

Facilitators and barriers to living with psychosis: an exploratory collaborative study of the perspectives of mental health service users

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Psychosis, user involvement, recovery.

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Introduction: The purpose of this research was to deepen understanding of what is helpful to those who have experienced psychosis, in order to facilitate best practice within mental health services. Psychosis presents challenges for people on an everyday basis, yet strategies can be developed to facilitate living with psychosis. Investigating the service user's perspective is crucial for informing recovery oriented occupational therapy practice.

Method: Initiated and designed by a service user research group, this research was exploratory and, primarily, participatory. Data were gathered from two focus groups, involving 13 people with experience of psychosis, facilitated by service user researchers and an MSc student. Data analysis was systematic and based on grounded theory principles

Findings: Participants shared experiences and thoughts about their everyday lives. Data analysis revealed six elements of the self: the social self; the occupational self; the integrated self; the unsupported self; the stigmatised self and the isolated self. The importance of balancing these six facets of the self is theorised as being essential to successfully managing the experience of living with psychosis.

Conclusion: This emergent theory could underpin occupation-focused approaches to living with psychosis, with interventions aimed at enabling service users to balance the experience of psychosis with satisfying and contributing lives or recovery.

Introduction

Psychosis is characterised by unusual, often frightening or distressing, auditory, visual and somatic experiences, and beliefs that are unusual for the individual in terms of his or her culture and biographical history (Pilgrim 2009). Living with psychosis involves challenges for people on an everyday and ongoing basis. Despite recognised diagnostic categorisations, psychosis is generally a deeply personal, unique and subjective experience. Therefore, understanding of such experiences can be best accessed through the direct accounts of people who experience psychosis (Gould et al 2005). Deeper understanding can enhance approaches used in practice: for example, those based on recovery principles (Slade 2009).

Recovery is a central concept in modern mental health service delivery and is understood as being able to live 'a satisfying, hopeful and contributing life, even with the limitations imposed by the illness' (Anthony 1993, p17). This distinguishes recovery in mental health practice from notions of clinical recovery from illness, which might include eradication of symptoms, for example.

Recovery as a concept, however, is contested (Pilgrim 2009, Slade 2009). Even among people who use the term there are concerns that it has become so widely used as to be meaningless (Davidson et al 2010). There are also concerns among mental health service users as to the ownership of the concept of recovery (Repper and Perkins 2003, Pilgrim 2009), and worries about mental health professionals 'doing recovery' to service users. For these reasons,

it seems essential that personal experiences and understandings of living with psychosis are explored and understood in order that they may contribute to optimal service delivery.

The Researching Psychosis Together group

Locally, service users had been involved in previous participatory action research (Bryant et al 2010, 2011) and the Researching Psychosis Together group was set up in 2007 by one of the researchers (WB), to offer an opportunity for involvement in further research, independent of local service agendas. At the regular meetings at Brunel University, a focus on psychosis was agreed by the group members who were, at the time: six service users with lived experience of psychosis, a community mental health occupational therapist (JP), a student who was also an occupational therapy assistant at the local in-patient unit and WB, an academic. Once this focus was agreed, the group shared insights into the experience of psychosis from personal, professional and theoretical perspectives. Some members (CA, LF and JP) learned how to search for and review the literature, while the whole group discussed the research design and practical aspects of obtaining funding and approval. Aspects of their collaborative work are discussed elsewhere (Bryant et al 2012).

The first National Institute for Health and Care Excellence (NICE) guidelines for schizophrenia had indicated the importance of narrative accounts (2002, subsequently updated 2009), confirming the group's belief that by exploring first-person accounts, the research could meet their aims, which were: to identify factors that help individuals to live with psychosis; to provide guidance for service users and those who care for them and to inform service provision towards optimal interventions for people living with psychosis. The research question agreed upon was: What is helpful in the daily lives of people experiencing the effects of psychosis?

Literature review

The specific issues of living with psychosis are currently represented in the evidence base by findings from qualitative studies that have considered direct user accounts of everyday lives with psychosis and factors that have either hindered or facilitated ways of living with psychosis. The experience of stigma, the impact of psychosis on relationships and on occupational engagement, and the impact of psychosis on sense of self proved to be key themes in the literature, which was searched at several points during the research by members of the research group.

