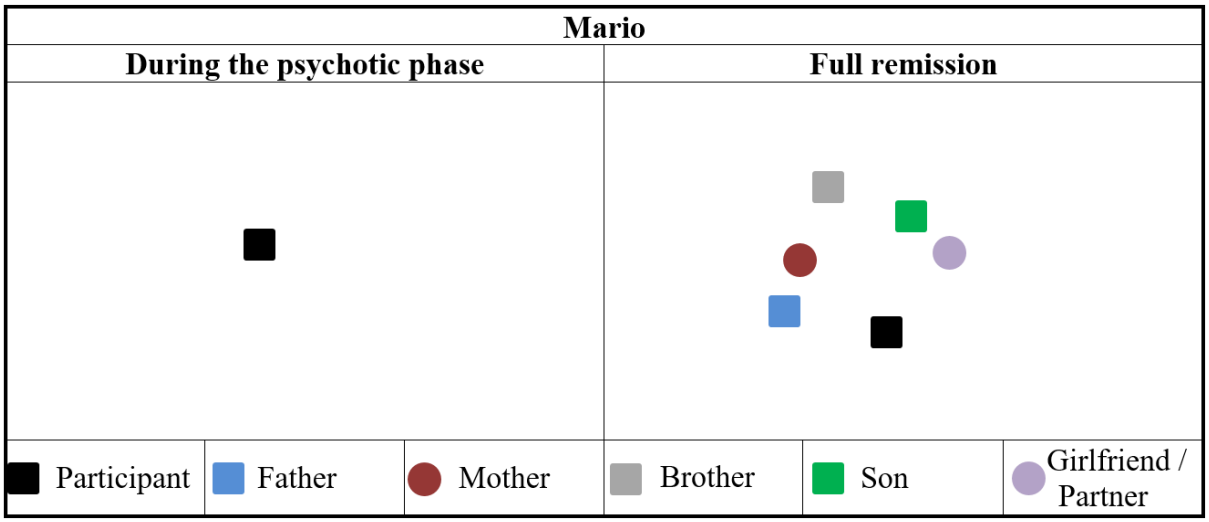

Figure 6: Sociograms – Mario

As illustrated in *Figure 7*, Sam included a significant amount of people who were present during his FEP. Considering that during such phase he wanted to transmit "a message efficiently and effectively", having so many people around was understandable.

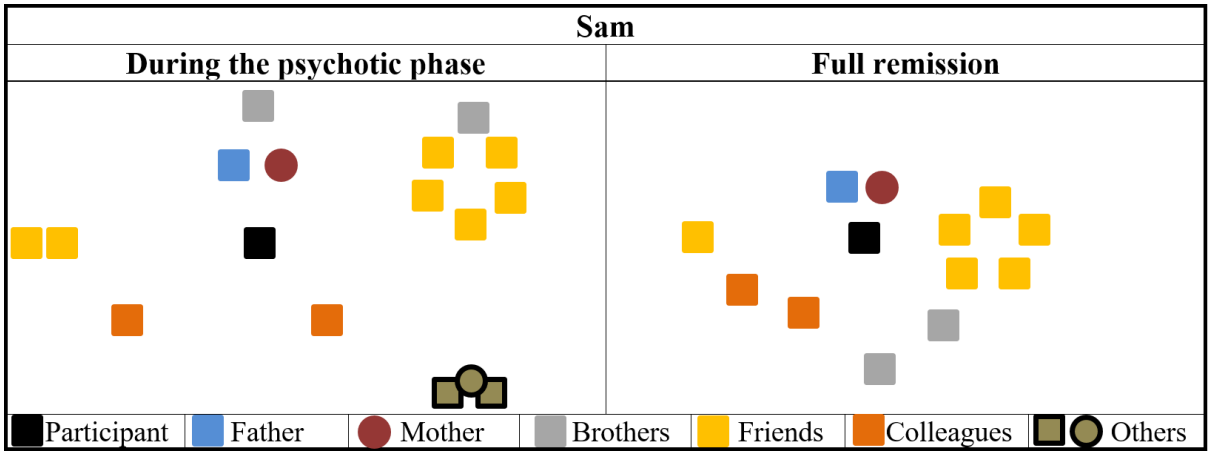

Figure 7: Sociograms – Sam

While constructing the second sociogram, Sam regretted having exposed himself to many people. Such exposure was magnified since he struggled with self-consciousness and an overwhelming fear of potential repercussions on his career. He explained how, throughout his recovery, his significant others became much closer. Sam found it challenging to rebuild boundaries which were socially adequate since through his FEP, he experienced a breakdown of boundaries that exacerbated his delusions of grandeur.

Road to recovery.

Participants narrated stories of their recovery process, a process that for some started soon after their FEP. Sam narrated how he "sought help at a relatively early stage". Similarly, Frank explained that he felt the need for help soon after his unusual experience started; hence, recovery was initiated following a conversation with a priest.

Sam explained how, at the beginning, his realisation that his thoughts "may not be rational", did not mean that "delusions ended; the delusions just shifted". He explained that recovery could never be achieved entirely since there is "a lingering fear of it happening again". Sam also referred to his emotional state in recovery which shifted from "let's do this", to "it started wilting". He acknowledged that recovery commenced when he "allowed other people and trusted them in taking over a little bit for a while".

Bobby outlined how, on his road to recovery, his girlfriend was the most supportive. Both Bobby and Mario narrated episodes during which their families pushed them to seek help. Despite recognising that his climax in recovery was when he was stabilised on psychiatric medication, Bobby spoke at length about the adverse reactions and his mother's perceptions, which possibly contributed to him stopping treatment.

> "ttik f'għajnek il-ħaġa, tgħidlek ejja ħu l-pirmli […] tħaxxen ħafna, ittik naqa f'għajnek kif tibda tinduna. Eżempju, jiena bdejt nispiċċa li torqodli idi" (Bobby).

> *"My mother used to bother me by saying come take your medication […] weight gain, as soon as you realise, it bothers you. For example, my hand used to get numb" (Bobby).*

Frank's road to recovery was characterised by a five-week admission to a psychiatric ward; a challenging phase on multiple levels.

> "Ma tantx kien hemm x`tagħmel. Anke meta nitkellem ma ċertu pazjenti li kien hemm hemm ġew, kont niżboxla" (Frank).
>
> *"There wasn't much to do. Even when I used to talk to certain patients there, I used to go nuts" (Frank).*

Brandon narrated a somewhat different recovery story. He narrated several scenarios which posed considerable stress to him following his FEP. His heightened anxiety resulted in:

> "Tara iktar kuluri vivid, il-movement tarah iktar ċar. Like I tried different techniques, breathing exercises […] Kont immur għand psychologist u psychiatrist" (Brandon).
>
> *"Colors become vivid. You start seeing movements in a clearer manner. I tried different techniques, breathing exercises. […] I used to go to a psychologist and a psychiatrist" (Brandon).*

On becoming a patient.

Sam's description of mental health services was very critical. Sam argued that "it was an environment to assess physical state […] it can definitely be improved". He also complained that the excessive noises made his situation worse.

> "I assume the curtains were drawn open so people can observe. […] I was seeing people going through and fro the corridor. And people were observing me, and it just contributed to the whole shit" (Sam).

Sam emphasised that waiting time for a follow-up was "too long". He firmly believes that the earlier interventions happen, the better for the patient's well-being. Sam concluded the interview by going into the stigma related to mental health. He explained how for someone who struggles with self-consciousness and experienced persecutory delusions, even

practical things such as the medical file could be “very scary because it can easily go in the wrong hands”.

Similarly, Bobby spoke about the shame and stigma related to mental health services. He explained that attending follow-ups was very difficult for him since he was afraid that someone would see him. It seemed like he identified with the diagnosis of schizophrenia, despite him having one psychotic episode.

> “Jekk tgħid lin-nies li għandek schizophrenia, anke kif tinstema’ jitwerwru. Ħdejn min għandu schizophrenia vera, ħdejnhom jien m’għandi xejn” (Bobby).
>
> *“If you tell people that you have schizophrenia, even the sound of it is terrifying. Compared to someone with real schizophrenia, I do not have anything” (Bobby).*

On mental health services Bobby remarked that often patients are followed by a different doctor for each follow-up appointment; hence, lacking the development of a therapeutic rapport. Indeed, Mario outlined that one of the essential factors with the services was the “constant meetings” he had with the same professional.

Lastly, when speaking about the effectiveness of mental health services, Brandon explained that “you need to help yourself as well. There is no cure per se. It’s more like a game of mental states”. Though he recognises the benefits of medication, Brandon explained that whilst they control your irrational thoughts, one’s emotions “get dumped”. He concluded by stating that “I want to be my own self, medicine should just help not define”.

The Self

The narrative of the Self is further divided into three dominant themes: ‘Who I was’, ‘Who I became’, and “Who I am and wish to be”. In the following themes, I shall present the participants’ stories.

Who I was.

Frank and Bobby narrated stories from their school years. They stated that they do not easily reach out. Bobby stated that he is quite carefree and tends to avoid arguments. Moreover, Mario explained how his former lifestyle used to fuel his sense of self and sustain his motivation. He then explained that "it was an illusion". Most of his stories depicted quite a lonely scenario since he used to live away from home and barely had friends. Comparably, Bobby explained that:

> "Dejjem dak it-tip li nagħżel ftit ħbieb. […] Ma tantx jien xi wieħed caring. Lanqas jien ħabib tajjeb." (Bobby).

> *"I was always that type with just a few friends. […] I am not a caring person. In truth, I am not even a good friend." (Bobby).*

Brandon and Sam shared the most details about their identity and sense of self. They were the only participants who brought photographs that helped to elicit rich data in this regard.

Brandon narrated how he used to lead a fast-paced life dominated by hard-core leisure. He described himself as having an "edgy" personality. Brandon spoke fondly about his first photograph, which was taken before his FEP. Brandon explained how he is making "drastic changes" to his lifestyle. Lastly, the theme of self-consciousness ran through Sam's narrative. He explained how he was comfortable with himself "but looking at myself through the eyes of the others, that is where things change".

Who I became.

Frank gave a detailed account of several changes in his sense of self. Since art is a fundamental quality to his sense of identity, Frank explained that following his FEP, he noticed that:

"Qisu kien hemm xi ħaga ġo fija li kont nesprimiha fil-pittura, anka d-daqqa tal-lapes qisha skura" (Frank).

"It's like there was something within me that I used to express in paintings, even the pencil shadings are darker" (Frank).

Furthermore, Bobby shared touching details of how much he wished to improve his family' situation at the time he started using substances.

"Xtaqt hekk, nagħmel xi ħaġa kbira. Nagħmel somma flus tajba. Essaċ mhux għalija ta għax xtaqt nara lill-familti f'pusizzjoni aħjar" (Bobby).

"I always wanted to accomplish something big. Make a big sum of money. As such, I wished to see my family in a better situation, not for myself" (Bobby).

Brandon's interview was characterised by much detail of who he had become following his FEP. He started experiencing anxiety, which was "going through the roof".

"kienu bdew ituni l-panic attacks imbagħad, qalbi tipo riedet toħroġ minn sidri ". (Brandon).

"I started having panic attacks; my heart was pounding out of my chest" (Brandon).

Similar to Frank and Brandon, Sam narrated several details about how he perceived any changes to his sense of self following his "psychotic break". He spoke at length about such experience which he described as a "huge shatter in self-confidence".

Who I am and wish to be.

Frank described how he perceives any changes in his sense of self following his experience. He stated that he is prioritising self-care and that he has become more aware of

his limits. Although Frank explained that he is quite an introvert and tends to face any potential issue on his own, he is trying his best to reach out to others if need be.

Mario outlined how his "life changed quite a lot by then. And I would say I am pretty happy and satisfied". He feels "calmer and more calculative". One of his goals is to improve his ways of relating to others since "friendships in life are a piece of my life that is missing". Mario explained how his "planning now is more achievable; more real"; yet, he still feels "not completely satisfied". Similarly, Bobby explained that he is not so interested in making money; instead, he is more sociable and somewhat less obsessive about things that used to bother him. Ultimately, he experiences himself as leading a more satisfying life and seems to be relatively future-oriented.

Brandon spoke about significant changes in his sense of self, especially since he will soon become a father. He explained how he is "trying to make a dividing line between who I was and who I will be":

> "meta jkolli l-baby ma rridx li nidher stramb, f'għajnejn in-nies" (Brandon).
>
> *"When the baby arrives, I do not want to look strange in the eyes of others" (Brandon).*

He stated that his FEP was a growing experience; "don't know who I'd be today. So that experience, defines who I am today". On the other hand, Sam described his sense of self as "definitely an ongoing process".

> "I like to think that I am an insightful person who is, who likes to be sensitive to other people […] how has the experience changed me on the other hand? I get to find out" (Sam).

Part Two: Structural analysis

Bobby.

In terms of structure, considerable parts of the interview were characterised by short-answer responses. Although the interview was semi-structured with open-ended questions, Bobby often responded with "yes" or "no" responses. Bobby stated that he is relatively withdrawn. His narrative flowed more easily when he was illustrating his support network through the sociograms. Nevertheless, there were some incongruent sentences*[2] as we spoke about the proximity of his significant others.

It is significant to comment on the elaborated details he shared about the two principal characters in his story: his mother and his girlfriend. He stated that he holds a good rapport with both of them and expressed gratitude towards the care and support they provide. Sentences in this regard seem to be integrated and comprehensive.

"ommi ma taffordjax, ħarġet taħdem u hekk." (Bobby)

"My mother does not afford much, she returned to work and so on" (Bobby).

