ART AND ADAPTATION TO PSYCHOSIS:

ART THERAPY AS A TREATMENT METHOD, DRAWINGS AS A RESEARCH METHOD

By

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A thesis submitted to the University of Birmingham in partial fulfilment of the degree of

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Volume I

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Thesis overview

This thesis is submitted in partial fulfilment of the requirements of the degree of Doctorate of Clinical Psychology at the University of Birmingham. It comprises both research and clinical components of the course.

Volume I of the thesis includes two research papers. The first is a systematic review which aims to examine the effectiveness of Art Therapy (AT) in the treatment of people with psychosis and to explore how acceptable and meaningful AT is for this population. A thorough systematic search through seven databases resulted in sixteen articles. A critical review of their methodology and results revealed that there was inconclusive evidence for the efficacy of AT for people with psychosis due to the paucity and limitations of the literature. This was incongruent with the view of service users and art therapists who highlighted the benefits experienced through AT and that this intervention was meaningful and acceptable to people with psychosis. The review discusses various methodological, clinical and theoretical issues that underpin the current evidence base. It makes recommendations for how future research can be developed to ensure that AT is effectively evaluated and its benefit is not lost to people with psychosis.

The second paper is an empirical study which explores the meaning of adaptation to first episode psychosis, through individual's creation of images. Ten participants who experienced a first episode of psychosis took part in an interview in which they verbally and visually explored their experience by creating an image. The data were analysed through Interpretative Phenomenological Analysis and image analysis. Four super-ordinate themes were identified. Through the first theme, '*Figuring out how psychosis fits into my story',* participants highlighted the process they went through to make sense

of psychosis and how it fit into their life. In the second theme, '*Breaking free from psychosis',* they described their active attempts to re-engage with and rebuild their life and relationships and to find themselves again. The third theme, *'Fighting my way through psychosis',* captured that this was not easy and participants faced ongoing hurdles. Yet, they were determined to continue to work towards their goals. The final theme, *'Finding a new way of being 'me'',* highlighted that following FEP, participants developed new beliefs about their sense of self, life and relationships. Whilst these changed beliefs were not always easy to accept, they allowed many participants to grow as individuals. These results add to the recovery and growth literature by illuminating that adaptation to psychosis is a complex and ongoing process that entailed both painful and growth-inducing experiences. The results are discussed in light of the current literature and clinical and research implications are outlined.

Volume II includes the clinical component of the thesis and contains five Clinical Practice Reports (CPR) which present examples of clinical work completed over the course of training. All the names and any identifiable information in these CPRs have been altered or omitted in order to protect the service users' anonymity and confidentiality. CPR1 is the case of David, a 64 year old gentleman who is diagnosed with idiopathic Parkinson's disease and presenting with moderate anxiety problems. His difficulties are formulated from a cognitive-behavioural and psychodynamic approach. A service evaluation is carried out for CPR2 which investigates the equality of dementia services provided for older adults of Black Minority and Ethnic groups in comparison to the White Majority. CPR3 is a single-case experimental design which evaluates a cognitive-behavioural and exposure-based intervention for Tom, a 12 year old boy, who

has a long-standing food neophobia, or a fear of eating new foods. CPR4 describes a case study of Raj, a 16 year old male referred to an Early Intervention Service due to his risk of developing psychosis following personality changes and apparent hallucinations. A cognitive-behavioural assessment and formulation and an integrative intervention are described. Finally, an abstract is presented for CPR5 which summarises an oral presentation given about Tracey, a 48 year old women with a learning disability who was admitted to hospital due to risk issues associated with hearing a voice.

Dedication

To Alan, Grandma, Mama and Papa

For always being there, even from afar

Acknowledgements

I would like to thank all the participants who took part in my research, for their time and courage to share their story with me. This was a privilege and your strength is admirable and a source of inspiration to me and others.

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Contents Page

Volume I: RESEARCH COMPONENT

V TABLES AND FIGURES

Systematic Review

Empirical Paper

Contents Page

Volume II: CLINICAL COMPONENT

VII TABLES AND FIGURES

Clinical Practice Report 4: Case Study

SYSTEMATIC REVIEW

THE EFFECTIVENESS AND MEANINGFULNESS OF ART THERAPY IN THE TREATMENT OF PEOPLE WITH PSYCHOSIS: A REVIEW OF THE LITERATURE

Paper to be edited for submission to the International Journal of Art Therapy

ABSTRACT

Objective: To examine the effectiveness of Art Therapy (AT) for people with psychosis and to explore whether AT is a meaningful and acceptable intervention for this population.

Method: Seven electronic databases were searched for empirical papers that concerned AT and adults with psychosis, that were published from 2007 onwards, and available in English. Articles with various methodologies and outcome measures were included. The search identified sixteen papers which were reviewed.

Results: The high quality quantitative articles provided inconclusive evidence about whether AT is effective for people with psychosis. However, the qualitative articles indicated that art therapists and people with psychosis considered AT a beneficial, meaningful and acceptable intervention.

Discussion: There is a discrepancy between the scientific evidence regarding the effectiveness of AT and the value given to it by clients and therapists. This may be attributed to insufficient theoretical understanding of AT and of how, when and for whom it works. This makes it difficult to evaluate its effectiveness. Theoretical, clinical, and methodological issues are discussed and recommendations are made for the development of more robust research. This has important clinical implications given that AT is a nationally recommended treatment for people with psychosis.