Stigma has been highlighted as a major barrier to recovery (Repper and Perkins 2003). People with mental health problems are one of the most stigmatised and discriminated against groups in society (Schulze and Angermeyer 2003). Mezzina et al (2006) found that self-stigma (internalised stigmatising attitudes) was a major barrier to social interaction. Stigmatising attitudes towards people with psychosis do not only come from the general population, but equally from mental health professionals (Nordt et al 2006). This

might explain why relationships with mental health professionals have been found to have both positive and negative aspects (Cook and Chambers 2009, Corring and Cook 2007, Mancini 2007). Therapeutic relationships with staff whose human qualities were characterised by warmth and acceptance helped to sustain hope for recovery, and were strongly valued by service users (Schön 2009). Conversely, unsatisfactory relationships with mental health workers and poorly perceived services restricted opportunities for recovery processes to develop (Cook and Chambers 2009, Corring and Cook 2007).

The potential of social relationships for facilitating recovery has been highlighted yet it is recognised that social relationships can in themselves be a source of distress (Slade 2009, Schön 2009). Peer support has been found to contribute positively to a sense of self-efficacy and identity, enabling recovery by sharing experiences with understanding and acceptance (Gee et al 2003, Mancini 2007, McGrath 2009). Contact with peers who had positive experiences of recovery to share elicited a sense of hope for others who experienced psychosis (Mancini 2007).

The direct experience of psychosis was found to disrupt established routines and occupations, including the loss of life roles (Corring and Cook 2007, Mezzina et al 2006), as well as limiting opportunities to engage in fulfilling hobbies, activities and leisure opportunities (Cook and Chambers 2009, Corring and Cook 2007, Laliberte-Rudman et al 2000).

An episode of psychosis can be experienced as a major assault on the sense of self, changing perceptions of identity and self-control (Koivisto et al 2004). Separate consideration of the self from the mental health problem, such as psychosis, has been suggested as a significant part of recovery (Davidson 2003, Dilks et al 2010, Eklund and Backstrom 2005, Mezzina et al 2006). Davidson (2003, p31) has referred to this as 'living outside mental illness'. However, separating oneself from one's experiences could seem impossible. Understanding what enables living with psychosis can be achieved by attending closely to the everyday life of people with direct experience. This notion applies in occupational therapy practice, which is primarily guided by the service users' personal needs, whereby they become active participants in working towards their recovery (Creek 2008). Furthermore, with one exception (Cook and Chambers 2009), published research in this field has been designed and carried out by academic researchers. Although people with lived experience of psychosis may have been consulted about their experiences, they did not have the opportunity to shape the research from the outset.

Method

This research was primarily participatory and emancipatory, based on the belief that knowledge from direct experience has power to inform service provision and development. Every stage of the research involved service users, as researchers and participants, based on the perspective that research is

an occupation that can be designed and adapted to enable participation in diverse ways (Bryant et al 2010). To appreciate the individual experience of psychosis, a qualitative approach was adopted. Sharing experiences using focus groups was believed to be most appropriate, for several reasons. Firstly, the interactive and naturalistic nature of focus groups allows for the facilitation of discussion of a range of issues to which individuals in the group can add their perspectives and responses, often generating more insights than individual interviews with the same number of participants (Krueger and Casey 2000). Additionally, focus groups also help investigate sincere attitudes and beliefs about the subject, in comparison to one-to-one interviews of a usually inhibited and formal nature (Kitzinger 1994, Merton et al 1956). Furthermore, the interaction between participants in a focus group helps to reveal the true language they use, which could be important in the data analysis stage. Lastly, the service user researchers' own experiences of groups in community mental health settings helped build peer support and often generated discussion of issues relating to recovery (Bryant et al 2010, 2011). Two focus groups were conducted on two different days of the week so as to maximise service user participation and hence gather more data. The sixth author (JP) was funded by the Brunel University Knowledge Transfer scheme to oversee the preparation for approval and explore funding sources. Ethical issues were discussed in detail and service user group members ensured a practical focus, for example, considering the likelihood of difficulties arising in the groups, and discussing the most helpful responses from their service user perspective. At this stage, knowledge, understanding and skills in data collection and analysis were acquired in an innovative process of research training which is described elsewhere (Bryant et al 2012).