"Tara li ma jonqosni xejn. Fis-sens għamilt sena ma naħdimx kważi."
(Bobby referring to girlfriend).

"She makes sure that I do not run out of anything. I was unemployed for around one year." (Bobby referring to his girlfriend).

In comparison to the other participants' narratives, Bobby gave the least details about his unusual experience which he described as "funny" while detailing how he perceives his personality. He elaborated on how he prefers having very few friends and about his determination to remain off-medication. Bobby smiled while saying that he does not have the

[2] *indicating the possibility of frozen narratives which will be discussed in Chapter Five since in this chapter I intend to remain faithful to the participants' experiences.

qualities of a "good friend". He minimized his experience of anger, and used negative adjectives when he described his brother; with or without being aware that earlier on he had stated that he was quite similar to his brother at his age.

> "Maqtugħ għalih. Naqra antipatku, qansħa, jieħu għalih mix-xejn. Rasu iebsa" (Bobby).
>
> *"In his world. A bit unpleasant, choosy, touchy. Hard-headed" (Bobby).*

When Bobby spoke about himself before his FEP, he described himself as "Kont qisni tifla. Kont sensittiv ħafna" *("I was like a girl. I was very sensitive").*

A dominant shift in the structure of his story occurred as he spoke about the lack of rapport he had with his late father. Consequently, long pauses and fragmentation of sentences were apparent. He explicitly stated that living with the awareness that his father remained distant still had its toll on him.

Lastly, a significant incoherence was noted as Bobby spoke about psychiatric medication*. He gave incongruent details and switched from stating that he had several unpleasant adverse reactions such as weight gain, later stating that he did not bother about such reactions. Bobby seemed to be highly motivated to better several aspects of his life and was fully aware of the possible future challenges he would have to face were he to increase substance consumption.

Brandon.

Brandon's narrative structure was highlighted by a detailed description of specific events. When asked about his life-story, Brandon skipped the first fifteen years of his life which he described as isolating since he did not have friends and spent most of his days at home. However, he chose one specific life-event which could have possibly been compelling.

> “l-ewwel ħmistax –il sena, l-ewwel ħaġa wara sebgħa snin ommi u missieri sseparaw” (Brandon).
>
> *“Let us say the first fifteen years, first of all after seven years, my parents separated” (Brandon).*

He continued by giving a brief description of subsequent years as characterised by leisure time, Brandon underscoring “I overdid it”. He seemed to be uncertain about how long such phase lasted and was continuously correcting the timeframe* of the plot. The timeline became more precise as he spoke about the last five years. The story became quite fast-paced, fragmented, and characterised by unfinished sentences while he spoke about clubbing and the hours he spent away from home.

The photograph that Brandon chose to bring with him was taken during this phase described above. While describing the photo, his sentences were somewhat incoherent*, yet he stated that it is a phase which gives him a sense of identity.

> “Dan ta’ qabel, meta kelli sixteen. Like dik l-iktar, like hawn as in, l-iktar fażi li I relate, mhux I relate to it. Li naraha jiena speċi” (Brandon).
>
> *“This is an earlier one, when I was sixteen. Like that is the most, Like here as in, the phase I relate to most, not I relate to it. I see it like it is me” (Brandon).*

He described the photograph with extreme details, perhaps indicating its significance. This photo can be considered as a representation of his former sense of identity. For instance, he described several physical features which he believed distinguished him from the people around him; features which he described as “my thing”.

There were specific instances when Brandon used powerful words and soon after he corrected himself, appearing to diminish the impact of the experience. This was highlighted as he spoke about his mother* with whom there seem to be unresolved issues. He used a similar technique when he spoke about the panic attacks he started having, following his FEP, which were visibly traumatic.

> "Imbagħad bdew ituni l-panic attacks u I just wrote them off like, u iva, like, fuck it" (Brandon).

> *"Then I started having panic attacks, and I just wrote them off like, so, like, fuck it" (Brandon).*

Brandon's narrative about his FEP mainly evolved around his visual hallucinations. He described these experiences in elaborate detail; including the people who were present, the dialogue between them, and the emotions he associated with the event. Such a story was also presented in fragmented sentences*.

> "rajt siġra tikber fil-kanturniera. Le kuġinwi ra siġra tikber fil-kantuniera pero' illum il-ġurnata jiena wkoll daħħaltha f'moħħi li qisni rajtha jiena" (Brandon).

> *"I saw a growing tree in the corner (pause) No my cousin saw a tree growing in the corner, but nowadays, I came to believe that I saw it" (Brandon).*

Brandon's narrative structure shifted as soon as he stated that his girlfriend is expecting their first child. His story evolved around his struggle to change his image and to adapt to a new sense of being which he experiences as incongruent with his former self-image.

> "jiena kelli esperjenzi fejn għax jarawni bil-beanie u b'naqra daqna. Kienu jiġu fuqi, "Hawn man. Isma inti għandek tbiegħ" […] meta jkolli baby ma nridx li nidher shady" (Brandon).
>
> *"I had experiences where because people saw me wearing a beanie and I grew a beard. People came to me like "Do you sell drugs" […] when I will have the baby, I do not want to look shady" (Brandon).*

The way he structured his present life-story mirrored his process of adapting to several changes in his sense of self.

> "who I am and who I will be. Like, ma nixtieqx li nibqa' dak it-tip ta persuna li kont qabel. So, I am changing physically, I guess, to change mentally" (Brandon).
>
> *"who I am and who I will be. Like, I do not wish to remain that type of person whom I used to be. So, I am changing physically, I guess, to change mentally" (Brandon).*

Lastly, Brandon seemed to be fully aware of the triggering factors that could have contributed to his experiences. Within his dominant narrative about the self there seemed to be a great sense of responsibility and an element of a 'saviour complex'.

> "I'm trying to get him off of the things he's taking […] I understand him by all means, just don't die" (Brandon about his friend).

Frank.

Frank's narrative presented a lack of chronological sequencing of events*. His story started with a sequence of present aspects of his life, such as his passion for arts. Although

Frank shared some childhood anecdotes, he rushed through the narrative and when I reminded him of the photographs, which he did not bring, he shifted to discussing his FEP.

Although Frank's story was dominated by details of unusual thoughts and perceptions, he could not recall the timeframe of these experiences. There seemed to be a sense of nostalgia in his tone. His precise detail* made the story appear as palpable as if it were taking place in front of my eyes.

One of the most dominant features of Franks' narrative structure lies within his sentence fragmentation*. A significant increase in fragmented sentences was observed as he spoke at length about his FEP. Moreover, he shifted from past to present tense as he went deeper into the story*.

> "Meta kont qisni qed ninqata' daqsxejn mir-realta'… ftit niftakar ta' […] jekk qed ngħid sew, dak inhar stess, dak il-lejl" (Frank).
>
> *"When I was like slightly detached from reality… I only remember some details […] If I am stating correctly, on the same day, that night" (Frank).*

The plot of his story comprehended an unorganised sequence* of events which was characterised by a continuous back and forth movement. Frank shifted his train of thought each time he remembered or felt comfortable to share further details of an experience he had already narrated. His plot took a striking shift and appeared to be more coherent as sentences became integrated when he spoke about his elder sister and the excellent rapport they enjoy. If one had to view Frank as the main character in his autobiographical narrative, his elder sister would be his alibi. , Lastly, Frank did not use any diagnostic labels or clinical explanations but used relatively neutral words or euphemisms* ("Meta ġrali li ġrali / meta ġara li ġara" "*When what happened to me, happened / when what happened, happened"*).

Mario.[3]

Mario did not bring any photographs for the interview. His narrative had a flowing structure. He took me back to when he was sixteen when he left his parents' home to study abroad. It seemed like the plot for his life-story started from then on; missing details from his childhood and adolescence*.

Mario gave a very detailed account of his late adolescence and early adulthood years. There were several instances when he took a retrospective perspective and recognised the difference between how he perceived his experiences back then and his perceptions of them in the present. In retrospect, he acknowledged that his lifestyle had possibly contributed to further difficulties.

> "I was twenty-years-old, alone in London doing whatever I want. I was literally living the dream. […] But in the long term, I did find myself not enjoying it anymore" (Mario).

The structure of his story reflects his overall awareness and ability to recognise and resolve issues that were pertaining to his state-of-being. He gave a very detailed and honest account of his former substance and alcohol misuse. His narrative followed a sequential pattern; details of an event, time and place, any thoughts and/or feelings that accompanied the event itself, and a critical account of the experience.

> "I used to think like "Ok tomorrow, I am going to do that". […] And then, in the end, I was doing nothing at all. It was an illusion*" (Mario).

[3] Mario's structural analysis has to be interpreted with caution since sentence fragments and other grammatical inconsistencies could be attributed to the language barrier.

Despite the language barrier, Mario's narrative was somewhat coherent. However, when he spoke about his paranoia, his sentences became somewhat fragmented* and he could not attribute such phase of his life to a specific timeframe.

> "After a couple of years, two, three years, it started the paranoia quite badly; I wasn't enjoying it anymore because I couldn't go out of my house" (Mario).

The most captivating part of Mario's narrative was when he spoke about one specific episode which he later discovered was his FEP. The details were so vivid that it seemed like he was reading a monologue in a script. Though at present, he is aware that it was probably cannabis-induced, he stated that the whole experience remains very real. The story was characterised by fragmented sentences*, extreme detail*, and an immense lack of chronological sequence*, possibly mirroring the chaos. Although he spoke in great detail of this episode, he got to a point when he could not articulate the word "paranoia"*.

> "That basically was the peak of the … of the, then I said "OK, no more marijuana" (Mario).

Most of Mario's narrative was detailed except when he spoke about his family of origin and his relationship with them. He shared some details about the relationship with his partner: yet, he acknowledged that it is "the strangest". The interview was entirely flowing with minimal pauses. There was a long pause* following the construction of the sociograms when I tried to explore the relationship Mario has with his parents and his brother, a relationship which he also described as "strange". He did not elaborate further.

Sam.

Sam's narrative structure was characterised by details of several experiences. The photos he brought facilitated a flowing structure through which he explained what was happening at the time the photos were taken. Notably, when he spoke about the surroundings

of the photo, the characters in it, the atmosphere and time and place; however, he gave minimal details of himself. He only made reference to himself as an afterthought: “And anyways, *dak jien* (that’s me)”.

He described the former photograph which was taken before his “psychotic break” with a sense of nostalgia and acknowledged the meaning it holds for him; a meaning he had underestimated. There was a shift in the structure of his sentences as he described the second photo which was taken recently following his FEP. Sentences became somewhat fragmented*, and he was unsure about the timeframe*.

> “But if I am not mistaken, it was probably around February. So, February means, I was well in to recovery. Much, yes February. Quite into recovery” (Sam).

Furthermore, when I invited Sam to elaborate on his experiences during the time gap between the photos, he seemed confused and stated that he would not know where to start. His sentences became further fragmented* as he moved on to the theme of self-consciousness.

He divided this part of his story into shorter stories as if he was reading separate chapters; the two primary ones were about delusions of grandeur and delusions of persecution. Another prominent chapter within his story was about what he called “the model”; a model of how to convey a powerful message to the people around him. He explained how, in his mind, such a model applied to every system. As he spoke about the model, there were several silent pauses*.

> “Of most, of whatever. Of most of the thoughts. By the end of the thoughts or of the delusions, it was tiring” (Sam).

As he moved on to share details about becoming aware of the delusions, his manner of narrating followed a sequential pattern. He shared the following metaphor to explain the moment he started to realise that he was unwell.

> "Can you bring that file from that cabinet?" And they just say, "There is no file in the cabinet. There has never been a file in the cabinet". So, then you're like, oh shit, what I am thinking, it may not be rational after all" (Sam).

Sam seemed to have reached a good sense of resolution: the way in which he acknowledged past difficulties and anticipated possible future ones. He was aware that substances could have been a contributing factor; "as soon as I was feeling off, I stayed away" (Sam).

As we tried to explore how people around him reacted and whether his needs were met, an element of doubt* characterised his narrative. Sentences became fragmented and influent*.

> "Probably I don't even know the whole story myself. But I have the clearest idea. I think everyone was closer. The challenge is to define which boundaries go where" (Sam).

A noticeable shift in the narrative structure occurred while Sam was elaborating on how he sought professional help. Throughout his life story, he spoke primarily about himself as the main character, emanating a certain sense of control over his life. However, a long silence* preceded a detailed description of how he allowed others to take over. It seemed like he shifted from being a strong character with a marked sense of control, to a secondary, more depleted, character in the story.

Ultimately, Sam narrated a coherent, detailed description of the "unsuitable" environment at the CRISIS Intervention at Mater Dei Hospital. It was evident that the experience he described remained imprinted in his memory.

Part Three: Process analysis

Bobby.

Since Bobby did not bring any photos with him for the interview, we moved to the SQUIN method which he found immensely challenging and found it difficult to share anything about his life story.

> "(Pawża twila) imma fis-sens… ma nafx vera x'se naqbad ngħid" (Bobby).
>
> *"(Long pause) But I mean…I do not know what I am going to say" (Bobby).*

In order to facilitate a flowing conversation and possibly, out of genuine care towards the participant, I supported him by providing several prompts that could have made it easier to elicit details of his life story. Bobby's sense of humour, also conveyed through his jolly tone of voice, shifted the atmosphere between us.

> "Kultant inkunu se nitqatlu… qisna tiġieġ […] ma nistgħux naraw lil xulxin. Imbgħad orrajt. Ma noqgħodux miegħajr xulxin" (Bobby).
>
> *"At times, it would be like killing each other… like chickens […] we cannot see each other, and then it is fine. We cannot stand being apart" (Bobby).*

At times Bobby spoke at length, and as a researcher, I intervened minimally. This could be observed whenever he was speaking about his former delusions and paranoid thoughts. His narrative was captivating and intriguing to me.