1.0 INTRODUCTION

The Diagnostic and Statistical Manual of Mental Disorders (5th Ed.; DSM-V; American Psychiatric Association, 2013) and International Classification of Diseases–10 (WHO, 1992) recognise that schizophrenia forms part of a cluster of psychotic disorders. These include schizotypal, delusional, psychotic, schizoaffective and schizophreniform disorders, although the latter is only included in the DSM-V (2013). Throughout this review, the overarching term 'psychosis' will be used to refer to these disorders in accordance with the National Institute for Clinical Excellence (NICE, 2014) guidelines for schizophrenia and psychosis, and the British Psychological Society (2014).

Prevalence of psychotic disorders is estimated to be 0.4% (Kirkbride et al., 2011) or 0.5 % in England (McCrone, Dhanasiri, Patel, Knapp, & Lawton, 2008). They have common features which are present to different degrees. These include positive symptoms[1] such as delusions, hallucinations, thought disorder, and unusual motor behaviour, and negative symptoms such as diminished emotional expression, motivation, pleasure, and social interaction (DSM-V, 2013).

A national audit in 2007 (Royal College of Psychiatrists [RCPsych], 2012) indicated that schizophrenia can have a debilitating impact on people's lives and mortality. Pharmacotherapy is a primary source of treatment for schizophrenia, though its effectiveness can be limited and undermined by its side effects (Moncrieff, 2013). People may also be treatment resistant (RCPsych, 2012) and continue to experience

[1] Description of some of the positive symptoms:
Delusions: beliefs that remain rigid even in light of contrary evidence
Hallucinations: vivid, life-like perceptions in relation to all sensory modalities
Thought disorder: disorganised and incongruent speech (DSM-V, 2013)

symptoms together with psychological, social and functional difficulties (Thornicroft et al., 2004). Medication non-compliance is also a problem commonly linked to relapse (Weiden, 2007). Therefore, NICE (2014) highlights the need for psychological therapies, particularly for people who do not benefit from medication. In addition to Cognitive Behavioural Therapy (CBT) and family intervention, Art Therapy (AT) is recommended.

According to Uttley et al. (2015), the definition of AT remains indistinct despite its recognition as an official psychological therapy in the UK. There has been a long-standing divide between AT being considered as 'art as therapy' and 'art psychotherapy' (Wood, 1997b). 'Art as therapy' considers art to be an activity that is soothing and enables artistic skill acquisition. Conversely, in 'art psychotherapy', psychodynamic theory guides understanding and interpretations of clients' art and its meaning (Wood, 1997b). The definition of AT provided by the British Association for Art Therapy (BAAT, 2015) is in line with 'art psychotherapy'. AT is considered "*a form of psychotherapy that uses art media as its primary mode of expression and communication*" (BAAT, 2015) to support people in distress. The person in AT forms part of a tripartite relationship with their art and the art therapist. This definition of art therapy is also adopted by the NICE guidelines for psychosis and schizophrenia (2014).

AT is frequently offered when other interventions are ineffective for people with psychosis (Uttley et al., 2015). Yet, art therapists have advocated for its suitability for this client group more routinely. Negative psychotic symptoms may hinder people's ability to identify, express and explore their experiences (Schaverien & Killick, 1997). People with schizophrenia often have difficulties with mentalisation or identifying their own or others' mental states (Brüne, 2005) and tend to withdraw socially (Schaverien,

1997). AT has a longstanding role in facilitating engagement when direct verbal interaction is considered difficult or intimidating (Fonagy, 2012; Schaverien, 1997). Inspired by the psychoanalytical theories of Jung (1928) and Cassirer (1955), Killick (1993) and Schaverien (1997) suggest that art is a mediating factor between the person with psychosis and the therapist; it is a transactional object that is a safer, indirect means of communication and connection with oneself and others.

People with psychosis may also have blurred boundaries between their internal and external worlds (Greenwood, 2012). This may make their lived experience overwhelming and confusing. Therefore, based on Bion's psychoanalytic idea of containment, AT aims to contain these experiences (Wood, 1997b). People can project their cognitions and emotions (Greenwood, 2012), or externalise fragmented parts of themselves onto art (Schaverien, 1997). Here, they can be held until individuals are ready to re-integrate them into themselves (Greenwood, 2012).

AT commonly occurs in a group setting. This format can help individuals feel that they belong within a community where art is a communal means of self-expression and experiences can be shared verbally or non-verbally (Schaverien & Killick, 1997). AT has been found to enhance people's well-being and development of interpersonal connections (Wood, 1997b).

This support for the appropriateness and helpfulness of AT is rooted in theoretical work and clinical experience and is weakly substantiated by rigorous, controlled research. National guidelines that make recommendations on the care and treatment of specific conditions, are based on the highest quality of scientific evidence. These include Randomised Control Trials (RCTs) and systematic reviews which have at

least one RCT (Rose, Thornicroft, & Slade, 2006). In this hierarchy of evidence, cohort, case-control, cross-sectional, and case studies, and opinion papers are increasingly considered weaker sources of evidence (Slade & Priebe, 2001). Therefore, the effectiveness of AT is primarily established through RCTs.