Ethical approval for the study was obtained from Brunel University (reference 09/09/STF/08) and NHS local Research Ethics Committee (reference 09/H0709/78). The first author (LM) joined the group during the final stages of gaining approval, providing the group with an important resource for data collection, analysis and dissemination. In return she gained an opportunity to conduct real-world research for her MSc degree and have direct experience of collaborative research. The close links with local mental health services, via JP, reassured the committee that appropriate supports for the research were in place.

The research was publicised at local mental health service venues, both statutory and non statutory, through flyers, posters and word of mouth. A launch event was held at a local community centre, with lunch provided; 14 people attended this event, which was an informal, friendly opportunity for anyone interested to find out what was involved and whether they were eligible to take part. Participants needed to have had direct experience of psychosis, to be between 18 and 70 years, have used adult mental health services within the 5 years preceding the study and not currently detained under the Mental Health Act (2007).

Focus groups and data collection

Six participants attended the first focus group and eight the second. One participant had to be excluded as she was detained under the Mental Health Act (2007), resulting in 13 participants. There were eight men and five women of various ethnicities and ages, reflecting the profiles of people using local services. Some of these participants knew each other through community mental health services and others were unfamiliar with their co-participants.

The focus groups took place in a local community centre and were facilitated by the first author, co-facilitated with the researchers (CA on the first day; LF on the second day). Participants completed consent forms following an opportunity to ask questions. Guidelines set out by Krueger and Casey (2000) were used to inform the questioning route, beginning with the introductory question and then moving on to the transition question, the key questions and finally the closing question (see Appendix 1). The key questions helped shed the most light on the findings, in asking what participants found helpful in dealing with psychosis in their everyday lives, what had been unhelpful and whether they had sought advice or help on how to manage it. The focus groups were audio recorded and transcribed verbatim by the first author. At the end of the session, participants were each given £20 (cash) towards their personal expenses and as thanks for their involvement.

Data analysis

The first author analysed the data on behalf of the Researching Psychosis Together group. Regular discussions with the group enabled them to question and shape the emerging findings, to maximise the reliability of the study.

It is recognised that grounded theory enables the researcher to capture the complex nature of focus group data by providing a structure to collect, organise and analyse data, making it an appropriate methodology for this study (Silverman 2000). Coding of the data followed grounded theory techniques set out by Corbin and Strauss (2008) and comprised three stages in sequence: (1) open coding, which develops over-arching concepts from the raw data; (2) axial coding, which restructures the data and the forms categories and (3) selective coding, which integrates the various categories to form a core category and emergent theory. The open codes are shown in the far left column of both Figs. 1 and 2, with the axial codes shown in the second column from the left and selective codes as categories on the far right. These figures illustrate how the themes were identified and condensed through the three stages to produce the findings. The coding process required sustained engagement with the transcripts and facilitated extensive exploration of the meanings behind the data.

Findings

The findings convey a dynamic interaction between six aspects of the self, and indicate the need to balance these aspects in order to manage a life with psychosis. Six essentials of the self

were identified in the process of data analysis: 'the social self', 'the occupational self', 'the integrated self', 'the unsupported self', 'the stigmatised self' and 'the isolated self'. The overall findings from the study are presented in Fig. 3, which brings together the six aspects of the self identified in the data analysis, and

shown in Figs. 1 and 2. Findings suggested that the participants were engaged in a complex task of balancing the experience of living with psychosis with personal and social identity. They described aspects of their lives that made living well with psychosis possible, and those that made this difficult.

Fig. 1. Facilitators to living with psychosis.