As soon as I acknowledged that in his first sociogram he had placed most of his family members at a distance, he became confused and stated that his efforts to explain what was going on in his mind would have been useless.

> "Le, uu iva. […] Għalxejn tispjegalhom hux. […] As such qatt ma pruvajt ta'" (Bobby).

"No, oh, yes. […] Explaining to them is useless. […] As such, I never tried" (Bobby)

I could see the pain in Bobby's eyes when he spoke about his childhood and how his late father had left them. I was touched by his memories of being an unseen child to his extended paternal family. Although his narration was fluent and most of the details were coherent, I could decipher that there were unfinished stories and possible trauma memories.

"minn dejjem xtaqt rapport aħjar. Pero' ma kienx mexa sew m'ommi hux. Kien jieħu d-droga, […] Familtu qatt ma riedet taf bija" (Bobby).

"I always longed for a better rapport. However, he did not treat my mother right. He used to do drugs […] His family never wanted to have to do anything with me" (Bobby).

Considering the sensitivity of the research question, Bobby trusted the research process and shared delicate details about his life-story, despite acknowledging that he struggles with trust issues. Possibly, the dynamic process was a reflection of the story's depth itself and a reflection of how I experienced and perceived it as the researcher.

Brandon.

Brandon shared a number of sensitive details, which at some points seemed overwhelming, yet he trusted the safe space that we co-created. At the beginning of the story I felt that I had to catch up with his pace in order to connect and remain attuned since he shared significant life-stories immediately. Notably, he narrated significant stories with a smile on his face.

"U ommi ma tantx ħaditha b'mod tajjeb. Allura, bdiet tinjorani minflok tipprova żżomni iktar viċin tagħha, speċi. Qatgħet qalbha minni" (Brandon).

"My mum did not take it well. So, she started ignoring me rather than tried to keep me closer to her. She lost all hope in me" (Brandon).

Despite him describing the lack of a father-son relationship and an erratic relationship with his mother, he saw himself as a "father-figure" to his fellow students who were around five years younger than him. Moreover, he described himself as someone who "gets attached very quickly".

Another significant aspect was the meaning behind his self-image and identity. I connected with his struggles, sense of responsibility to change the way he looked, and strived to better his present situation to accommodate the arrival of his first child. He spoke so passionately about his former self-image that I wondered about how comfortable he was in choosing to make such a "radical change".

"Imbagħad saret beanie my thing […] filfatt meta jsaqsuni n-nies […] ngħidilhom noħroġ bla beanie kont nħossni qisni like ħriġt bla flokk jew ħriġt bla qalziet" (Brandon).

"Then after some time my beanie became my thing, […] In fact when people ask me […] I tell them that going out without a beanie it's like I went out without a shirt or trousers" (Brandon).

The more Brandon spoke about his efforts to change, the more I connected with the theme of self-consciousness. There were moments of hesitation during which he seemed to be overwhelmed; he later confirmed that lately, he has been relatively stressed since he had a lot on his plate.

"Inħoss (quick moment of hesitation), diġa' bdejt naħdem ħafna speċi like biex nipprova, qed nipprova ninbidel in a way biex nkun nista', to accommodate the change" (Brandon).

"I feel (quick moment of hesitation), I have already started working a lot, like to try, I am trying to change in a way to be able to, to accommodate the change" (Brandon).

As he spoke about the physical changes he is making, I wondered what the meaning behind it was. He stated that he is trying to get rid of things that covered his face; such as his long hair and his beanie. I was intrigued by how reflexive he was.

Our 'in-between' took another shift as he gave a detailed account of his FEP; an experience which he does not feel comfortable sharing with his girlfriend since it is "a strong conversation to have with someone". He described his former hallucinations with a terrified look in his eyes. An even more profound fear could be felt when he spoke about his fear of having recurrent episodes and ending up like his cousin, whom he described as "an empty shell of his former self". Lastly, as Brandon spoke about his girlfriend and how she is the one who is providing financially for both of them at present, I could sense his discomfort, or rather an obligation, to take on the responsibility in shifting such roles.

"Bħalissa ghadni qed nistudja, I'm living off of her basically l-punt. Imma hopefully fil-futur, I'm gonna pay her back" (Brandon).

"At the moment I am still studying, I am living off of her basically the point, but hopefully in the future, I'm gonna pay her back" (Brandon).

Frank.

Frank's gregariousness, gestures, and charismatic smile kept me intrigued by his life-story. He found it challenging to initiate his narrative.

"Mhux qed… ma nista' naħseb xejn. emminni ma nafx. […] Ma nafx, ma nista' naħseb f'xejn dal-għodu" (Frank).

"I am not… I cannot think of anything. Oh believe me; I do not know […] I do not know, I cannot think of anything this morning" (Frank).

Although he needed several prompts, I did not feel the need to fill in the gaps, convinced that he needed some time to accustom himself to the process. There were moments when I reassured him since he was becoming concerned about his difficulty in recalling specific experiences. He was genuinely worried about forgetting to bring photographs. I wondered whether there were other reasons behind his forgetfulness, a hypothesis which Frank confirmed later on.

"Għax jien mhux it-tip li ħa noqgħod nippostja fuq Facebook u hekk jiġifieri, ġieli jippostjali xi ritratt xi ħadd ieħor" (Frank).

"Because I am not the type of posting on Facebook and so on, sometimes someone else uploads a photo for me" (Frank).

The manner in which Frank narrated unusual experiences was characterised by a deep sense of fear. As opposed to the moments when he felt stuck, he narrated these in a fluent, fast-paced manner without pauses. It felt like it was a breath-taking experience that changed his life-story. His non-verbals were indicative of an overwhelming fear since the content of the story mirrored the process.

"Kont qiegħed fil-kamra tas-sodda kont qed nara film u tant kemm impressjonajt ruħi dak il-ħin bżajt u ħrabt niġri l' barra jiġifieri mid-dar u ġrejt ġirja (Frank).

"I was watching a movie in my bedroom and I at that moment I was so influenced by it that I ran out of the house and ran fast" (Frank).

The more time I spent with Frank, the less I intervened. As I went through several readings of the transcript, I became more aware that Frank guided me into his life-story and

trusted me enough to allow me to be the audience he never had. This was also shown by how he shifted back to elaborate on previous experiences regarding which he had stated that he could not recall further details.

> "Naħseb illum l-unika darba li rrakkontajt qisni dħalt, mhux fid-dettal għax id-dettal diffiċli nidħol ġo fih" (Frank)
>
> *"I think that today is the only time that I narrated and sort of went into, not in detail because going into details is difficult" (Frank).*

Although Frank described himself as a scatty person, it seemed like I was hooked to his narrative. Though there were several instances when it was evident that he was switching from one thing to another, he still managed to hold my full attention as he narrated a somewhat comprehensible story.

Mario.

Mario adopted a comfortable pace in narrating his life-story which made me take a less active role and only intervene when necessary. I could sense that he had processed his experiences as he was very articulate and fluent. My hypothesis was confirmed at a later stage when Mario shared details about his journey in psychotherapy.

As he was narrating one episode about experiencing persecutory thoughts, our 'in-between' was characterized by a strong sense of concern and fear. Possibly, it was an atmosphere that was a parallel process of what he felt at that moment in time. He narrated in a fast-paced manner as if "people were following" him. Mario's narration was breath-taking; to the extent that when he shared the last details of the event: "and then I went home, I went to sleep", it felt like a breath of fresh air that lowered the energy between us.

Congruent with Mario's narrative structural analysis, process analysis yielded similar data around Mario's narrative about his family of origin. While he spoke about the time he

spent in the UK, and he had not seen his parents for around ten years, he had a blank look on his face. Up to the present day, his parents are not aware of his past psychotic episode.

> "They do not know, I think I never told them about it. About those kind of things. I didn't find it, needed to" (Mario).

Furthermore, the energy between us changed as Mario spoke about his one-year-old son. His face lit up when he spoke about the motivation that he derives from the relationship with his son.

> "And my son obviously is, you know a big push, a big boost to live the life in the right way" (Mario).

I could feel a sense of emptiness and isolation when Mario spoke about intimate relationships. He acknowledged that the way he detaches himself from building secure connections is a form of defence mechanism, a growing edge which he is motivated to process further in psychotherapy. His sentence structure was relatively fragmented.

> "It is a kind of defence that I built up myself to, like a wall and to people" (Mario).

Lastly, Mario's sense of determination and perseverance is laudable. Although he spoke about various experiences comfortably, his determination created a substantial presence and positive energy. His tone of voice became stronger and he sat straight as he spoke of how he strives to change some ways of relating to others.

Sam.

There were instances during the interview when I connected with a profound sense of self-consciousness; a sensation that Sam articulated as the interview progressed. During other instances, I was caught between picking up an overwhelming fear of being seen and therefore, possibly judged by others and a sense of caution and suspiciousness.

One of the most critical parts of the interview was Sam's story about being unwell. I was in touch with his profound suffering as he narrated his experiences. Moreover, his perseverance in regaining hold of his life was immensely commendable. There were other instances when I sensed his disappointment in not managing to fight his delusional thoughts.

> "And that I was fighting being unwell. But sometimes you believe your own delusions and sometimes you don't. Sometimes I didn't manage" (Sam).

Sam seemed to struggle to find the right words to explain what he called "the model" which was a fundamental part of his delusions. He tried his best to describe his delusions with precision. As the moments of silence became more frequent, I felt the need to reassure him that he could take all the time he needed and consequently withdraw should he feel uncomfortable.

Sam described the whole experience of his FEP as "tiring" and lonely; to an extent, this sensation was being co-created between us. Additionally, I felt his pain when he explained how he felt when people around him did not respond to his thoughts; ultimately realising that such ideas were delusional.

> "They could understand to some limit, to some point. They could let's say, maybe empathise. Did they know? They had an idea. No one really knows" (Sam).

Another significant point in our process was when Sam explained how he feels about exposing himself to others through the way he shared his thoughts and ideas.

> "Then it starts toying with you in recovery, I was exposed to so many people Cioe mhux *(I mean not)* I was exposed, I exposed myself." (Sam).

The atmosphere between us was transformed when Sam shared his fear of "it all happening again". The atmosphere became rather heavy and his tone of voice reflected

seriousness and fear. A possible sense of regret was evident as he stated that he only needed to remain quiet rather than be assessed in an environment that "did not help".

As I went through several readings of the transcript I felt intrigued by Sam's level of awareness, coping strategies, and his continuous struggle against his persistent thoughts of being judged by others; explicitly referring to the stigma associated with mental health challenges.

> "Who is listening? Who is over-hearing? And what is the idea that the person listening is going to form? […] My leisure life and my career life, I cannot separate them. They are who I am. But I don't want one to jeopardise the other" (Sam).

Conclusion

The above chapter highlighted the findings obtained from the interviews. I presented the raw data following a thorough narrative analysis that was divided into three main parts; themes, structure and process. Three dominant narratives were elicited: 'Losing the grip', 'Me, us, and them', and 'The Self', each having three subordinate themes respectively. Direct quotes have been presented in both Maltese and English as to remain faithful to the participants' idiosyncratic experience.

In the second part, I have presented a structural analysis of each narrative. Possibilities of frozen narratives were highlighted *(*)* and shall be discussed in the following chapter. In the last part of the chapter, I have presented a process analysis of each narrative.

In the following chapter, I shall discuss the results, provide a critical appraisal of the methodology and present a reflective commentary for the analysed data.

Chapter Five Discussion

Introduction

In this chapter I shall discuss the findings that emerged from the interview data. Dominant narratives, subsequent themes, structural and process analyses were conducted as per Dallos's and Vetere's (2016) narrative analysis model and were presented in Chapter Four.

I will discuss the findings in the light of the literature which was presented in Chapter Two. Due to the idiographic nature of the study and the fact that it is data-driven, data has directed me beyond the literature presented in the same chapter. The discussion of findings is divided into three parts: In the first part, I will address the dominant narratives. In the part on narrative structure, I shall outline an analytic review of the potential 'frozen narratives' and present a reflective commentary on the process analysis in part three.

Part One: Dominant narratives and subordinate themes

Losing the grip.

The 'Losing the grip' narrative incorporated graphical descriptions of the participants' unusual experiences, authentic stories of substance misuse and their process towards realising that their experiences were not shared with the world around them. The stories within the narrative seem to have a sequential flow; a demon that filled the void in the participants' life-stories followed by a realisation that their thoughts, perceptions, and emotions were illusionary. I shall discuss such process in the light of existing literature and the participants' subjective experiences.

The demon that filled the void.

Khantzian (1997) suggested that in order to understand why people use and possibly become dependent on substances, psychological suffering needs to be considered. The U.S

National Institute of Drug Abuse (2018) outlined four primary factors which contribute to substance-misuse: to feel good, feel better, do better, and due to curiosity and social pressure. Similarly, these were the four primary reasons that were outlined by the participants as contributing to their substance misuse.

Participants narrated that substances and alcohol bolstered their self-confidence and served as a false motivator. Themes of self-consciousness and fear of being judged were outlined in the light of the participants' perception of society's lack of understanding towards substance misuse. Some of the participants argued that they started using substances out of curiosity; however, one could hypothesise that they may have possibly experienced distressing, abrupt transitions. Hypothetically, such distressing experiences were illustrated through the anecdotes of the 'nugget of truth' within their unusual experiences.

The nugget of truth.