In an early Cochrane review (Ruddy & Milnes, 2005), the lack of RCTs prevented conclusive results regarding the effectiveness of AT for people with schizophrenia. However, by 2009, the findings of further RCTs resulted in NICE recommending AT especially for people with negative symptoms. Green, Wehling, and Talsky (1987) found that a 10-week AT outpatient group with standard care demonstrated significant gains in social interaction and self-esteem when compared to Treatment As Usual (TAU). Meng et al. (2005) showed that a 15-week AT group significantly improved mental health, quality of life and functioning of inpatient clients with psychosis compared to TAU. Richardson, Jones, Evans, Stevens, and Rowe (2007) explored the effect of a 12-week AT outpatient group compared to TAU. Although this study was underpowered and had high dropout rates, there was just about a statistically significant decrease in negative symptoms for the AT group at post-intervention and six months follow-up.

In an attempt to strengthen this scientific evidence base, the largest 3-armed RCT to date, the MATISSE trial, was designed to investigate the clinical effectiveness of AT for people with schizophrenia (Crawford et al., 2010, 2012). Contrary to previous RCTs, the outcomes indicated that those who received AT with TAU did not experience significant improvements in psychotic symptoms and functioning compared to an activity group with TAU and a TAU alone group. AT was not more cost-effective. These conclusions, together with the trial's design, execution and limitations, provoked

a wave of clinical and academic responses and concerns regarding the future of AT for people with schizophrenia (Holttum & Huet, 2014; Wood, 2013). This included a critical review of six articles regarding the execution and processes of the trial to assess the validity of the results (Holttum & Huet, 2014).

The growing interest in AT is also evident through the increase in recent systematic reviews. These evaluated some schizophrenia literature, however, without synthesizing it comprehensively. Slayton, D'Archer and Kaplan (2010) reviewed quantitative literature investigating the effectiveness of AT within clinical and non-clinical populations from the year 1999 to 2007. They concluded that AT was effective but did not specify for which clinical populations or how it was effective. Van Lith, Schofield and Fenner (2013) reviewed the implications of art-based practices on recovery amongst people with mental health problems and concluded that it aided social and psychological recovery. The articles that focused on schizophrenia were dated 2009 or earlier and a weakness of this review was that they did not always consider AT. In some articles, the interventions were art-based studio projects which focused on skill development and were not facilitated by art therapists (e.g., Hacking, Secker, Spandler, Kent, & Shenton, 2008; Howells & Zelnik, 2009). The most recent RCT review by Maujean, Pepping and Kendall (2014) also indicated the benefit of AT; however this referred to various other client groups.

In light of this, the current review aims to get a more focused understanding on the effectiveness of AT as an intervention for people with psychosis. Additionally, it aims to understand whether AT is appropriate and meaningful for this population. This systematic review will build upon the latter reviews by focusing on literature from 2007

onwards and including all research methodologies. Two research questions will be asked of the literature:

1. What is the effectiveness of AT for people with psychosis?
2. How meaningful and suitable is AT for people with psychosis? The views of service users and clinicians.

2.0 METHODOLOGY

2.1 Search Strategy

A thorough systematic search of the literature was conducted through seven electronic databases (Embase, Medline, Psychinfo, Psycharticles, Web of Science, EBSCO CinaHl, and ProQuest ERIC). Further searches through reference lists of the identified articles and Google scholar elicited two additional papers. The main search terms used were 'art therapy' and 'psychosis'. The term 'art therapy' was operationalised in line with the definition of the BAAT (2015) and the term 'psychosis' was used as an umbrella term as described above. The search terms were expanded based on the terminology used in the literature to ensure that all the relevant articles were identified, as seen in Table 1.

Table 1. Search Terms

Main Search Term	**Expanded Search Terms** (* is used to identify words that begin with that prefix)
'Art therapy'	"art therap*" **OR** "art psychotherap*" **OR** "creative art psychotherap*" **OR** "creative art therap*"
AND	
'Psychosis'	"schizophrenia" **OR** "psychosis" **OR** "psychotic" **OR** "psychiatric"

Figure 1 illustrates that the search elicited 766 papers in total. These were screened by title, abstract and full-text for their suitability based on the inclusion and exclusion criteria. Articles were omitted if they were published earlier than 2007, unavailable in English, not empirical papers, and did not focus on adults with psychosis

or use AT. The effectiveness of AT was considered in comparison to any control groups or TAU and no restriction was put on the outcomes measured.

The full-text screening revealed that the interventions were sometimes ambiguously defined making it difficult to distinguish between 'art psychotherapy' and 'art as therapy'. Following discussion with a consultant art therapist, it was decided that a more reliable indicator of the provision of AT was the involvement of art therapists as intervention facilitators or supervisors. This ensured that only studies exploring AT were reviewed.

Sixteen papers were included in this review. Papers related to the MATISSE trial, which were recently reviewed by Holttum and Huet (2014), were also included in order to evaluate them in light of the wider research identified. The papers by Crawford et al. (2010) and Crawford et al. (2012) will be presented and discussed together and referred to as 'MATISSE'.