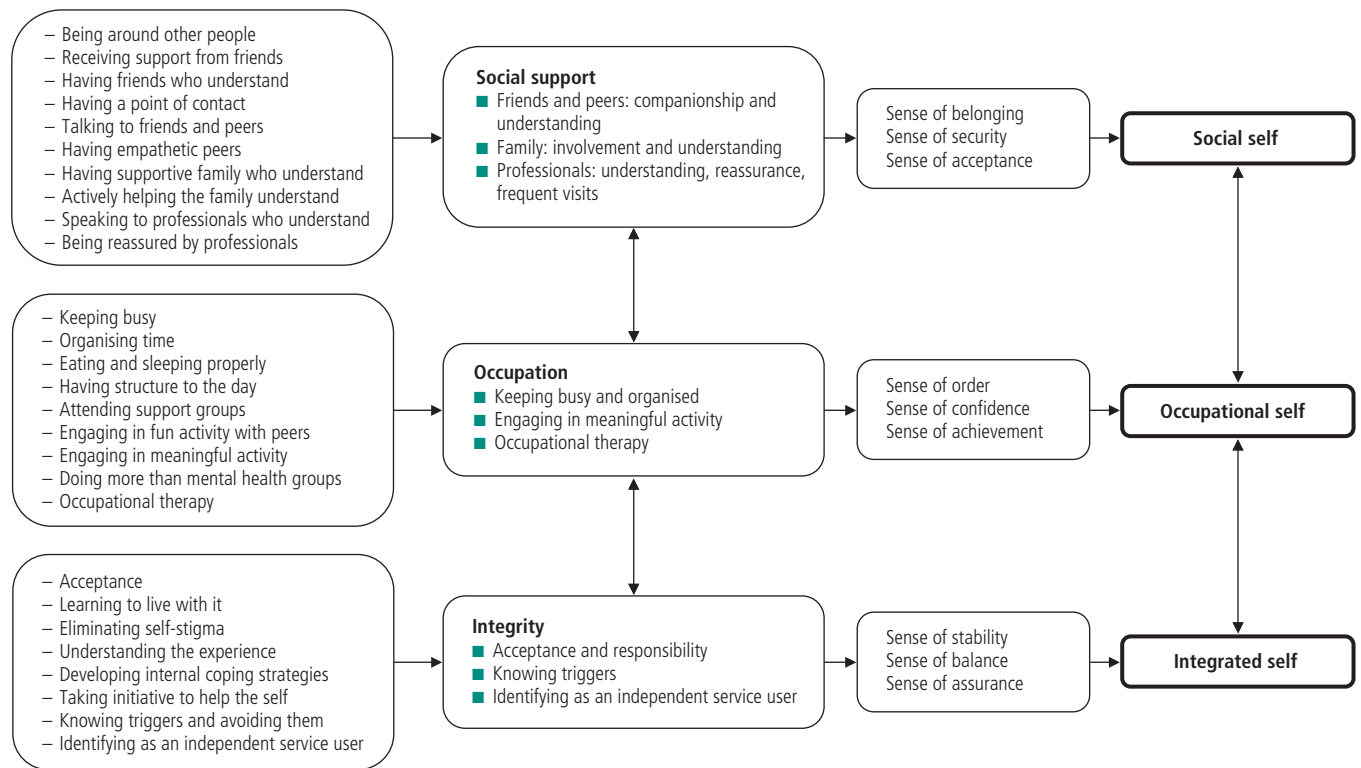


Fig. 2. Barriers to living with psychosis.