Recent studies have emphasised the importance of conceptualising psychosis as a reflection of the individual's real-life experiences (Benning, 2007). The content of the patient's delusions could be either their real biographical life experiences or possibly linked to their anxieties (Rhodes & Jakes, 2000).

Some of the participants narrated stories that are congruent with the above literature. Other persecutory delusions were based on a sense of guilt and remorse for not living up to the family's expectations; consequently, perceptions of being followed and spied-on indicated a 'nugget of truth'. Interestingly, participants also narrated how during their FEP, they used to engage in conversations around topics which they often avoided; for example, sharing their experiences about their bereaved significant others.

A film in graphic detail.

Participants narrated their subjective experiences which Jaspers' (1997) hoped to elicit through the application of his phenomenological method. Therefore, participants' distressing experiences were elicited from their subjective worlds and discourses. Participants provided a graphical description of a series of events which they had experienced as part of their FEP.

Since avoiding diagnostic and possibly stigmatising jargon was an essential aim of my study, participants were given the space to narrate their stories in their language and choice of words. Thus, the auto-biographical method reflected the importance of considering the patient's mental challenges as part of their life history (Jaspers, 1997). Through a phenomenological inquiry, I was allowed the space to take a neutral scientific view of the participants' world views (Bracken & Thomas, 2005). However, one could argue that such neutrality is somewhat partial because it is through empathy that we tune into the patients' experiences (Jaspers, 1997). Therefore, though one strives to remain objective, the researcher both participates and becomes affected by such the process; consequently, defying neutrality and objectivity.

Insight and awareness.

Conceptualisations of 'insight' are built around on various combinations of several areas of neuroscience, which since the late twentieth century have been derived from the concept of the 'self' (Segarra Echebarría, et al, 2010). From a clinical approach, the notion of 'insight' incorporates a complex mental faculty that may be multidimensional, continuous, and often influenced by social and cultural factors (Segarra Echebarría, et al, 2010). Insight has been defined as not only compassing awareness over the illness but also awareness over its consequences which could potentially impact the patient's relation with the world (Amador & Kronengold, 2004).

The data gathered from the interviews highlighted the multidimensional aspects of insight and awareness. Though some of the participants had immediate awareness over the signs and symptoms of their FEP, there were others who were aware of the changes within their relationships and rapport with their significant others, yet they themselves were not fully aware of their unusual experiences. Moreover, most of the participants' stories outlined a fluctuating level of awareness which varied across the intensity and stages of their FEP (Amador & Kronengold, 2004).

Some of the participants outlined that their transition from illusion to reality posed several challenges, especially during instances when their relatives drew attention over the recent shifts in their behaviour and perceptions. Though insight and awareness varied across participants, the psychodynamic formulation of insight in psychosis holds that a poor insight is indicative of an unconscious defence mechanism which is adaptive to the patient in order to cope with the distressing diagnosis and consequences of psychosis (Amador & Kronengold, 2004).

Melanie Klien suggested that denial is the most common defence mechanism in psychosis which is related to poor insight. Moreover, literature outlined that denial could serve as a protective factor from depression and that a relative decline in denial may be a possible ethological factor for post-psychotic depression and depressive realism (Mutsatsa, et al, 2006). Indeed, some participants outlined that a heightened level of awareness and insight over their unusual experiences preceded post-psychotic depression.

Road to recovery.

The 'Me, us and them' narrative was dominant in the participants' stories. Their recovery process was illustrated through the subordinate themes of 'The family and the outside world', 'Road to recovery' and ''On becoming a patient'. I have incorporated the

salient findings that emerged from such themes and will discuss them in the light of the family and the outside world, fear of relapse, and the shame behind becoming a patient with regards to the Maltese context.

The family and the outside world.

As illustrated in Chapter Four, there seemed to be a considerable shift in the proximity between the participants and their relatives as they recovered from their FEP. Participants positioned themselves at a much closer space towards their relatives; highlighting a significant increase in their level of connectedness.

Research confirms that the impact of psychosis extends beyond the patient himself; family members and close social networks endure tremendous impacts (Kuipers, et al, 2010). Considering the large body of evidence about the impact of psychosis on carer well-being, evidence-based family interventions are suggested as treatment guidelines for psychosis (NICE, 2014). Given that the notion of the self is central to the research question, adopting a family-systemic approach raises various arguments.

Despite the various approaches to family therapy models, diverse schools of thought seem to be in agreement on one aspect: that of not taking a blaming and pathologising approach to the reported difficulties (Patrika & Tseliou, 2016). Moreover, "identified patients" are considered by these schools as bearing the brunt of the dysfunctional family dynamics, proverbial receptacles of the family pathology (Satir, 1991). Families often have linear, causal attributions to their difficulties and place the "identified patient" as a source of their difficulties (Parker & O'Reilly, 2012). Results obtained from the sociograms highlighted that most of the participants were relatively distant from their family members, if not alone, during their FEP. One could argue that participants moved away from adhering to

the “identified patient” role. Furthermore, considering the local context, such argument brings about discussions around individuation and emancipation from the family of origin.

Individuation within Western cultures occurs during adolescence and is considered an as important transition from childhood to adulthood (Darmanin Kissan, 2016). Kaufman (1992) explained how most of the Mediterranean cultures are organised around shame and honour (as cited in Darmanin Kissaun, 2017). In Malta, there still remains an emphasis on collective needs, interdependency, and conformity (Darmanin Kissaun, 2016). Clark (2012) described the Maltese society as communitarian and stated that shame and honour are considered important means for maintaining group and individual reputation (as cited in Darmanin Kissaun, 2017). Furthermore, religious beliefs, traditions, gossip networks, and multiple role relationship (O’Reilly Mizzi, 1994) are some of the cultural mechanisms that make Maltese citizens more shame prone.

Despite the trend to conform to the Western individualistic standards, Maltese adolescents tend to continue to live with their family until they marry or find partners (Darmanin Kissaun, 2016). Most of the participants seemed to have made the leap towards individuation, filled their void, started experiencing unusual experiences, and returned to baseline; hence, closer to their significant others. Furthermore, following their experiences, rather than becoming emancipated, participants moved closer to their families; a move that is incongruent with the fact that they have grown and changed following their FEP. However, such changes could also be attributed to the fragility of becoming a patient, hence, possibly more dependent on the family.

On becoming a patient.

Research outlined that stigma is a common concern of individuals who experience a FEP (Judge, et al., 2008). Self-stigma is said to occur when one internalises negative

stereotypes associated with mental health challenges (Evans-Lacko et al., 2012) which are often associated with shame about having a mental health disorder (Rūsh et al., 2006).

Shame was a common theme within each of the participants' stories. Participants stated that, to present, they have barely spoke to anyone in such depth about their FEP; not even their partners, since it is quite a "strong conversation" to hold. Some of them shared their fear of people becoming aware of their FEP whilst others expressed their fears about being labelled "mentally ill". Some of the participant stated that prior to seeking psychiatric help, they made sure that the clinic was not allocated near the reception area; hence, less crowded.

Miller (1993) defined shame as a set of feelings about the self that "carry the conviction that one is small or inferior or defective" (as cited in Darmanin Kissaun, 2017 pp.3). He stated that at the core of experiencing shame lies a state of distress that the person believes as defining the self as no good or not good enough. Shame is felt at the core of the self. Morrison (1989) stated that in order to understand shame, one needs to conceptualise the damage sustained by the self and its subsequent structural deficits (as cited in Darmanin Kissaun, 2017).

Participants expressed their challenges in taking on the "patient's role" since it posed disruptions to their sense of self. Such experiences were reflected through their use of euphemisms and by differentiating themselves from the "them", referring to patients that were admitted in the same psychiatric ward. Hypothetically, this sheds light on their challenges in integrating their unusual experiences into their life-script since that would trigger the thoughts of having a "defective self".

Fear of relapse.

A significant issues related to recovery following the FEP is fear of relapse (Tagore, 2014). This was prominent in all the participants' narrative. Some emphasised that full recovery is nearly impossible since they compared mental health difficulties to a 'game of mental states'. They narrated how their experience was a huge blow which remains too frightening. Therefore, fear of relapse poses questions around the impact on their sense of self.

Literature outlined that a common negative cognitive dysfunction following trauma is the extent to which the individual perceives loss; "My life will never be the same again" (Ehlers & Clark, 2000 p323). Therefore, one would question whether life following a FEP will ever be the same again. This would be due to questions around the possibility of being an eternal patient and fully accepting such role, mourning the former "healthy" self, and the likelihood of getting over the fear of relapse. It seems that relapse must always remain a possibility for these individuals, due to the sometimes chronic nature of some types of psychosis.

A changing self.

'The Self' narrative was dominant in the participants' stories. Since the subordinate themes are founded on one of the biggest existential questions about who we are and the meaning we attribute to our being, they will be discussed collectively.

Who I was, Who I became, Who I am and wish to be.

Oyserman (2012) outlined that the concept of 'self' is sometimes used interchangeably with 'identity'. Therefore, she defined identity as a set of characteristics, traits, roles, social relations, and social memberships that define who one is. Identity can be elicited from the past – what was true of one, present – what is true of one now and future –

the person one wishes to become or the person one fears one may become (Oyserman 2012)). In line with literature, participants' identity was constructed through the characteristic of who they were, are at present, and who they wish or fear to become. Thus, identities provide a meaning-making lens (Oyserman, 2007).

The term 'self' incorporates both the actor who is able to think and the object of thinking (Oyserman 2012). Therefore, it also included reflexive capacity (Kihlstrom, Beer, & Klein, 2003). Some of the participants narrated stories with a heightened level of reflexivity. However, it is necessary to mention that although there were thoroughly reflexive, one could not state that they had processed and hence fully integrated their experiences as part of their self-identity. Despite the fact that some of the participants were well read and reflexive, there were several incoherencies within their narrative. Moreover, there was a striking fear of relapse which could lead to a potential crumbling of their sense of self.

Self and identity are social products since individuals define themselves in terms of what is relevant to their time and place; being a self requires others who endorse and re-inforce one's selfhood; and thirdly because they are constructed and determined by what is relevant from moment-to-moment (Oyserman, 2007). Participants' narratives reflected aspects of their sense of self according to what was dominant to them at a specific time and place. They divided their stories in three separate timeframes; who they were prior to their FEP, who they become, and who they wish to become.

A common aspect within 'The self' narrative of each participant was the dynamic process of the self. Most theories within the social sciences field outline that the self is constituted of stable and fluid aspects (Oyserman 2012). Various theories argued in favour and against such stability; some argued that the self protects itself from change (Markus &

Kunda, 1986) while others argued that changes to the self occur as a result of life circumstances and are thus consequential (Swann, 1985).

The research findings are indicative of a fluid sense of self which undergone changes potentially due to the FEP. Some of the participants narrated how at present, they experience themselves as more sociable. Such changes were magnified since the same participants described themselves as "strange". They explained how integrating their experiences and making sense of them, remain an on-going process.

Recovering from psychosis is a unique process to each individual. Andresen and colleagues (2003) proposed a recovery model that is formulated on four processes: finding and maintaining hope; taking responsibility for life and well-being; redefining self and identity; and finding meaning and purpose in life. These are distributed over a five-stage model:

i. *Moratorium* - characterised by confusion, denial, a deprived sense of one's life, loss of purpose, and self-protective withdrawal.
ii. *Awareness* - the turning point in the recovery process since the individual takes agency of his life and responsibility for recovering.
iii. *Preparation* - characterised by the foundations of building a meaningful life
iv. *Re-building* - building of a more positive sense of self, overcoming failure and becoming more resilient
v. *Growth* - the culmination of recovery; one seeks personal growth and self-actualisation through adopting a positive outlook towards the future (Andresen, et al, 2003).

The research findings highlighted the process of the recovery model and the concept of post-traumatic growth (PTG). Calhoun and Tedeschi (2001) defined PTG as positive

changes experienced by an individual following the cognitive and psychological efforts made in order to deal with challenging circumstances. They stated that PTG "is the individual's struggle with the new reality in the aftermath of trauma that is crucial in determining the extent to which posttraumatic growth occurs" (p. 5).

Participants' stories highlighted elements of PTG, such as, a shift in their priorities and a greater appreciation towards life. Participants perceived a stronger support network and closer relationships following their FEP. Furthermore, a greater sense of personal strength was outlined by most of the participants. Most of the narratives were characterised by a new adjusted self, a more resilient and 'battle-scarred' self; yet, a self who learned from the scars and become deeper and more mature.

Part Two: Narrative structure

In conducting the structural analysis, I analysed the story coherence and whether it contained details and clarity of timing of events (Vetere & Dallos, 2016). The methodology chosen proposed that incoherent memories, lack of detail, verbal connection, and clarity are considered responses to unprocessed trauma; what Dallos and Vetere (2005) coined as 'frozen narrative'. They defined frozen narratives as trauma memories in which the individual is in a trauma state of mind. Although most of the narratives contained fragmentation and were not fully coherent, one needs to consider literature on how trauma impacts memory.

Trauma memories and their connection to the recollection of the events is another part of the puzzle (Ehlers & Clark, 2000). Research outlines that individuals who have experienced trauma, often, have difficulties in intentionally retrieving a complete, coherent memory of the traumatic event. Their recall was found to be poorly organised, fragmented,

details might be missing, and they often experience challenges in retrieving the exact temporal order of events (van der Kolk & Fisler, 1995).

A critical evaluation of 'frozen narratives'.

Traumatic memories are defined as inaccessible for retrieval under ordinary conditions and beyond conscious control (Janet, 1889; 1919; 1925). Such memories consist of intrusive recollections, sensory experiences, emotional states, and behavioural re-enactments (van der Kolk & Van der Hart, 1991). Although memory fragments could be remembered with particular vividness, they resisted integration into existing mental structures; thus, leaving the individual "incapable of making the necessary narrative which we call memory regarding the event" (Janet, 1925 p.663).