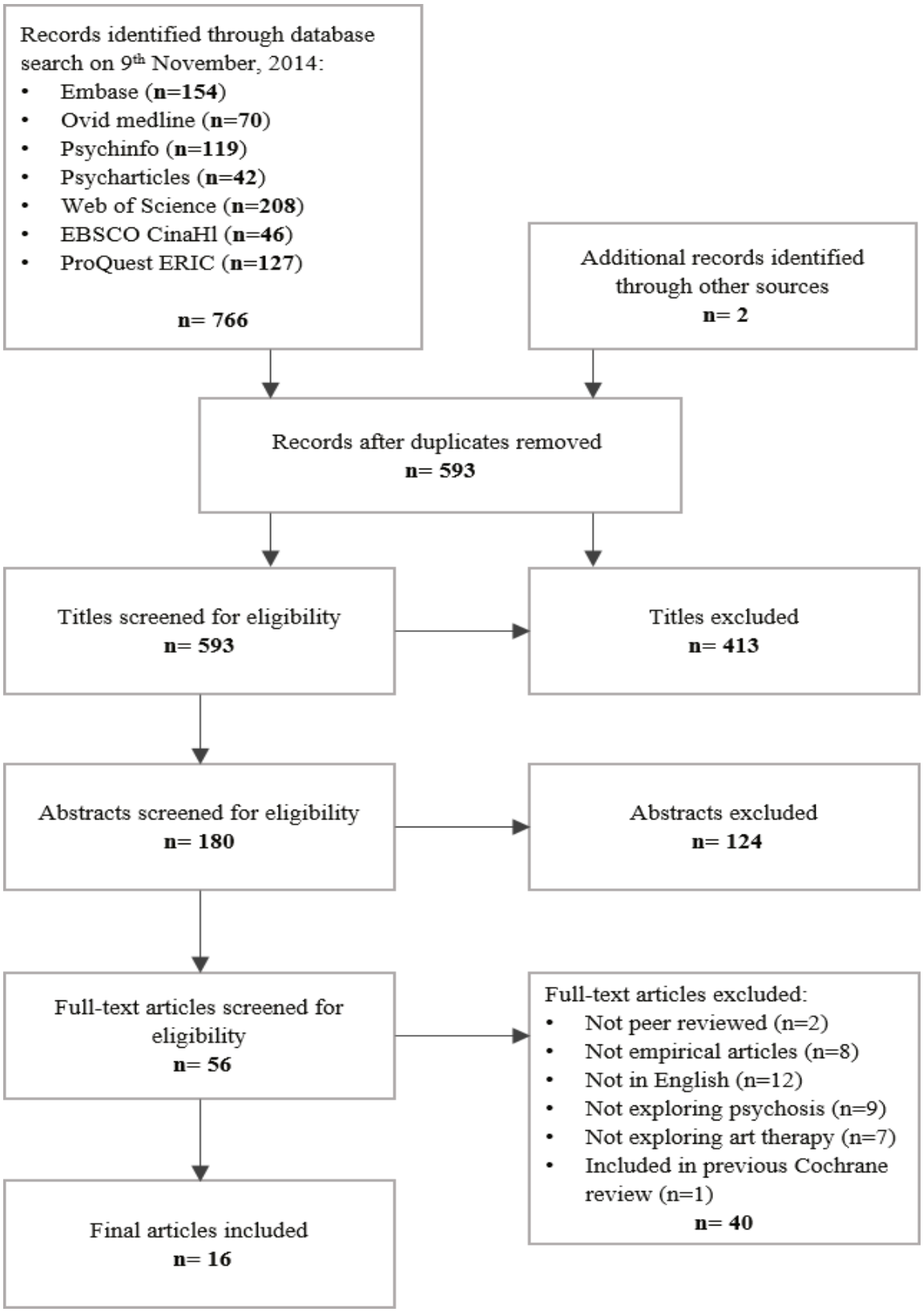

Figure 1. Flow diagram for included and excluded articles

2.2 Quality Appraisal

The 16 articles included five different methodologies: quantitative, non-experimental, qualitative and case studies and one mixed-method study. A multi-method quality framework (see Appendix 1) was developed to systematically review the quality of the articles according to standardised criteria (Centre for Reviews and Disseminations [CRD], 2008). The framework was based on the quality criteria for mixed-method studies by Sale and Brazil (2004).

Sale and Brazil (2004) acknowledged that their criteria were an initial proposal that required further development into an effective and efficient framework. Therefore, items from other quality frameworks were integrated when criteria were deemed missing. Items were added from the Critical Appraisal Skills Programme (2006) appraisal tool for qualitative studies, a mixed-methods framework (Pluye et al., 2011), and the Consolidated Standards of Reporting Trials checklist (Moher et al., 2010) to address the unique aspects of RCTs. There is currently no quality framework for case studies despite these having their own unique features (Atkins & Simpson, 2002). A set of criteria for case studies was therefore collated from three papers (Atkins & Sampson, 2002; Huws & Dahlmann, 2007; Lowman & Kilburg, 2011) and integrated into the multi-method framework. In accordance with CRD (2008) recommendations, the framework was piloted with an independent researcher.

The final framework was organised into four main quality categories: Truth Value, Applicability, Consistency and Neutrality. Each article was rated against these four categories based on a traffic light system where each category was scored as good

(green), moderate (orange) or poor (red) in quality[2]. The scores for the four categories were then averaged to give each article an overall quality rating which reflected its robustness. Table 2 details the defining features of the ratings.

Table 2. Overall Quality Rating Definition

Traffic Light Quality Rating	Quality Rating Definition
Green Good	All or most of the criteria have been fulfilled for Truth Value, Applicability, Consistency and Neutrality. Criteria that have not been fulfilled are not a major limitation and are thought unlikely to significantly impact on the quality or overall conclusions of the study.
Orange Moderate	Some of the criteria have been fulfilled whilst other criteria have not been fulfilled or have not been adequately described. These are thought to partially impact on the quality or overall conclusions of the study, though no major flaws are identified.
Red Poor	Most of the criteria have not been fulfilled or have not been adequately described. The unfulfilled criteria are thought likely to contribute major flaws to the methodology, analysis and results and have a significant impact on the overall conclusions and quality of the study.