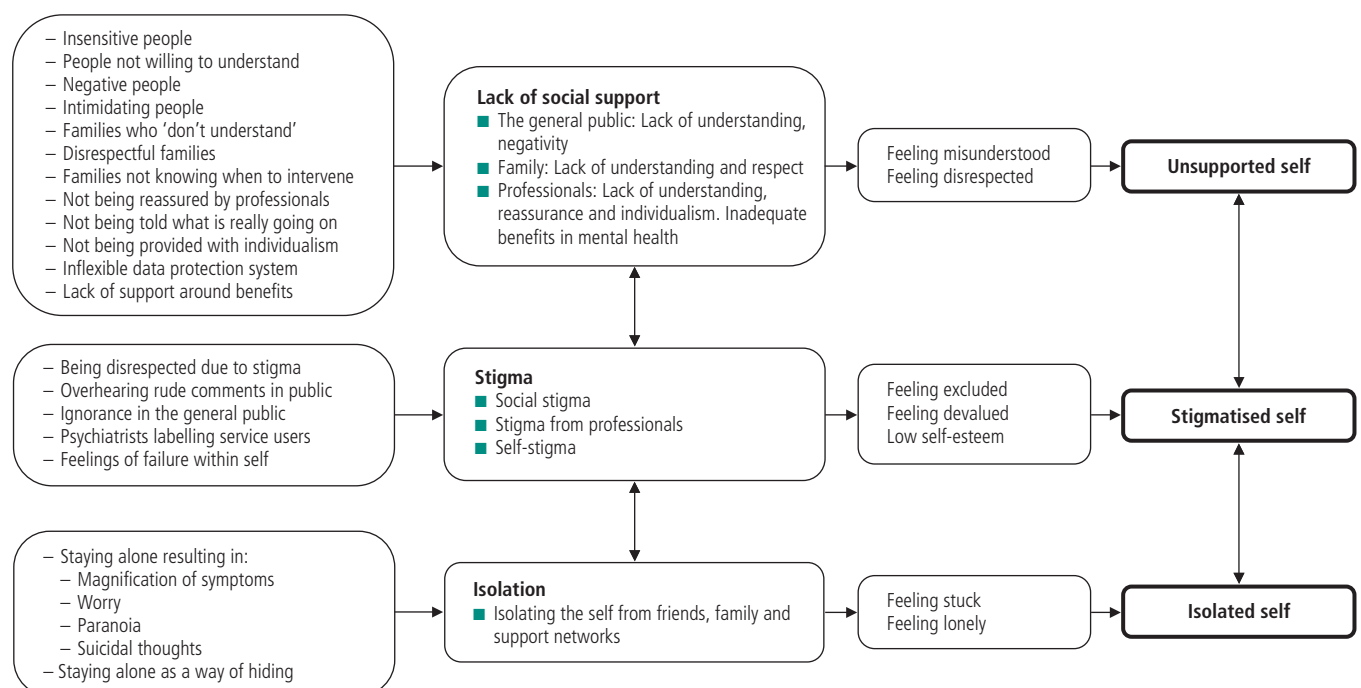
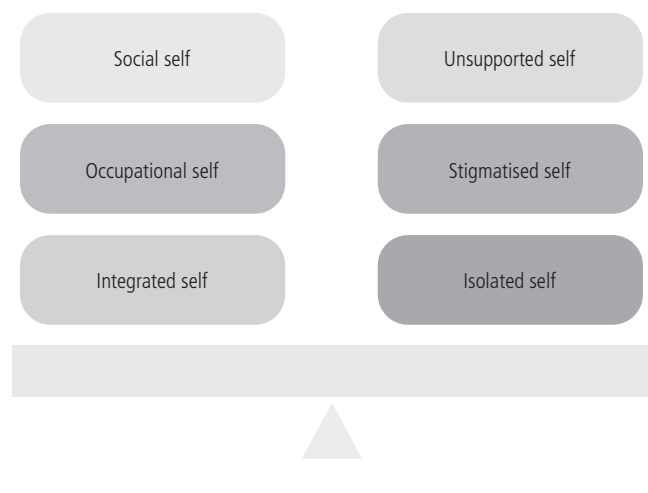


Fig. 3. Dynamic interactions to achieve balance.



Facilitators and barriers to living with psychosis

The conditions listed in the first column of Fig. 1 represent the facilitators to living with psychosis that had been identified in the focus group transcripts (for example ‘being around other people’ or ‘receiving support from friends’). These were then condensed to produce three categories: (1) social support; (2) occupation and (3) integrity. Corresponding consequences were then mapped out, as illustrated in the third column, and further developed to produce ‘the social self’, ‘the occupational self’ and ‘the integrated self’.

By the same process, a second matrix was devised to show the barriers to living with psychosis (Fig. 2). Conditions included ‘families who don’t understand’, ‘being disrespected due to stigma’ and ‘staying alone’. These codes were then developed into the three categories of ‘lack of social support’, ‘stigma’, and ‘isolation’, which were further developed to give the consequences of ‘the unsupported self’, ‘the stigmatised self’, and ‘the isolated self’.

Each of the elements of the self that were identified in the analysis is presented, highlighted with extracts from the focus group (FG) transcripts, alongside the researchers’ analysis. Pseudonyms are used throughout.

The social self

Participants spoke about the different relationships in their lives. The accounts revealed that some of these were experienced as more helpful than others, with positive qualities in peers noted as particularly important in feeling supported:

... you can see people like your own and you’re free to talk, and most of your disease goes away cause you can just see you’re not alone in the world (Elin, FG1).

The feeling of solidarity evoked by Elin’s use of ‘like your own’ spoke of a kinship with other users of mental health services, which seemed shared by other participants:

[Other service users] can really understand you (David, FG1).