Despite their precise details, the manner in which participants narrated their stories was characterised by an element of distress. Their behaviour re-enactments were so real that at some points they appeared like a scripted scene. Indeed, some participants explicitly stated that their FEP was traumatic. Following such experience, some of the participants started having post-traumatic stress disorder-like symptoms. Though there were stories which lacked details, it is pertinent to take several aspects into consideration. Primarily, some participants described themselves as reserved and uninclined to engage in lengthy conversations. Additionally, they outlined that taking on the patients' role was quite challenging and evoked a sense of shame.

Most of the incoherencies were illustrated by fragmented or incomplete sentences. According to the proponents of the methodological approach, such characteristics are considered to be frozen narratives (Vetere & Dallos, 2016). Fragmented and incomplete sentences were also highlighted in the literature as an indication of disintegrated memories

(Janet, 1926). However, since one of the participants was a foreigner, some of his fragmented sentences were possibly attributable to a language barrier.

There were incomplete sentences and several pauses within some of the narrative. Arguably, it seemed like the more time I spent with the participants, the more they shifted between stories and felt comfortable to provide further details. My hypothesis was strengthened since at the beginning of the interview most of them stated that they do not remember much detail; yet, stories were immensely vivid.

Therefore, in my view, it might be somewhat reductive to conclude that incoherence, pauses and unclear temporal order are indicative of an underlying trauma, due to which narratives 'freeze'. It may indeed be the case in certain situations, yet many other aspects, such as, shame, intense emotions, and mastery of language, might have contributed to such incoherence.

Part Three: Reflective commentary on process analysis

The process dimension in psychotherapy is multifaceted and complex because different levels of communication coincide (Teyber & McClure, 2006). For a clearer understanding of what is meant by 'process', it is significant to distinguish between the overtly spoken content of what is being discussed and the 'process' dynamic of how the client and therapist interact (Rüsch, et al, 2013). Below I shall provide a reflective commentary on the 'co-created' process between each participant and myself as the researcher. I shall shift away from the overt content and comment on the relational process of **how** we were interacting since this was pertinent to analyse whether process mirrored content and vice versa.

Bobby.

Metaphorically, I would compare the interviewing process with Bobby to a tango dance in which the most challenging task was not the steps but the interaction between the partners. There were several instances during which Bobby felt stuck in providing details. Through probing, I might have contributed to his terse "yes/no" responses out of a genuine concern towards his psychological well-being and safety. More so, Bobby was the first participant who took the interview; hence, I believe that my enthusiasm and anxiety could have played a role.

Bobby shared compelling details that triggered strong counter-transferential responses; mostly empathic responses, for instance, compassion, and benevolence. As he spoke about being the unseen child, I connected with a painful sadness. My biases could have impacted my interpretation of the process since I resonated with aspects of his story. Yet, the content of Bobby's narration was incongruent to the process. I could sense an element of disconnection which was reflected through his blank look on his face. Hypothetically, this could be indicative of Bobby's defence mechanisms to cope with distressing memories.

Brandon.

Brandon's interview was characterised by powerful moments that triggered profound counter-transferences. I felt a strong sense of compassion and to a certain extent, sadness while he described his mother's reaction to the way he was behaving in order to compensate for the years he spent at home. I connected with a sense of longing for connection and protection. However, I could have found it difficult to comprehend such maternal relationship; partly due to the fact that I hold a very good relationship with my mother.

He seemed to be narrating painful stories with a smile on his face; hence, content and process were incongruent. Such incongruence was visible as Brandon narrated episodes about

the lack of “father-son” relationship with his father. Hypothetically, Brandon’s relationship with his parents does not reflect secure attachment.

Brandon spoke about the distinction he is trying to make between who he was and whom he aspires to be. The more he spoke, the more content became incongruent to process; hence, I wondered how genuinely comfortable he was with such a radical change. At a later stage, Brandon spoke about how he is getting rid of things that covered his face, such as a shorter hairstyle, that triggered thoughts of exposure and readiness to be exposed to the world.

Frank.

The interviewing process with Frank highlighted a unique sense of togetherness. It felt like I was sitting with him and watched him in awe while he painted his life-story in colours. The most potent transferences were felt during the ‘Losing the grip’ narrative. However, I am aware that my interest in psychopathology might have impacted my interpretations of Frank’s graphical descriptions of his FEP.

I became aware that there were moments when I had to take a meta-position and observed what was happening within the researcher-interviewer space since I felt that I was too immersed in the story. Frank’s charming personality and sense of humour could have contributed to such captivation. However, there were moments when Frank’s smile, or rather his humour masked the pain behind his experiences. He continuosly articulated that his unusual thoughts were ridiculous, possibly indicating shame.

Mario.

As I skimmed through my research journal, I became aware of the few notes I jotted down following Mario’s interview. Possibly, such detail reflects our interacting process.

Mario's interview was the most flowing since he narrated details with minimal interventions from my end.

Content mirrored process; especially, when he narrated details of an event during his FEP. His narration was quite fast-paced and contained extreme details. I felt captivated by his graphic description and his imprinted memories. However, unconsciously, I could have directed Mario to explore another theme since the atmosphere between us became so heavy and engulfed in the paranoid delusions that at some point, it resembled a suffocating sensation.

There were specific instances during which I resonated with Mario's stories; hence my biases could have impacted my interpretations. I resonated with his choice of words he used to describe his self-guardedness; phrases which were indicative of a parallel process. Moreover, I felt intrigued by his processing and circular reasoning

Sam.

The co-created space between Sam and I was a delicate space that allowed him to trust the process and recount painful experiences; consequently, I took a relatively passive stance since I felt that he was meticulous in fulfilling the participant's role sufficiently.

There was a constant fragile atmosphere which was possibly fuelled by the themes of self-exposure and shame. Process mirrored content since it was evident that experiencing a FEP did impact Sam's life-script. Apart from articulating such details, this was translated through the several pauses and specific details in the story.

Furthermore, there were multiple instances when I resonated with Sam's caution and concern of keeping his story preserved out of his potential fear of being judged. Therefore, I am aware that my biases might have impacted my interpretation of the intensity of such

experiences. However, as Sam narrated such experiences, process mirrored the content since I could sense his hesitation and efforts in sharing sensitive information.

Conclusion

This chapter provided a detailed discussion of each narrative, narrative structure, and process analysis. Since the study took a bottom-up approach, most of the literature presented differs from the literature presented in Chapter Two. It is significant to mention that although the methodology elicited frozen narratives from the narrative incoherence, fragments, and lack of detail, above I have presented a counter-argument that exhorts caution when interpreting trauma memories. In the following chapter, a conclusion to the study will be presented.

Chapter Six – Conclusion

Overview

In this chapter, I shall present a summary of the salient findings and outline the strengths and limitations of the research. Recommendations for future research, policy and practice, and a critique of the method adopted for the study will also be presented.

Summary of salient findings

Following the five semi-structured interviews, a narrative analysis was employed to elicit the dominant narratives and subordinated themes, analyse the structure of the narrative, and evaluate the process which was 'co-created' with each participant. The three dominant themes were 'Losing the Grip', 'Me, Us, and Them', and 'The Self'.

'Losing the Grip' was a dominant narrative which vividly highlighted the participants' stories about their unusual experiences. Their stories were captivating and, at several points, it seemed like a scripted story. In this respect, Frank's analogy of a movie scene adequately outlined the complexity of their experiences. Stories within such dominant narrative followed a sequential flow; the demon that filled the void was followed by a state of realisation through which they became aware that their unusual experiences were not shared by the outside world. Most of the results indicated that the content of the participants' stories contained a 'nugget of truth'. In line with literature, participants' awareness and insight was multidimensional and fluid whereas having poor insight could reflect the participants' defence mechanisms.

The 'Me, us and them' narrative dominated most of the participants' stories. Sociograms indicated that following their FEP participants became relatively closer to their significant others. Such findings posed questions around individuation and emancipation, especially when considering the local context. Furthermore, narratives highlighted the

participants' challenges on becoming a patient. The most prevalent themes within their stories were mental health stigma, shame, and how they impact their sense of self. This process gave rise to discussions regarding whether the "patient's role" meant mourning the "healthier me" and adjusting to "a defective self" or whether a more mature sense of self was achieved, where the symptoms no longer evoked a sense of defectiveness but the participant's imperfections could be accepted and integrated into a wider sense of self.

The narrative of the Self was an integral part of each interview. Participants frequently referred to their sense of self based on who they were, who they became and who they are and wish to be following their FEP. Results outlined the participants' recovery process which reflected a meaning-making process and a process of redefining their sense of self and identity. Lastly, their narratives outlined a degree of post-traumatic growth; a new adjusted self, a more resilient and battle scarred; yet, a self who learned from the scars and became deeper and more mature.

Following Vetere's and Dallos' (2016) narrative method, each narrative was analysed in terms of incoherencies, minimal details, fragmentations, and unclear timing of events. They proposed that the above characteristics are indicative of a frozen narrative. Although there were several incoherencies within each story, it is difficult to assume, in the absence of further evidence, that these were indications of 'frozen narratives'. However, when bringing the three parts of the analysis together, one would be in a better position to decipher whether the story actually reflected a traumatic memory or otherwise.

The manner in which each participant narrated their stories contributed to a unique co-created process. Their captivating stories transmitted and evoked various transferences and counter-transferences. There were instances when the participants appeared to be visibly hesitant and often narrated their unusual experience with a smile on their face; possibly

indicating shame about having such unusual thoughts, emotions, and perceptions. Therefore, a thorough process analysis paved the way for a clearer understanding of the participants' idiosyncratic experience since one was able to observe whether process mirrored content and vice versa.

Strengths and limitations of the study

To my knowledge, to date, there seem to be no local or international research studies focussing on the individual's subjective experiences and the potential impact on the sense of self following a FEP. The study gave a voice to participants whose voices are seldom heard (Steffen, 2014). One of the strengths of the study was that data was elicited through the participants' choice of words, details, and sequencing of events. Four of the participants explained that the interview was their only opportunity to narrate their stories about their FEP in such detail. Narrative analysis, particularly the SQUIN method of eliciting narratives, adequately answered the research question since the researcher followed the participants' pace. Vetere and Dallos' method (2016) facilitated a thorough inquiry since each story was analysed in terms of dominant themes, structure, and process. Furthermore, adopting a critical approach to the method enhances the strength of this study.

Taking a phenomenological approach throughout my research contributed to my remaining faithful to the participants' experiences. Such approach sustained the overarching aim of the study; that of gleaning the constructed life story of the participants; how the person experiences his selfhood and any changes in the life-script occurring following a FEP.

Having worked in mental health services for years could have had positive and less positive influences on the data collection process. Psychopathology is an area in clinical practice which fascinates me and fuelled my interest in gleaning a better understanding of the patient's subjective world following a FEP. Having such work experience could have

benefitted the participants. Yet, as Brinkmann and Kvale (2008) explained the danger of semi-therapeutic relationships in qualitative research, I am aware that there could have been instances during the interviews at which I might have over-empathised. Hence, I took a meta-position to remind myself that I was in the role of researcher, not psychotherapist. My biases and perceptions could have inadvertently influenced or highlighted specific themes more than others, as described in the reflective commentary presented in Chapter Five.

Since most of the interviews were conducted in Maltese the direct excerpts had to be translated. This could have possibly caused some of the nuances of meaning to become lost in translation. In order to remain faithful to participants' experiences as much as possible, both the original and translated versions were included in the findings chapter. Similarly, Mario seemed to have found it challenging to articulate his story through the use of adequate words since his interview was not conducted in his mother-tongue.

Recommendations for future research

There seems to be a lacuna in the literature on the individual's subjective experience following the FEP, a gap addressed by this research. The results yielded several recommendations for future research:

i. Most of the participants narrated how their sense of self is fluid; a continuous process which still requires exploration. Hence, it would be interesting to conduct a follow-up study on whether the participants' fear of relapse abates or remains as indicated in the findings, and whether family relationships remain the same.

ii. All the participants being males, another recommendation would be that of gleaning the females' subjective experience of a FEP with a history of substance misuse.

iii. Since all the participants' narratives included stories about their families and significant others, future research on FEP could be conducted from a family-systemic perspective.

iv. Sociograms indicated that participants became relatively closer to their families following their FEP; sociograms could be used for future research with a large sample in order to investigate this matter further.

v. The concept of PTG which was founded on the recovery process was one of the most salient findings. This could be studied more closely as to glean a better understanding of the participants' process towards PTG. Another suggestion could be a comparative study between therapists of patients who experienced PTG and adopted the recovery model in their sessions post-psychosis and those who do not adopt it. Such study would shed light on whether such model makes a difference to patient self-esteem or otherwise.

Implications for policy, practice, and psychotherapy

NICE (2016) recommended early intervention in psychosis (EIP) to individuals who experience a FEP following substance misuse such as cannabis. Whilst providing a holistic care-plan to each patient, EIPs also provide family interventions. To my knowledge, to date, there are no mental health services that are specifically designed for patients who experience a FEP. Such a lack of services might have contributed to the difficulty in finding participants who have had experienced just one psychotic episode.

Participants emphasized the lack in continuity of care they experienced. They all exhibited a degree of unease and shame in recounting their unusual experiences. They emphasized the inconvenience posed by the fact that for every psychiatric follow-up, they

would be seen by a different psychiatrist or junior doctor. Therefore, their discomfort to narrate their story repeatedly would be heightened.