[2] If an individual category was rated as good quality, it was given a score of either 5 or 6, where 6 signified that the category met all of the criteria.
If a category was rated as moderate, a score of either 3 or 4 was given. '3' signified that only some criteria were fulfilled and that these partially impacted on the category's quality. However, just enough were fulfilled to prevent the quality of the category being significantly reduced.
If a category was rated as poor, a score of either 1 or 2 was given. '1' signified that the category met at most one of the criteria and this had significant negative implications on the quality of the category.

3.0 RESULTS

The description and results of the 16 studies, in relation to the two research questions were extracted and presented in Table 3. Following that is an overview of the most significant methodological issues across the studies according to the four quality categories. The studies are then summarised based on their demographics, the AT interventions, and the evidence they provide in relation to the two research questions.

Table 3. Summary of the Final Studies

Authors, Year, Country	Type of Study	Study Aims	Participants	Methodology	Analysis	Results: The acceptability and meaning of AT	Results: The effectiveness of AT
Crawford, Killaspy, Kalaitzaki, Barrett, Byford, Patterson et al. (2010) Crawford, Killaspy, Barnes, Barrett, Byford, Clayton, et al. (2012) United Kingdom	3-arm Randomised Control Trial	To investigate how health and social functioning of people with schizophrenia is impacted through AT, compared with an activity group and standard care alone. To examine differences in engagement and benefits between groups and cost effectiveness of AT.	417 participants with schizophrenia. 140 people were randomly allocated to the AT group with standard care, 140 people to the activity with standard care group and 137 people to the standard care alone group.	Weekly AT, activity or standard care alone groups took place for 1 year. Primary outcomes were functioning (Global Assessment of Functioning scale), and psychotic symptoms (Positive and Negative syndrome scale) at 2 years. Secondary outcomes were functioning and symptoms at 1 year, and attendance, functioning, medication adherence, satisfaction, well-being and quality of life at 1 and 2 years.	An intention-to-treat (ITT) analysis took place. An ANCOVA examined group differences, and controlled for outcome, site, sex and age. The same was done for secondary outcomes. A secondary analysis, a two and three level heteroscedastic model, and a two stage least squares estimate were carried out.	Nearly 40% of the AT group did not attend. A few attended regularly though this did not influence outcomes. AT attendance was better than activity group attendance. For both groups, the main dropout reasons were death, withdrawal and getting lost to follow-up. Withdrawal occurred because participants were not interested in attending or found it difficult to attend.	At 2 years follow-up there was no significant difference between groups for primary outcomes, though those in the activity group had less positive symptoms that those in AT. At 1 and 2 years, there were no significant differences in secondary outcomes. AT had no clinical advantage and was not more cost-effective.

Authors, Year, Country	Type of Study	Study Aims	Participants	Methodology	Analysis	Results: The acceptability and meaning of AT	Results: The effectiveness of AT
Leurent, Killaspy, Osborn, Crawford, Hoadley, Waller, & King (2014) United Kingdom	Secondary analysis of the MATISSE RCT	To re-analyse the MATISSE results and examine differences in the effectiveness of subgroups in AT and standard care. The characteristics explored were gender, treatment compliance, interest in art, comfort with emotional expression and time since referral.	MATISSE included participants in standard care (n= 137), AT and standard care (n= 140) and activity group and standard care (n= 140). This study considered the AT and standard care group.	MATISSE involved weekly groups over 12 months. Primary outcomes were functioning and mental health symptoms. Secondary outcomes were: functioning and symptoms measured at 12 months, and attendance, social functioning, medication adherence, care satisfaction, well-being and quality of life measured at 12 and 24 months.	Through an ITT analysis, groups were compared on interest in AT and symptoms at 12 months using a mixed-effect linear model. The intervention effect was investigated by stratifying by subgroup and examining the effect of interaction or continuous variables. Differences in attrition were compared.	There were no significant differences between groups in rates and reasons for attrition. Only site of recruitment was relevant. AT attendance was poor because 39% attended no sessions and in a year, the average attendance was 11 sessions. Although non-significant, a prior interest in art and comfort sharing emotions influenced attendance positively.	There was no significant difference in the effectiveness of AT on symptoms of psychosis between subgroups who had more or less negative symptoms of psychosis or interest in AT. There were no significant differences in any of the other subgroup analyses.
Montag, Haase, Seidel1, Bayerl1, Gallinat, Herrmann, & Dannecker (2014) Germany	Pilot Randomised Control Trial	To investigate the efficacy of psychodynamic AT for people in acute psychosis, on symptoms, functioning, mentalising abilities, self-efficacy, care satisfaction and quality of life.	There were 58 inpatients with schizophrenia. Following randomisation, 29 received AT with treatment as usual and 29 received treatment as usual, which excluded art activities.	Twice weekly groups for 6 weeks occurred. Primary outcomes were symptoms (Scale for the assessment of negative/positive symptoms), depression (Calgary depression scale for schizophrenia), and functioning (Global assessment of functioning scale). Secondary outcomes were mentalisation, self-efficacy, locus of control, quality of life, and care satisfaction.	The analysis was based on the per-protocol sample. Differences between group demographics and illness was investigated through T- and Chi2-tests. ANCOVA compared primary outcomes at post-treatment and follow-up, whilst controlling for baseline ratings, verbal IQ and gender. An ITT analysis of primary outcomes was also carried out.	The data at 6 weeks were based on 59% of participants from AT and 69% from treatment as usual. At 12 weeks follow-up, the data were based on 55% of participants in AT and 66% in treatment as usual. Reasons for dropout related to unplanned discharge and practical difficulty attending groups. Apart from this, those in AT had good attendance.	The per-protocol sample results showed that the AT group had a significant decrease in positive symptoms and functioning at post-intervention and follow-up, and in negative symptoms at follow-up. There were no significant changes in depression. In the ITT, AT had improved positive symptoms at post-treatment and a lower trend in negative symptoms.