... help pull you through (Ben, FG1).

know how you feel (Ahmed, FG1).

Most of my friends have got mental issues; they seem more sensitive and kind to communicate with, than the so-called ‘normal’ people (Louisa, FG2).

A number of participants also found great support from their families, with some crediting their families with keeping them alive:

My brother was the most important person. He was on the phone to the people in the hospital, etc. and ... I’d be dead if it wasn’t for him (Jon, FG2).

If it wasn’t for my friends and family, I’d be in a box. I’ve attempted suicide more times than I can count (Ben, FG1).

However, not all of the participants had good experiences of family support:

Well, being bipolar is difficult in a way because if you’re normally happy, your family think you’re going to get high again. I hate that word ‘high’, you could be just happy naturally and if you’re quiet, they say ‘oh, you’re withdrawn, you’re depressed’. I think your family is the worst enemy really (Louisa, FG2).

I don’t think my sister’s got any respect for me whatsoever ... she criticises me all the time and picks fault with me all the time and it really gets me down. I’ve had enough! (Karolina, FG2).

Relationships were a major theme in our findings, with positive experiences within relationships leading to participants feeling supported and understood. Relationships that were difficult contributed to difficult feelings and could compound feelings of isolation, as will be seen when presenting ‘the isolated self’.

The integrated self

Acceptance of themselves and responsibility for their own recovery, including knowing their triggers and identifying as an independent service user, all contributed to the third component, integrity:

... there is help out there and [there is] nothing to be ashamed of [in being a mental health service user] (Bryan, FG1).

Another participant highlighted the risk of becoming unwell again and the need for constant vigilance:

You’ve got to look at your danger points, look at them and maybe avoid them or look at ways of dealing, a strategy of dealing with your trigger points, or anything that you know could bring you back into a psychosis episode or relapse, and to look at it before it actually happens and to be able to deal with it when it does and looking at strategies of coping with it (Ahmed, FG1).

Living with psychosis sounded demanding, with a need for constant attention to one’s inner world, as well as the need to maintain equilibrium:

[You can] still be in the community [as opposed to in hospital], be independent ... you feel quite assured and achieve a sense of balance. You know you’re independent and you still can be okay about being a mental health sufferer (Ahmed, FG1).

Acceptance of one's mental health problems and developing strategies for coping appeared to make important contributions to feelings of personal integrity and authenticity.

The occupational self

Many of the participants spoke about the value of being engaged in meaningful and fulfilling occupations as a way of maintaining balance in their lives and staying well:

I just find that structure is really important to my day ... structure is key for me to feel better. I need things to do (Jon, FG2).

However, not everyone felt they needed a structure to their day:

I just like to take things day by day. I don't make plans, because whenever I make a plan, it goes wrong. If I don't plan it, it usually works (Ben, FG1).

Participants spoke about the different functions of occupations; providing a focus, a distraction or giving confidence were some of the purposes of occupations that were described:

... my writing does help; it's very cathartic and gives me something to focus on, and that helps me out a lot (Ben, FG1).

... have your little interests, you know, get away from it a bit (Louisa, FG2).

... [occupation] gives you more confidence in yourself and doing things can distract; you feel a bit better about yourself, that you've done something or achieved something — some of these things you may really enjoy and want to take up (Ahmed, FG1).

Engagement in a variety of occupations, and specifically meaningful occupation as promoted in occupational therapy practice, was presented by most of the participants as being important for health and wellbeing and for enhancing their lives with psychosis.

Most of the participants described aspects of their lives that were difficult, challenging, painful and often frightening. These aspects have been cast as the unsupported, isolated and stigmatised elements of the self and are in many ways the converse of the elements of self, described above. These elements overlap with each other to greater or lesser extents but will be presented as discrete categories for clarity.

The unsupported self

Many of the participants offered accounts that suggested that they felt very misunderstood by other people:

People don't see the upset your mind is in. People have a very insensitive way of talking and don't understand and [are] not willing to understand how you feel (Ivan, FG1).

Some offered accounts that suggested they felt very different from others because of their mental health problems, and that it was this difference that made them feel that others did not understand them:

It is difficult for the normal people to understand. They think 'oh get over it'. They can't understand what you're going through or what you're thinking ... (David, FG1).