The results obtained from this research illustrated the need for an improved environment within mental health services. Participants emphasized the need for refurbishing of the setting that could help mitigate the effects of exposure and thus limit the shame experienced by participants. The need for a less clinical, less sterile environment was also outlined and considered to be beneficial both for professionals and patients (Phelps, et al, 2008).Participants emphasised that being in an environment where anyone could listen to what is being said during reviews, exacerbates one's suspicious thoughts. This highlights the importance of catering for patients' privacy in the setting, given the small size of the island that heightens a sense of exposure due to the risk of patients knowing each other.

Results indicated the continuous need to overcome the stigma associated with mental health challenges. Stigma was found to have multiple repercussions for various reasons; one of which is society's attempt to maintain the ideal identity; hence, possibly avoiding someone with a mental illness (Crandall & Eshleman, 2003). Therefore, stigma is a contributing factor to people abstaining from seeking treatment and support. (Martin, Pescosolida & Tuch, 2000). Hence, the need for increasing the general public's awareness remains a growing edge.

Furthermore, it is necessary to mention some implications for psychotherapy which were elicited from the findings. Some of the participants used metaphors and euphemisms to refer to their unusual experiences. Therefore, it is crucial for psychotherapists to adopt a phenomenological inquiry, understand such metaphors and use patients' language (Bracken & Thomas, 2005) so as to remain faithful to the patients' idiosyncratic experiences. One of the participants highlighted the necessity to respect the patients' pace and readiness to delve deeper into issues that lie beneath their unusual experience. Ultimately, it is pivotal to

comprehend a good understanding of the patients' psychotic defences which according to the psychodynamic school of thought are often pertinent to unconsciously hinder the patients' insight and awareness.

A critical appraisal of the methodology

Different methodologies were considered for this study, such as Interpretative Phenomenological Approach (IPA).A narrative approach was the most appropriate since it does not only look into the meaning individuals attribute to a lived experience but also at the construction of stories, the self, and any possible changes to their life "script" (Byng-Hall, 1995).

Dallos and Vetere's (2016) method proved to be adequate for this research due to its in-depth analysis to elicit dominant narratives, narrative structure, and process analysis. As illustrated in the data gathered, the notion of 'frozen narratives' could have been elicited from the process analysis and not solely from pauses, incoherence, lack of details, and unclear temporal order of events.

Concluding reflections

As I approach the end of this journey, I recognise how much it made me grow professionally and personally. The idea of studying the phenomenological meaning patients attributed to their FEP was present prior to commencing the Master of Psychology journey since I had been working in Mount Carmel Hospital for years. Witnessing patients' immense suffering as they recover from their FEP and trying to make sense of what had happened to them were major motivation to this research.

The more I read, the more I realised that the patient's idiosyncratic experience was somewhat overlooked. Hence, my motivation and enthusiasm were reinforced. Though my passion for the research remained intact throughout the research process, there were times

when exhaustion became figure. However, with each participant's story, my enthusiasm was rekindled. There were several aspects of the participants' stories that resonated with my process, themes and anxieties that I shared.

As I read through the complete work, I realise how the whole process enriched my personal growth and contributed to my understanding of these patients, which will prove invaluable for my work in the field of Clinical Psychology. It has also piqued my interest to the extent that I would like to conduct further research in the area. This is in line with the clinical-science model (McFall, 1991; 2006) that I would like to follow in my future practice as a Clinical Psychologist. It sustained my idea that life experiences change people's life stories. I believe that it was an eye-opener to continue striving to strike a balance between the need for treating the overt symptomology, yet remain focused on the deepest suffering endured by the patient and its consequent impact on their sense of self.

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Appendix A

Recruitment Letter

Dear potential participant,

My name is Justine Attard and I am currently reading for a Master of Psychology in Clinical Psychology at the University of Malta. I am writing to invite you to participate in my research study **Constructing Stories of the Self Following the First-psychotic Episode and Substance Misuse**. The aim of the study is to obtain a deep understanding of your life story following a first psychotic episode with a history of substance misuse.

You are eligible to participate in the study since you have benefitted from professional services offered either in mental health or in any other agency from which you sought support and also because the same professionals confirmed that you fit the inclusion criteria. Should you participate; a semi-structured interview will be conducted by myself during which we would explore your narrative behind experiencing a first-psychotic episode. The interview would take around 50 minutes to 1 hour. You are free to skip any questions that you feel uncomfortable answering.

The purpose of the research is to get a deeper understanding of your subjective experience of a first-psychotic episode and to move beyond diagnosis.

The dissertation will be submitted in part fulfilment of my Master degree and excerpts of your interview may be presented. However, identifiable information will not be included and anonymity is assured. Therefore, a pseudo name will be used to protect your identity. With your permission, our interview will be audio-recorder. Following submission of my dissertation, audio-recordings will be deleted and destroyed in June 2019.

May I remind you that participation is completely voluntary. Moreover, should you wish to withdraw from the interview at any time, you are free to do so without explaining yourself.

Should you wish to participate, please contact me via email on justine.attard.07@um.edu.mt or contact me on mobile number: 79308185

Thank you for your time.

Sincerely,

_____	_____
Justine Attard	Dr. Greta Darmanin Kissaun
Researcher	Supervisor

Appendix B

Ittra ta' Reklutaġġ

Għażiż parteċipant/a,

Jiena, Justine Attard, qed nistudja l-Universita' ta' Malta fuq livell ta' Masters fil-Psikoloġija Klinika. Qed nikteb biex nistiednek tipparteċipa fl-istudju ta' riċerka ***"Bini ta' Stejjer fuq l-Identita' Wara Ewwel Episodju Psikotiku u l-Użu ta' Sustanzi".*** L-għan ta' dan l-istudju hu li nikseb rakkont dettaljat tal-istorja ta' ħajtek wara li tkun esperjenzajt l-ewwel episodju psikotiku b'rekord ta' użu ta' sustanzi.

Inti eliġibbli tipparteċipa f'dan l-istudju peresli bbenefikajt mis-servizzi professjonali fil-qasam tas-saħħa mentali jew minn għajnuna ta' agenzji oħrajn kif ukoll għax l-istess professjonisti kkomfermaw li inti tapplika għal kriterja ta' inklużjoni li tiddetermina l-parteċipazzjoni. Jekk inti interessat/a tipparteċipa, intervista semi-strutturata se tkun qed ssir minni stess. Waqt l-intervista, se nkunu nistgħu nesploraw l-istorja tiegħek wara li tkun esperjenzajt episodju psikotiku. L-intervista tieħu bejn ħamsin minuta u siegħa. Nixtieq ninfurmak li jekk ikun hem mistoqsijiet li ma tħossokx komdu/a twieġeb, inti liberu/a li taqbiżhom.

L-iskop ta' din ir-riċerka hu sabiex nikseb rakkont dettaljat tal-esperjenza suġġettiva, prifonda tiegħek tal-ewwel episodju psikotiku li esperjenzajt kif ukoll nħarsu lil'hinn mid-dijanjosi.

Din it-teżi se tkun sottomessa bħala parti mill-istudji tiegħi fuq livell ta' Master. Siltiet mill-intervista jistgħu jiġu nklużi fid-dokument uffiċjali. Minkejja dan, informazzjoni li ista' tikxef l-identita' tiegħek se titħalla barra biex tiġi assigurata l-anonimita' Għaldaqstant, isem fittizju se jintuża biex nipproteġi l-identita' tiegħek. Bil-permess tiegħek,

l-intervista se tiġi rrekordjata; ir-rekordings jiġu distrutti ladarba t-teżi tkun sottomessa f'Ġunju tas-sena 2019.

Nieħu l-opportunita' biex infakkrek li l-parteċipazzjoni tiegħek hija volontarja. Għaldaqstant, jekk tħoss li trid tieqaf milli tipparteċipa, inti liberu/a tagħmel dan mingħajr ma' tagħti spjegazzjoni. Jekk tiextieq tipparteċipa, jekk jogħġbok ikkuntattjani b-imejl justine.attard.07@um.edu.mt jew ċempilli fuq: 79308185

Grazzi tal-ħin tiegħek.

Dejjem tiegħek,

_____	_____
Justine Attard	Dr. Greta Darmanin Kissaun
Riċerkatriċi	Supervisor

Appendix C

Capacity to Consent

Question to assess the participants' capacity to consent adapted from The Older Adults Capacity to Consent in Research (Lee, 2010).

1. What is the purpose of the study?
2. Tell me some of the things that you will be asked to do in the study.
3. What are the risks or discomfort that you might face as a result of participation in the study?
4. If you don't want to, do you have to be in this study?

Appendix D

Kapaċita' għall-għoti tal-kunsens

Mistoqsijiet biex nassessja l-kapaċita' tal-għoti tal-kunsens tal-parteċipanti (adapted from The Older Adults Capacity to Consent in Research by Lee, 2010).

1. X'inhu l-iskop ta' dan l-istudju?
2. Għidli xi affarijiet li se tkun mitlub tagħmel f'dan l-istudju.
3. X'riskji u skumditajiet jista' jkollok taffaċċja jekk tipparteċipa fl-istudju?
4. Jekk inti ma tixtieqx tpparteċipa, int bilfors trid tipparteċipa?

Appendix E

Consent Form

Constructing Stories of the Self Following the First-psychotic Episode and Substance Misuse

You have been invited to participate in a research study on "Constructing Stories of the Self Following the First-psychotic Episode and Substance Misuse" conducted by Justine Attard under the supervision of Dr. Greta Darmanin Kissaun. The aim of the study is to obtain a deep understanding of your life story following a first psychotic episode and substance misuse. It is expected that this study will heighten the general public' and mental health professionals' awareness of the participants' subjective experiences which moves beyond diagnosis and medication. Therefore, participation in this qualitative study is considered to give a voice to participants whose voices are seldom heard.

Risks and Discomforts

Participation in the research is not associated with any known risks or harm. However, should there be any sensitive issue which might become overwhelming during the interview; I shall proceed with the necessary interventions to ensure your psychological well-being. Having years of experience in mental health and being a psychotherapist, facilitates such process. You are free to skip any questions you do not wish to answer, without giving a reason. Moreover, you can choose to withdraw from the study at any time without giving a reason.

Confidentiality

I confirm that all measures will be taken to protect the privacy of your identity and your data as stated by the General Data Protection Regulations (GDPR) and national legislation that implements and further specifies the relevant positions of said regulations.

Your personal data will be highly protected. Each one-hour (approximately) interview will be audio-recorded and therefore transcribed verbatim. The audio-recordings and the transcripts will be password-protected and/or stored under lock and key. No identifiable information will be revealed in the dissertation or any publications resulting from the study. This will be ensured by using codes rather than names for each transcript. Only the researcher would know which code is allocated to a specific participant. Confidentiality will be maintained throughout.

You hold the right to access the transcript and verify that there is no data that you would like to add, clarify, or erase. Moreover, the use of any direct quotes in the dissertation will be verified with the respective participant. Ultimately, both audio-recordings and transcripts will be destroyed after submission of dissertation in June 2019.

Consent

By signing this consent form, you are confirming that you have been given and read the *"Recruitment Letter*" that described the research and your role as a participant. Time was also allowed for you to address any questions and concerns.

_____	_____
Name of participant	Participant's signature
_____	_____
Dr. Greta Darmanin Kissaun Supervisor Email: greta.darmanin-kissaun@um.edu.mt Tel: 23403129	Justine Attard Researcher Email: justine.attard.07@um.edu.mt Mob: 79308185

Appendix F

Formola ta' Kunsens

Bini ta' Stejjer fuq l-Identita' Wara Ewwel Episodju Psikotiku u l-Użu ta' Sustanzi

Inti qed tiġi nvitat biex tipparteċipa fl-istudju "Bini ta' Stejjer fuq l-Identita' Wara Ewwel Episodju Psikotiku u l-Użu ta' Sustanzi" li se jsir minn Justine Attard taħt is-superviżjoni ta' Dr. Greta Darmanin Kissaun. L-għan ta' din ir-riċerka hu li niġbor għarfien dettaljat tan-narrattiva wara l-ewwel episodju psikotiku u l-użu ta' sustanzi. Dan l-istudju hu mistenni li jżid l-għarfien tal-professjonisti fil-qasam tas-saħħa mentali u tal-pubbliku nġenerali dwaar l-esperjenza suġġettiva tal-parteċipanti. Dan imur lil hinn mid-dijanjożi u l-mediċina. Għaldaqstant, il-parteċipazzjoni f'dan l-istudju se tagħti vuċi lill-parteċipanti li mhux dejjem huma mismugħa.

Riskji u Skumditajiet

Il-parteċipazzjoni tiegħek fir-riċerka mhiex assoċjata ma' riskji meqjusa jew xi forma ta' ħsara. Madanakollu, jekk ikun hemm xi aspetti ta' natura sensittiva li jqanqlu emozzjonijiet profondi, nixtieq ninfurmk li jien se nintervjeni bl-aħjar mod possibbli biex nassigura s-saħħa psikoloġika tiegħek. Dan se nkun nista' nagħmlu peresli ħdimt għal diversi snin fis-saħħa mentali, filwaqt li jien ukoll psikoterapista. Nixtieq nassigurak li inti liberu/a biex taqbeż mistoqsijiet li ma tixtieqx twieġeb mingħajr ma tagħti raġuni. Għaldaqstant, tista' tagħżel li tieqaf mil-intervista mingħajr ma' tipprovdi raġuni.