Authors, Year, Country	Type of Study	Study Aims	Participants	Methodology	Analysis	Results: The acceptability and meaning of AT	Results: The effectiveness of AT
Patterson, Debate, Anju, Waller, & Crawford (2011b) United Kingdom	Survey design	To describe the availability, accessibility, structure, delivery and content of AT for people with schizophrenia in the NHS. To explore therapists' views of how AT may support people with schizophrenia.	71 art therapists were randomly recruited from 27 NHS Trusts.	A questionnaire was piloted and developed by considering literature, organisational policies and experiences of art therapists. The closed and open questions related to the assessment process, outcome measures and AT mechanisms. Therapists rated their level of agreement on statements about the benefits of AT using a 5-point Likert scale.	Simple descriptive statistics investigated how many agreed with the questionnaire items. Univariate statistics indicated associations between therapist traits, type of practice and views of working with other professionals. Open-ended questions were analysed through thematic analysis though these results were not reported.	Most therapists used a non-directive approach and believed that art-making and reflection were fundamental parts of AT. This enhanced self-understanding, control, expression and conflict resolution. Acquiring new skills was not a key aspect of AT. Therapists stated that this population had limited access to AT. Less than half thought it was not well integrated with services, albeit valued.	N/A
Caddy, Crawford, & Page (2012) Australia	Non-experimental, non-randomised	To explore changes in mental health across a 5 year period for inpatients who took part in art and craft creative therapy groups in a private hospital.	Existing de-identified data was used of 403 patients who participated in at least 6 sessions and attended no other therapy groups. Most had a diagnosis of depression, bipolar or other mood disorders. 14.1% had a diagnosis of schizophrenia.	The creative activity group was attended by 16 patients daily. It involved art, craft and expressive projects which addressed patients' issues. Changes were measured using the Depression and Anxiety Stress Scale (DASS-21), Quality of Life Enjoyment and Satisfaction (Q-LES-Q), Medical Outcomes Short Form (SF-14) questionnaires and Health of the Nation Outcome Scale (HoNOS).	Data were analysed using descriptive and inferential statistics to investigate the correlations between mental health outcomes and participation. Paired t-tests were used to identify whether there were significant changes in measures from admission to discharge.	N/A	Participation positively correlated with better mental health from admission to discharge, with moderate to strong effect sizes. The largest, statistically significant improvement was on the HoNOS. Large effect sizes were observed on the Q-LES-Q and DASS-21 Depression and Anxiety subscales. Moderate effect sizes were observed on the Stress subscale and the SF-14.

Authors, Year, Country	Type of Study	Study Aims	Participants	Methodology	Analysis	Results: The acceptability and meaning of AT	Results: The effectiveness of AT
De Morais, Dalecio, Vizmann, Bueno, Roecker, Salvagioni, & Eler (2014) Brazil	Mixed Methods design: Non-randomised controlled study and qualitative interviews	To investigate the effect of a clay work group on levels of depression and anxiety amongst inpatients in a day hospital compared with patients who did not receive therapy.	There were 24 participants: 12 in the control group and 12 in the clay work group. They had various diagnosis such as depression, bipolar, anxiety, dementia, schizophrenia and psychotic disorder.	Each group received 8 weekly clay therapy sessions. In the clay group participants described their sculptures and feelings. The Beck Depression Inventory and Spielberger State-Trait Anxiety Inventory were completed. Interviews took place to explore how participants felt about their art. It is unclear when the interviews occurred and if everyone was interviewed.	The hospital psychologist who was not involved in the research, administered and interpreted the results of the measures. The Mann–Whitney test was used to compare the scores between the groups. No information was provided about the qualitative analysis.	Interview extracts suggested that some found clay work enjoyable and relaxing and it helped them to reflect. It was unclear whether these quotations appertained to participants who had schizophrenia. Two participants attended half the clay work sessions and were excluded from the analysis. Their dis-engagement was attributed to the clay work being overwhelming.	Therapy using clay improved depression compared to receiving none at all. The clay work group had mild depression on average and the control group had moderate depression. The difference was statistically significant. The clay work group had lower anxiety though this was not statistically significant.
Teglbjaerg (2011) Denmark	Qualitative study	To understand whether and how AT effects the mental health of people with schizophrenia and whether patients with nonpsychotic and psychotic disorders use AT differently.	There was 1 group of 5 outpatients with schizophrenia and 1 comparison group of 5 nonpsychotic patients with depression and/or personality disorders.	Participants attended weekly, formative group AT for 1 year. They were interviewed before, immediately after therapy and at 1 year follow-up. Interviews concerned experiences of mental illnesses, life, relationships, and AT. Data were gathered from logbooks, participants' art and evaluation forms.	Modified grounded theory was carried out. This included 4 analysis levels: giving a narrative description of therapy, identifying themes, comparing participants' themes to the research questions and evaluating whether they were answered.	Both groups found AT helpful, even at follow-up, and all attended. The main benefit was a strengthened sense of self as they expressed themselves, problem solved, socialised, felt confident, felt included, and less paranoid. Those with schizophrenia achieved these benefits by using art to become present, to find meaning, connect with themselves and others and to become creative.	N/A