Feelings of difference, of not being 'normal', elided in many accounts with feelings of stigma and self-stigma.

The stigmatised self

Most of the participants wanted to be afforded the same considerations as any other person and not feel they were treated differently because of their mental health problems:

[I want to be treated] like a normal human being and treated with the same respect as everybody else, but they don't, they treat you like an imbecile (Frank, FG2).

Mental health professionals were also guilty of such behaviour, according to one participant:

... they [mental health workers] stigmatise the most ... they preach about not stigmatising, they do it the most, honestly, they are the biggest load of sycophantic hypocrites ... It's all about us and them and there's no talking to you as a person, they talk to you as a patient and it doesn't do you any favours (Ben, FG1).

Not all participants sounded as angry as Ben but, instead, took a defeatist and defeated tone, saying:

I think that it's just something within ourselves that, you know, [if someone has] got mental health issues [we associate that with] 'failure' (Lena, FG2).

The isolated self

The isolated self could be seen as the converse of the social self, presented above. Participants found that being alone could make them feel more distressed and increase their experience of psychosis:

When you stay alone, it's magnified (Louisa, FG2).

... all I do is think, and get more and more paranoid, and get things out of proportion (Frank, FG2).

At times, participants experienced feelings that made them want to isolate themselves, such as feelings of mistrust or fear:

[You feel that] you can't trust anybody (Martha, FG2).

... fear overtakes you (Havil, FG2).

However, some recognised that being alone was not necessarily helpful in maintaining wellness, and that being around other people was the better option, despite the difficult feelings that social relationships could provoke:

I think being amongst people and not staying on your own [is better], because when you're on your own you're in that spiral place and you go down (Louisa, FG2).

One participant described the very frightening effects of being left alone in his room and implied that being with other people would have been helpful in avoiding the terror he experienced alone:

They [staff] didn't talk to me and I was allowed to be in my room, thinking that there was people in the cupboard, etcetera,

and thinking the persecution thoughts that I had ... I would've liked, when I was experiencing the symptoms, so frightened I was wetting myself ... I would've liked someone to talk me through it and say 'this is what is really happening' (Jon, FG2).

What these participants' accounts convey is a vulnerability that can accompany being isolated, and how the company of other people can help to combat this. However, there was a tension evident, with some relationships being causal in participants' painful feelings.

Discussion

The findings suggest that there are complex factors that the participants felt they needed to consider in the task of living with psychosis. The concept of recovery, defined earlier in this article as being able to live 'a satisfying, hopeful and contributing life, even with the limitations imposed by the illness' (Anthony 1993, p17) seems synonymous with living well with psychosis. The participants in the study did not specifically refer to recovery but described aspects of their lives that made living with psychosis more or less difficult. The concerns expressed by Pilgrim (2009) and Davidson (2010) about the concept of recovery becoming 'professionalised' seem pertinent, and we would suggest that when speaking with service users about their experiences it is important to understand how they describe their experiences; whether or not this is called 'recovery' is less important.

The perspectives of the service user participants suggested that the experience of living with psychosis was linked with the concept of sense of self. Six aspects of the self were identified in the data analysis, described above. To live well with psychosis, individuals articulated a need to balance all elements of the self. If one of the more challenging elements of the self became ascendant, the balance of experiences became threatened and living with psychosis became more challenging as a whole. Balancing required constant attention, and was experienced as an ongoing and dynamic process in which the participants were striving to maintain a sense of self in the face of the experience of living with psychosis. The support of other people and engagement in occupations could help with this process; feeling stigmatised, unsupported and isolated could sabotage it. This perspective on balance is different to occupational balance, incorporating occupation as an element. Pentland and McColl's idea of occupational integrity (2008) is perhaps more closely related to it, being concerned with the importance of understanding the personal values that underpin occupational choice.

The assault on the sense of self that occurs in psychosis has been described as one of the core manifestations of the experience (Koivisto et al 2004). Many authors have described the transformation and reconstruction of the self as one of the main tasks in recovery from psychosis (Charmaz 1983, Erikson 1957, Estroff, 1989, Jacobson and Greenley 2001, Slade 2009). The present study, however, produced distinctive findings that did not describe a transformation or

reconstruction of the self but identified a need to achieve a balance between multiple facets of the self. Balancing the facets of the self seemed a delicate process, with an emphasis on keeping the positive aspects of self (social, occupational and integrated) in ascendance over the negative aspects (unsupported, stigmatised and isolated). The accounts of the participants in the present study would seem to suggest that constructing and balancing a sense of self is key to living well with psychosis, and they identified factors which helped and hindered this task.