Kunfidenzjalita'

Matul ir-riċerka se jittieħdu l-miżuri kollha meħtieġa sabiex l-identita' tiegħek u l-informazzjoni li tipprovdi jkunu protetti skond l-General Data Protection Regulations (GDPR) u l-leġiżlazzjoni nazzjonali li timplimenta u tispeċifika l-proviżjonijiet relevanti tal-imsemmija regulazzjoni. Informazzjoni personali se tkun protetta bis-sħiħ. Kull intervista ta'

madwar siegħa se tiġi rrekordjata u traskritta kelma b'kelma. Ir-rekordings u t-transkripts se jkunu protetti permezz ta' passwords u/jew maqfulin b'ċavetta u kantnazz li tinżamm għand ir-riċerkatriċi. Informazzjon li tista' tikxef l-identita' tiegħek mhux se tkun żvelata fl-istudju jew f'xi publikazzjoniet oħrajn relatati. Din se tiġi żgurata billi jintużaw kodiċi minflok ismijiet għal kull transcript. Ir-riċerkatur biss se jkun jaf liema kodiċi hu abbinata mal-parteċipanti. Il-kunfidenzjalita' se tkun massima tul l-istudju.

Inti għandek id-dritt li jkollok aċċess għat-transkript u tivverifika li ma hem l-ebda informazzjoni li tixtieq iżżid, tiċċara jew tħassar. Barra minn hekk, l-użu ta' kwotazzjonijiet diretti li se jintużaw fit-teżi se jiġu verifikati mal-parteċipant rispettiv. Għaldaqstant ir-rekordings u t-transkripts se jitħassru u jiġu meqruda ladarba l-istudju jkun komplut f' Ġunju tas-sena 2019.

Kunsens

Bil-firma tiegħek se tkun qed tikkomferma li għandek kopja u qrajt l-"Ittra ta' Rekrutaġġ" li tispjega l-istudju u l-irwol tiegħek bħala parteċipant. Dan juri wkoll li kellek ħin addatat għal xi mistoqsijiet jew diffikultajiet oħrajn.

_____	_____
Isem tal-parteċipant	Firma tal-parteċipant
_____	_____
Dr. Greta Darmanin Kissaun Supervisor Email: greta.darmanin-kissaun@um.edu.mt Tel: 23403129	Justine Attard Riċerkatriċi Email: justine.attard.07@um.edu.mt Mob: 79308185

Appendix G

Semi-structured interview: Prompts

The below questions will be used to engage participants in the interview and to help them feel more at ease. Since data will be evaluated through a narrative analysis, participants would be asked **one overarching question**.

- Name:
- Age:
- Occupation:
- Nationality:
- Relationship status:

SQUIN - Can you tell me something about your life story? You can take as much time as you wish, I am interested to hear anything that you deem important.

*The following questions will only be used **as prompts** and not necessarily asked in the order they are presented. A less structured approach will be taken during the actual interview.*

- Participants would be asked to bring 2 photos; one taken recently and one taken some time ago. Participants would be invited to talk freely about the photos.
    - What do these pictures mean to you considering all the other pictures that you have?
    - Have has your life changed from when the first picture was taken to the second one?
- Do you remember a time when you experienced unusual thoughts – emotions - perceptions?
    - Can you describe these thoughts – emotions – perceptions?
- Why do you think that these unusual experiences happened?

    - Do you think it had anything to do with something you were drinking or smoking at that time?
- How did the others around you respond?
    - Were there any persons whom you found helpful?
- If you had to connect with that experience, how did you feel emotionally?
    - What were your needs?
    - Were they met?
    - What challenges did you face?
- How did you experience mental health services?
    - What was helpful and what would you change?
- Looking back at your experience, how do you feel about it now?
- What would you suggest to people who are going through a similar experience?
- Who are you now?

Adapted from The Thought Disorder Questionnaire (Waring, Neufeld, & Schaefer, 2003) & The First Episode: Psychosis NAMI Survey (The National Alliance for Mental Illness, 2011).

Appendix H

Intervista semi-strutturata: Mistoqsijiet faċilitattivi

Il-mistoqsijiet li ġejjin se jintużaw biex jiffaċilitaw il-parteċipazzjoni tal-parteċipanti kif ukoll biex jibnu rapport mar-riċerkatur. Ladarba l-informazzjoni miġbra se tiġi analizzata b'mod narrattiv, il-parteċipanti se jigu mitluba jwieġbu **mistoqsija prinċipali waħda**.

- Isem:
- Eta':
- Professjoni:
- Nazzjonalita':
- Status:

SQUIN - Tista' tgħidli ftit fuq l-istorja ta' ħajtek? Tista' tieħu l-ħin kollu li għandek bżonn, nixtieq nisma' dak li inti taħseb li huwa importanti

Il-mistijiet li ġejjin se jkunu użati biss bħala **mistoqijiet faċilitattivi,** u mhux neċċesarjament fl-ordni li preżentati fiha. L-intervista mhux se tkun daqstant strutturata..

- Il-parteċipanti se jkunu mitluba jġibu magħhom żewġ ritratti: wieħed li hu meħud riċentament u ieħor li ilu daqsxejn meħud. Huma se jingħataw l-ispazju biex jitkllmu fuq iż-żewġ ritratti b'mod liberu.
    - Xi jfissru għalik dawn ir-ritratti forsi meta tikkunsidra ir-ritratti kollha li għandek?
    - Kif inbidlet ħajtek maż-żmien bejn iż-żewġ ritratti?
- Tiftakar fi żmien meta esperjenzajt xi ħsibijiet, ideat, jew perċezzjonijiet li mhux tas-soltu?
    - Tista' tkellmni ftit iżjed fuqhom?
- Għalfejn taħseb li bdew jiġrulek dawn l-esperjenzi mhux tas-soltu?

    - Taħseb li dawn l-esperjenzi kienu relatati ma’ xi xorb, tipjip jew xi sustanzi li kont tuża dak iż-żmien?
- Kif irreaġixxew in-nies ta’ madwarek?
    - Kien hem nies li sibthom ta’ għajnuna?
- Jekk terġa’ tiftakar f’dik l-esperjenza, kif kont tħossok emozzjonalment?
    - X’kienu l-bżonijiet tiegħek?
    - Kienu milħuqha?
    - Xi sfidi kellek taffaċċja?
- Kif esperjenzajt is-servizzi tas-saħħa mentali?
    - X’għenek u x’tibdel fihom?
- Jekk tħares lura lejn l-esperjenza tiegħek, kif tħossok illum?
- X’tissuġġerixxi lil nies li għaddejjin minn esperjenza simili tiegħek?
- Min inti illum?

Adapted from The Thought Disorder Questionnaire (Waring, Neufeld, & Schaefer, 2003) & The First Episode: Psychosis NAMI Survey (The National Alliance for Mental Illness, 2011).

Appendix I

Transcript Sample

	Structure	Thematic	Process
P: After a couple of years, two, three years, it started the paranoia quite badly and I decided that it was, I wasn't enjoying it anymore because I couldn't go out of my house. I was, my paranoia was I was feeling that all the people that I met, everybody is staring at me, looking at me.	Fragmented sentence when speaking of paranoia.	Unwell	Aware of how little I intervened
I: Mhm.			
P: And at the time, when the peak of the paranoia, I was in London.	Clear memory to recall events	Unwell	- He tried to outline the depth of the fear and make sure I was understanding the depth of it.
I: Ok.			
P: So, think about, a guy, I think I was twenty-one by then. Going around London, with the paranoia that everyone is staring at you.		Fear	
I: Mhm. It was quite difficult ey?			
P: It was very, very scary.	Resolution, yet created another issue		
I: Yes.			
P: So, after a few months that I realised that it was that, I said ok, stop with the marijuana and I switched to alcohol, so.			
I: Ok. And what, back then, what do you believe made you stop using marijuana?	Resolution ✓		
P: The paranoia.			
I: The paranoia?			
P: Yes. I was aware.			

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I: So, that what I was going to ask.			
P: That it was, the marijuana signs and it was not worth it anymore.	Resolution		
I: Yes.			
P: And I just switched to alcohol. Which is much easier. Much more accessible.	Resorted to another difficulty		
I: So, you were aware that these thoughts, of being spied by others, looked over by other, you were aware?			the more he spoke the more I realised that he was mainly on his own.
P: I was kind of aware.			
I: Mhm.			
P: But I was still pretty scared of it.		Fear *	
I: Yes, yes.			
P: And I remember the event that has been, it was a Saturday night and I was, you know, I still can explain, we say that it is the cannabis, if I think about it was, it feels real.	- Vivid details * - Fragmented * sentence	Fear *	
I: Mhm.			
P: I was looking for a rave party in London and so, taking buses, it was on the opposite side of London. So, we are talking about two or three hours drive in the night with the public transport. And, plus those areas, are not the most safest areas in London.	- Fragmented sentences - Retailed description of the event *		- The fear felt real. Process was supported by the plot.

I: Yes. And travelling alone, as well.			
P: Travelling alone. A small guy.			
I: Mhm.			
P: Because I'm not. A huge ten feet tall so . And, you know, a series of events, that I can still can explain. Because I was at the, I managed to find the rave party.	Went back to the * event he was narrating		Details to make me realise how difficult it was for him.
I: Mhm.			
P: Then I went inside. It was a squat, an abandoned house. And there were those guys. And everyone kind of follow me, inside the party.	Detailed description of environment.		Story felt so real.
I: Mhm.			
P: Then, at one point, when I decided that I wasn't feeling comfortable anymore. I said, "I am going to leave". And when I tried to leave, they closed the door and they stopped the. You know, I couldn't even speak in English, at the time.		Unwell	Sensing fear
I: Ahh, ok. So, it was even harder for you.			
P: So, I managed to understood that they were thinking that I was an undercover policeman.		Unwell	
I: Ahh, ok.			

Appendix J

Table of illustrative quotes

Dominant narratives	Themes	Quotes
Losing the Grip	A film in graphic detail	"It's like a movie scene […] I remember that I was wearing shorts, and I went running to the door with an extreme fear that someone was running after me" (Frank).
	The Demon that Filled the Void	"But if we are more understanding of why people do what. Why people may make use of substances? We demonise or dehumanise the act of taking substances" (Sam).
	From Illusion to Reality	"that point when you start to realise your delusions. It's like everything breaks" (Sam).
Me, Us, and Them	The Family and the Outside World	"I did felt pretty much alone so I wouldn't put anyone. They don't know. I don't, I think I never told them about it and about these kind of things" (Mario).
	Road to Recovery	I used to go to a psychologist and a psychiatrist […] it was not that helpful because even going out of home was difficult" (Brandon).
	On Becoming a Patient	"I used to feel uncomfortable even because people might see me entering the premises (referring for mental health services) and then I discovered that the place is a bit isolated It was not close to the reception area which is more crowded" (Bobby).
The Self	Who I was	"I was not sociable; I was always that type with just a few friends. […] I am not a caring person. In truth, I am not even a good friend." (Bobby).
	Who I became	"Now, two years down the road, I feel much more better, I feel much more clear. I do have a clearer mind. My life changed quite a lot by then. And I would say I am pretty happy and satisfied" (Mario)
	Who I am and wish to be	"I am trying to change first of all my behavior. I don't want to look shady" (Brandon).

Appendix K

Central figures in the history of psychosis

The history of psychiatry harks back to hundreds of years. A central figure was Emil Kraepelin (Bentall, 2003) whose most significant contribution to psychiatry was his understanding of the connection between pathogenesis and the manifestation of psychiatric disorders (Möhler, 2003). Kraeplin differentiated between two forms of psychosis:

i. *Dementia praeco*x – a biological disorder caused by anatomical or toxic processes (Lehmann & Ban, 1997). Nowadays it is known as schizophrenia; a progressive neurodegenerative disease which results in an inevitable loss of cognitive functioning (Ebert & Bár, 2010).
ii. *Manic depression* – an episodic psychotic disorder which does not necessarily lead to unalterable cognitive impairment (Bentall, 2003).

Eugen Blueler, another central figure, placed great emphasis on the significance of the patients' phenomenological experiences (Heckers, 2011). He introduced core concepts which later became accepted as significant symptoms of psychosis, namely affectivity, ambivalence, and autism. Blueler paved the way to a less cynical view regarding the course and prognosis of psychosis (Heckers, 2011).

The antipsychiatry movement

The 1960s were characterised by the introduction of the antipsychiatry movement that moved beyond the symptomology of psychosis and focused on the social and economic underpinnings on mental illness. The antipsychiatry movement was promoted by four seminal thinkers; Michael Foucault, R. D. Laing, Thomas Szasz, and Franco Basaglia (Rissmiller & Rissmiller, 2006). Their ideas were formulated around the notion that one's reality is independent of any hegemonic definition of normality imposed by organised psychiatry.

Foucault focused on the social context of mental illness which he explained as somewhat defined by cultural and economic interests (Rissmiller & Rissmiller, 2006). Similarly, Laing explained mental illness as the specific behaviours exhibited by the patient as having a social function. He understood the patient's psychotic behaviour as having two possible meanings; ‘signs' of a ‘disease', or an expression of his existence (Laing, 1969 p.31). Laing stated that it is necessary to extend the understanding and assessment of clinical signs to an empathic understanding of their place within the patient's life history (Laing, 1969).

Thomas Szasz argued that madness had been represented incorrectly as a disease, consequently giving psychiatric professionals the power to “imprison and manipulate mad people in the name of philanthropy” (Miller, 1983 p.22). He also recognised that such institutions serve the purpose of protection in a paternalistic manner. (Miller, 1983).

Franco Basaglia was the driving force behind the deinstitutionalisation process which brought about the implementation of a law in 1978 calling for the closure of psychiatric hospitals in Italy. He understood mental illness as an expression of human needs rather than a disease (Rissmiller & Rissmiller, 2006).