Authors, Year, Country	Type of Study	Study Aims	Participants	Methodology	Analysis	Results: The acceptability and meaning of AT	Results: The effectiveness of AT
Patterson, Crawford, Ainsworth & Waller (2011a) United Kingdom	Qualitative study	To understand the process and outcomes of AT (i.e. what changes, how it changes and for whom) based on the experience of art therapists, and to improve provision of AT.	24 art therapists were recruited. There were 3 key informants (art therapists from MATISSE); 14 MATISSE art therapists (who delivered or supervised AT); and 7 non-MATISSE therapists.	Over 20 months, interviews and focus groups took place. Questions addressed the nature, process and outcomes of AT, therapists' understanding of schizophrenia and their concerns. 33.3% of the therapists substantiated the interviews with documents (e.g. publications).	Grounded theory was carried out using constant comparative method and 3 levels of coding; Initial coding to identify descriptive codes; Focused coding to group codes into themes; Theoretical coding to identify categories. The documents were analysed primarily through theoretical coding.	AT was considered valuable for this client group. Therapists' role, the therapeutic relationship, art making and group were believed to increase expression, well-being, identity and acceptance. Willingness to engage was beneficial. What made AT helpful was unclear but it entailed an interaction between therapists, clients, and art. The AT referral criteria were unclear.	N/A
Patterson, Borschmann & Waller (2013) United Kingdom	Qualitative study	To understand the experiences of participants who received AT in MATISSE, to understand who to refer to AT, how to evaluate its effectiveness, and the degree of generalisability of MATISSE results.	There were 19 trial participants diagnosed with schizophrenia and four participants who took part in a separate focus group at 12 months follow-up.	Interviews lasted 20 to 90 minutes and explored their reasons for participating, and response to the allocation and intervention. Key workers or partners were present in some interviews. Trial data, field notes and the experiences of therapists as presented in Patterson, Crawford, Ainsworth and Waller (2011), were considered.	A constructive grounded theory approach was used which involved constant comparison and multi-level coding strategies, in line with the analysis method outlined in Patterson, Crawford, Ainsworth and Waller (2011).	Some participants did not attend MATISSE because they were not interested in AT. Those who dropped out were not motivated and disliked group work. The 6 who attended enjoyed the social and therapist contact, and art. They experienced 'no change' or specific change. A few gained confidence, achievements, felt accepted and not judged.	N/A

Authors, Year, Country	Type of Study	Study Aims	Participants	Methodology	Analysis	Results: The acceptability and meaning of AT	Results: The effectiveness of AT
Colbert, Cooke, Camic & Springham (2013) United Kingdom	Qualitative study	To explore whether reflection through paintings in an art-gallery with staff improves clients' personal narratives of psychosis, well-being, and social inclusion and creates new community narratives about psychosis.	Five men and 2 women were clients with a diagnosis of psychosis. There were 2 female gallery-staff, 1 female art therapist and 2 NHS staff (1 male and 1 female)	Two groups took place for 4 weeks each. The first part was spent in the art gallery where paintings and their meaning were discussed and participants could sketch. They then moved to the art studio and created and reflected on more art that they produced. Interviews after 4 weeks explored participants' experience of the group and their well-being.	A literary context narrative analysis was used to understand the thoughts, aims, language and themes in the narratives. A social context narrative analysis explored dominant, personal stories of psychosis and whether community narratives developed.	Some participants changed their dominant personal narrative of psychosis. A new community narrative was developed. This identified the staff-client relationship as validating, amicable and honest. The group improved recovery, social inclusion, and well-being. Five clients attended all or most sessions and were accompanied by the staff.	N/A
Drapeau & Kronish (2007) Canada	Case Report	To investigate the benefits and clinical effectiveness of a creative AT group program for outpatients with psychiatric disorders by exploring vignettes of sessions.	There were 26 psychiatric outpatients with various diagnoses such as depression, schizophrenia, schizoaffective, dissociative, borderline, and bipolar disorders.	Psychodynamic AT groups were provided for just over one year. Each group met for 12 weeks. The sessions were bilingual, in English and French. No data collection method was specified.	No analysis method was specified. Changes in participants' psychological well-being were discussed and a comparison was made of the meaning of the drawings they created in earlier and later sessions.	Drawings enabled clients to express and explore their issues. Sharing drawings with others increased their self-acceptance and understanding. Drawings helped clients to connect with reality, trust others, deal with loss and socialise. It improved their self-esteem, quality of life, and humour. No information about attendance was provided.	N/A