The findings suggest that occupational therapy practice could be focused on enabling people to build and maintain identity by balancing aspects of the self. This concept is congruent with both client-centred and recovery oriented approaches to practice. The findings also indicate a need for professionals to engage with the person's experience so that they can understand how each individual understands recovery. This in turn may require the provision of environments and opportunities for meeting peers, gaining social support and becoming socially included.

Critical evaluation of the study

The trustworthiness and usefulness of this study can be evaluated principally according to two of Yardley's (2008) criteria: a detailed account of the analytic process, and sensitivity to context. The former has been given in the narrative of this article, illustrated by Figs. 1 and 2.

Sensitivity to context is a vital characteristic of high-quality qualitative research (Yardley 2008). As a participatory study, this research was highly sensitive to the context of living with psychosis, with service users leading decisions on the focus, design and implementation. The attention given to ethical considerations required detailed knowledge and understanding of the context, to gain approval and enable all members of the Researching Psychosis Group to be aware and confidently respond to ethical issues in an appropriate way. Some limitations to the study are intrinsic to the nature of qualitative research itself, such as the small sample size and limited number of focus groups. Nevertheless, it is hoped that the transparency with which the study is described enables the reader to judge the quality of the study and the usefulness of the findings for themselves.

Conclusion

Pivotal to the experiences of living with psychosis was the identification of the facets or 'identities' of the self. It is important to recognise that these identities are in constant interaction with one another and are never in isolation. Exploring the conditions that influenced these identities facilitated a better understanding of the complexities of living with psychosis. Findings indicated a need to balance the six facets of the self, which had been identified through the data analysis.

Helpful interventions for people who experience psychosis might involve working to minimise obstructive identities

such as 'the unsupported self', 'the stigmatised self' and 'the isolated self', as well as working to enhance the affirmative identities of 'the social self', 'the occupational self' and 'the integrated self'. However, it is impossible to disregard the factors that impact negatively on participants' lives, and especially those factors that may be beyond their control, such as the lack of social support. Therefore an awareness of the barriers to living with psychosis is essential to manage setbacks and devise effective coping strategies.

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Conflict of interest: None declared.

Key messages

- The experience of psychosis is an assault on the self.
- Recovery and living well with psychosis are synonymous.
- Attention to lived experience is critical to optimal understanding.

What the study has added

The research provides a deeper understanding of the experience of living with psychosis. Living well with psychosis requires balancing a range of complex internal and external factors that have an impact on the sense of self.

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Appendix 1. Focus group questions

Q1: OPENING

Let's find out some more about each other by going around the room one at a time. First round: Could you please say your name?

Second round: Can you please say a bit about yourself, for instance how you heard about the research or what made you come along to the group? Or have you been to [place] before? Do you know anyone here?

Q2: INTRODUCTORY

Do you use the term 'psychosis' and, if yes, when do you talk about psychosis or what do you say?

Q3: TRANSITION

Think back to when you had an episode of psychosis. This could be recent or going back years ago. How would you describe your experiences?

Q4: KEY

From your experience, what do you find has helped you deal with psychosis in your everyday lives?

- How did you come to find this out?
- Is there a personal meaning for you behind this? If so, what?
- Would you give this advice to others experiencing psychosis?

Q5: KEY

From your experience, what has been unhelpful to you, or an obstacle, in dealing with psychosis?

Q6: KEY

Have you sought after advice or help on how to manage psychosis?

- If yes:
 - At what stage in your experience did you seek help or advice?
 - What encouraged you to seek help or advice?
 - Where did you go looking for help or advice?
 - How easy or difficult was it to obtain?
 - Would you encourage others to use these resources?
- If no:
 - What prevented you from seeking help/advice?

Q7: CLOSING

(At this point, [co-facilitator] will give a summary of what you've all said)

- What do you think were the most important points?
 - Is there anything that we missed out?
 - Is there anything that you came wanting to say that you didn't get a chance to say?
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