Appendix L

Other philosophical root and influences of narrative research

Clandinin and Connelly (2000) referred to Dewey's theory of experience (1938) as a fundamental philosophical underpinning of Narrative Inquiry. His theory outlined two criteria for experience: interaction and continuity that are enacted in particular situations. Such criteria have set the ground for the narrative conception of experience through the three-dimensional narrative inquiry: space of temporality, place and sociality.

Other influences include pragmatic and narrative knowledge (Bruner, 1986). Pragmatic knowledge refers to the logical proof and empirical observations that can explain a cause and effect and hence create an objective truth that can be proven or discarded (Bruner, 1986). Narrative knowing refers to knowledge that is constructed and created through stories of lived experiences, thus, considering the ambiguity and complexity of human lives (Bruner, 1986).

Literary theory is considered to be one of the main disciplines that focused on narrative investigation. Literary theorists analysed narratives in both spoken and written fiction and arrived at meaning through the structural components (Mitchell & Egudo, 2013). Studying the functional process of the author and the reader while such meaning is transferred, using inductive and deductive structural methods, there was a shift from literal interpretation to the realisation that truth and understanding could be communicated through the narrative expression (Polkinghorne, 1988).

Lastly, the development of narrative analysis could be conceptualised through the history of psychology since the Freudian psychoanalytic tradition emphasised the patients' memories and dreams for a better understanding of their patients' lives as they formed more adaptive and coherent narratives (Polkinghorne, 1988). With the emergence of behaviourism

and the positivist approach, narratives became less prominent since the focus shifted toward behaviours and measurable data (Mitchell & Egudo, 2013). Narratives regained prominence with the development of cognitive psychology since cognitive therapists viewed narratives as reflecting a cognitive structure (Polkinghorne, 1988). Further developments in psychology and through the rise of other approaches such as family therapies, human-existential approaches, and narrative therapy itself, the clients' stories and life-scripts remained central (Atwood & Gallo, 2010).

Appendix M

Ethics Approval

Gmail Justine Attard <justine.attard13@gmail.com>

Research Ethics Proposal – Accepted by UREC following amendments

1 message

SWB FREC <research-ethics.fsw@um.edu.mt> Fri, Jan 25, 2019 at 12:07 PM
To: Justine Attard <justine.attard13@gmail.com>
Cc: Greta Darmanin Kissaun <greta.darmanin-kissaun@um.edu.mt>

Reference Number: FRECSWB_1718_167

Dear Ms Justine Attard,

Reference is made to the **resubmitted amendments** which were **requested by UREC**.

I am pleased to inform you that **your ethics proposal has been accepted**. Hence, you may now **start your research**.

You are kindly requested to pick up all your documents from our office between 08:00-12:15 and 13:30-17:00.

Thanks and regards,

Stuart Bugeja
Faculty Research Ethics Committee (FREC)
Faculty for Social Wellbeing
Room 113
Humanities A Building (Laws & Theology)
University of Malta
Msida MSD 2080

Tel: (+356) 2340 3958

Students' hours:
Monday-Friday
08:00-12:15 and 13:30-17:00 (1 October-15 June)
07:30-13:00 (16 June-30 September)

Website: um.edu.mt/socialwellbeing/students/researchethics

Appendix N

Institutional Approval for Access to Participants

Gmail Justine Attard <justine.attard13@gmail.com>

Dissertation: request for participation

8 messages

Justine Attard <justine.attard13@gmail.com> Tue, May 29, 2018 at 1:38 PM
To: anton.grech@gov.mt
Cc: Greta Darmanin Kissaun <greta.darmanin-kissaun@um.edu.mt>, catherine.dimech@gov.mt

Dear Dr. Anton Grech,

Hope this email finds you well.

I am a currently reading for a Master of Psychology in Clinical Psychology at the University of Malta. In partial fulfillment of my studies, I am planning to do my dissertation on the narratives of patients who have experienced a first psychotic episode that was substance-induced. My dissertation will be supervised by Dr. Greta Damanin Kissaun, here-in CC.

Working in mental health services (with Dr. David Cassar's firm) for the past six years has enriched both my personal and professional growth. Moreover, I believe that my dissertation will be a contribution to the field. The overarching aim of the study will be that of gleaning the participants' constructed life story; the manner in which they experience their selfhood and any changes in their life-script following a substance-induced first-psychotic episode.

Participants will be recruited through a gatekeeper, Dr. Catherine Dimech, also in CC. I am planning to conduct a fifty-minute to one-hour semi-structured interview with around five patients. With the permission of the participants, interviews would be audio-recorded and then transcribed verbatim. Data will then be analyzed through a narrative analysis. A detailed description of the study can be found in the attached recruitment letter.

I am kindly requesting your permission to select participants who have benefitted from Mental Health Services. Participants would not undergo undue distress. There are no known risks or harm in participating in the research study. Data would not be collected unless ethical clearance from FREC will be obtained.

Many thanks for your time and co-operation.

Regards,
Justine Attard
Clinical Psychology Trainee

Recruitment Letter 1.docx
41K

Grech Anton at Health-Mental Health Services <anton.grech@gov.mt> Wed, May 30, 2018 at 7:58 PM
To: Justine Attard <justine.attard13@gmail.com>
Cc: Greta Darmanin Kissaun <greta.darmanin-kissaun@um.edu.mt>, Dimech Catherine at Health-Mental Health Services <catherine.dimech@gov.mt>

Justine,

I will need endorsement from your supervisor.

Dr. Anton Grech MD PhD (Maas.) MSc (Psych)(Lond) FRCPsych(U.K.)
Clinical Chairman (Psychiatry), Dept. of Psychiatry, within Ministry of Health, Malta
Chairman of 'Fondazzjoni Kenn ghal Sahhtek', Malta
Resident Senior Lecturer, University of Malta
Senior Research Fellow, BCMHR-Cambridge University, UK
https://valletta2018.org/events/psychiatry-and-art-conference/

[Quoted text hidden]

<Recruitment Letter 1.docx>

Justine Attard <justine.attard13@gmail.com> Wed, May 30, 2018 at 9:20 PM
To: Grech Anton at Health-Mental Health Services <anton.grech@gov.mt>
Cc: Greta Darmanin Kissaun <greta.darmanin-kissaun@um.edu.mt>, catherine.dimech@gov.mt

Dear Dr. Grech,

Many thanks for your reply. On a different note, I have amended the dissertation title to "Constructed Narratives: First-Psychotic Episode With A Known History of Subtance Misuse"

Dear Dr. Darmanin Kissaun,

Kindly read the below correspondence from Dr Grech. Endorsement needed from your end to be able to get permission to recruit participants from Mental Health Services.

Many thanks.

Regards,
Justine Attard
[Quoted text hidden]

Greta Darmanin Kissaun <greta.darmanin-kissaun@um.edu.mt> Fri, Jun 1, 2018 at 10:27 AM
To: Grech Anton at Health-Mental Health Services <anton.grech@gov.mt>

Cc: Justine Attard <justine.attard13@gmail.com>, Dimech Catherine at Health-Mental Health Services <catherine.dimech@gov.mt>

Dear Dr Grech

As Justine's supervisor I hereby endorse

Thanks and warm regards

Greta

Dr Greta Darmanin Kissaun
PhD (Lond), Dott. Psicol. (Padua), B.A. (Hons), B.A. (Gen), Dip. GPTIM
Clinical Psychologist and Psychotherapist
Head, Department of Psychology
Deputy Dean, Faculty for Social Wellbeing
Room 215, Old Humanities Building, University of Malta
Msida, Malta MSD 2080

[Quoted text hidden]

Justine Attard <justine.attard13@gmail.com> Mon, Jun 4, 2018 at 1:42 PM
To: Greta Darmanin Kissaun <greta.darmanin-kissaun@um.edu.mt>
Cc: Grech Anton at Health-Mental Health Services <anton.grech@gov.mt>, Dimech Catherine at Health-Mental Health Services <catherine.dimech@gov.mt>

Dear Dr. Anton Grech,

Just a gentle reminder for the above since I need to submit Ethics form by the 6th June.

Please find endorsement in the above mail.

Many thanks for your time.

Regards,
Justine Attard

[Quoted text hidden]

Grech Anton at Health-Mental Health Services <anton.grech@gov.mt> Mon, Jun 4, 2018 at 1:46 PM
To: Justine Attard <justine.attard13@gmail.com>
Cc: Greta Darmanin Kissaun <greta.darmanin-kissaun@um.edu.mt>, Dimech Catherine at Health-Mental Health Services <catherine.dimech@gov.mt>

Approved.

Dr. Anton Grech MD PhD (Maas.) MSc (Psych)(Lond) FRCPsych(U.K.)
Clinical Chairman (Psychiatry), Dept. of Psychiatry, within Ministry of Health, Malta
Chairman of 'Fondazzjoni Kenn ghall Sahhtek', Malta
Resident Senior Lecturer, University of Malta
Senior Research Fellow, BCMHR-Cambridge University, UK
https://valletta2018.org/events/psychiatry-and-art-conference/

[Quoted text hidden]

Appendix O

Approval from Gatekeepers

L-Università ta' Malta

Justine Attard <justine.attard.07@um.edu.mt>

Access to participants

4 messages

Justine Attard <justine.attard.07@um.edu.mt> 28 March 2019 at 11:11
To: cynthia.bonnici@gov.mt
Cc: greta.darmanin-kissaun@um.edu.mt

Dear Ms Bonnici,

Trust this email finds you well.

As you are aware, I am currently reading for a Master of Psychology in Clinical Psychology at the University of Malta. In partial fulfilment of my studies, my dissertation, entitled **Constructing Stories of the Self Following the First-psychotic Episode and Substance Misuse**, will aim to obtain a deeper understanding of the participants' life story; the manner in which they experience their selfhood and any changes in their life-script following their first-psychotic episode with a history of substance misuse. My dissertation is being supervised by Dr Greta Darmanin Kissaun, here in CC.

Following our conversations earlier, I am kindly writing to request your assistance in recruiting participants who have made contact or benefited from mental health services. Hence, prospective participants would be identified by yourself, acting as a gatekeeper. Therefore, the process of recruitment would be fully ethical, voluntary and confidential.

Many thanks for your kind support.

Justine Attard
Clinical Psychology Trainee

Bonnici Cynthia at Health-Mental Health Services <cynthia.bonnici@gov.mt> 28 March 2019 at 12:16
To: Justine Attard <justine.attard.07@um.edu.mt>
Cc: "greta.darmanin-kissaun@um.edu.mt" <greta.darmanin-kissaun@um.edu.mt>

Dear Justine,

Thank you for your email.

I will gladly support you in your research.

Kind regards.

Cynthia

Cynthia Bonnici

Managing Psychologist

OASI Foundation
PREVENTION, INTERVENTION, TREATMENT & REHABILITATION SERVICES

3rd April, 2019

Dear Ms. Attard,

I acknowledge the receipt of your request to gather participants for your research through the OASI Foundation. On behalf of the OASI, I am pleased to inform you that this request has been approved.

The signed recruitment letter which you have provided will be forwarded to our clients so that those who wish to take part in your research can contact you.

Please note that, as a condition for its assistance in this matter, the OASI Foundation requests a copy of the final dissertation for its Research Library. We believe that the knowledge contained in dissertations such as yours is of great importance in drafting policy, educating the public, and for research purposes, including for future students such as yourself. Thus, we feel that it is very important that we have such resources at hand.

Kind regards,

Deborah Grech
On behalf of Mr. Noel Xerri, CE

Gmail Justine Attard <justine.attard13@gmail.com>

Gatekeeper request

3 messages

Justine Attard <justine.attard13@gmail.com> Tue, May 29, 2018 at 10:51 PM
To: catherine.dimech@gov.mt
Cc: Greta Darmanin Kissaun <greta.darmanin-kissaun@um.edu.mt>

Dear Dr. Dimech,

Trust this email finds you well.

Following our conversation earlier, in partial fulfillment of my Master of Psychology in Clinical Psychology, I will be conducting a qualitative research study entitled Constructed Narratives: First-Psychotic Episode with a Known History of Substance Misuse. My dissertation is being supervised by Dr. Greta Darmanin Kissaun, here in CC. The overarching aim of the study will be that of gleaning the participants' constructed life story; the manner in which they experience their selfhood and any changes in their life-script following the first-psychotic episode with a known history of substance misuse

I am writing to kindly ask you to be the gatekeeper for recruiting participants. The inclusion criteria are as follows:

- Participants need to be free from psychotic symptoms for the past one year.
- They need to be able to withstand the interview without experiencing undue distress.
- They need to be articulate and cognitively intact to be able to understand the implications of their consent.
- They need to have a known history of substance misuse prior to experiencing the first psychotic episode.

To ensure that participants' capacity to consent, prior to conducting the interview, I will conduct a four-question assessment adapted from The Older Adults Capacity to Consent in Research (Lee, 2010). I am attaching both this assessment and also the recruitment letter which explains the study in further detail.

There are no known risks or harm in participating in this research study. Thus, participants; psychological well-being is pivotal.

Many thanks for your time, co-operation and suggestions.

Regards,
Justine Attard
Clinical Psychology Trainee

2 attachments

Capacity to Consent doc.docx
41K

Recruitment Letter 1.docx
41K

Dimech Catherine at Health-Mental Health Services Thu, May 31, 2018 at 7:04 PM
<catherine.dimech@gov.mt>
To: Justine Attard <justine.attard13@gmail.com>
Cc: Greta Darmanin Kissaun <greta.darmanin-kissaun@um.edu.mt>

Dear Justine

Thanks for this email. I will gladly recruit participants for this interesting research study.

Regards
Dr Catherine Dimech