Authors, Year, Country	Type of Study	Study Aims	Participants	Methodology	Analysis	Results: The acceptability and meaning of AT	Results: The effectiveness of AT
Banks (2012) United Kingdom	Case Study	To explore the progress, development and role of AT in a male low secure ward, to explore how art can build safety and security and how violence can be understood through the meaning of the images.	1 man with a diagnosis of paranoid schizophrenia, which was triggered by drug misuse.	He attended individual and group AT (which also included music therapy) and a recovery group (which included art making) for 12 months. He co-created an audio image recording, and took part in an end of therapy interview where he reflected on art making using two images.	The author chose 11 key images and audio image recordings which were thought to enhance the client's reflection and understanding of his violence. These were used to describe the model of AT provided and the client's experience. No analysis method was described.	The participant found that art improved his emotional expression, hopes, and alleviated his worries. It provided containment and security. The non-judgemental atmosphere strengthened the therapeutic relationship. Through the meaning of his art, his sense of self strengthened as he linked his inner and outer experiences and made sense of his anger and life.	N/A
Michaelides (2012) United Kingdom	Case Report	To explore how AT groups help a client with schizophrenia who has a poor reflective functioning ability and whether it is a safe way of exploring mental states and improving reflective functioning.	A case study of 1 male participant diagnosed with schizophrenia who was functioning at a negative reflective functioning level.	An open AT group ran for 14 months. Clients with different diagnoses attended. Following art creation, the group discussed their drawings. Observations took place of the case study's level of engagement, involvement in the group discussions and the nature of drawings produced.	No analysis method was described. Changes in the participant's presentation were discussed as well as changes in the imagery produced, with emphasis on the 2nd, 4th and 32nd sessions.	AT was acceptable for the client with negative symptoms. He moved to stages of 'identification' and 'familiarisation' and possibly also 'acknowledgement' as his reflective functioning improved. He became interested in the group and his art was a means of expression. The group's reflection gave him a voice and allowed him to connect with himself.	N/A

Authors, Year, Country	Type of Study	Study Aims	Participants	Methodology	Analysis	Results: The acceptability and meaning of AT	Results: The effectiveness of AT
Gajic (2013) Serbia	Case Report	To present the clinical observations of 2 clients with schizophrenia who attended an AT group in a day hospital and to investigate their health and functioning at admission and discharge.	One female with paranoid schizophrenia and one male with schizophrenia.	Weekly AT sessions occurred over 2 months. Participants created drawings and reflected on them. At admission and discharge the Clinical Global Impression Severity (CGIS) and Global Assessment of Functioning (GAF) scales were completed and the Clinical Global Improvement (CGI-I) Scale was completed at discharge.	The researcher together with the group therapists conducted a qualitative analysis of the drawings' form and content and the group therapy protocols. Details about this analysis were not provided.	The participants were regular attenders. AT was considered useful for schizophrenia. It enhanced creativity, self-esteem and self-confidence. The group provided validation, support, security, acceptance, social connection and expression. The participants appeared less preoccupied by psychosis following their engagement in AT.	For both participants, minimal improvement was shown on the CGIS and GAF from admission to discharge, and on the CGI-I. These minimal improvement in functioning and health were attributed to participants having severe psychosis and therefore requiring a longer intervention.
Havenik Hestad, Lien, Teglbjaerg, & Danbolt (2013) Norway	Multiple Case Study	To describe the course and usefulness of an expressive AT group for women with psychotic diagnoses. To understand how and why AT aids in exploring psychotic experience and improving coping.	There were 5 female participants with various psychotic diagnoses which were bipolar disorder, schizoaffective disorder, schizophrenia and paranoid psychosis.	The group met weekly for 9 months in the psychiatric hospital. The start of the group included music, poetry and movement therapy, after which 3 art modalities were used to explore psychosis and its meaning. Observations of the therapeutic process were made and interviews were carried out at 8 months follow-up.	Participants' situation before and after AT was analysed through group notes and interviews using a modified 7-step method for case studies. This included: literature searching, analysing the different information sources, time-series analysis, pattern matching, and member checking.	All the participants felt able to explore psychosis, express themselves, gain awareness and feel alive. Two gained control as they cognitively reinterpreted psychosis. All learnt how to cope and felt valued though how this occurred was unclear. Spiritual and existential themes were common. Participants felt able to interact with and support each other safely.	. N/A

3.1 Quality of the Studies

When considering the hierarchy of research that guides evidence-based practice (Slade & Priebe, 2001), the evidence within this review was weak. It included two RCTs, a re-analysis of an RCT, one mixed-methods study, a survey design, a non-experimental design, four qualitative studies and five case studies. Table 4 indicates that nine studies were of good quality, two were of moderate quality and five were poor quality (see Appendix 2 for the full quality analysis). The moderate to good quality studies provided the most robust evidence. The poor quality studies were considered cautiously throughout this review.

Table 4. Summary of Quality of the Studies

Authors	Truth Value	Applicability	Consistency	Neutrality	Overall Quality
Quantitative Studies					
Crawford, et al. (2010) Crawford, et al. (2012)	5	5	5	5	Good Good
Montag, et al. (2014)	4	4	6	5	Good
Leurent, et al. (2014)	5	5	5	5	Good
Non-Experimental Study					
Patterson, et al. (2011b)	3	5	5	4	Good
Caddy, et al. (2012)	5	3	5	4	Moderate
Mixed Methods Study					
De Morais, et al (2014)	1	2	2	1	Poor
Qualitative Studies					
Teglbjaerg (2011)	2	3	3	1	Poor
Patterson, et al. (2011a)	6	4	5	4	Good
Patterson, et al. (2013)	6	5	4	2	Good
Colbert, et al. (2013)	5	5	6	3	Good
Case Studies					
Banks (2012)	3	3	2	1	Poor
Michaelides (2012)	3	3	3	1	Moderate
Havenik, et al. (2013)	5	4	4	5	Good
Gajic (2013)	3	2	2	1	Poor
Drapeau & Kronish (2007)	1	2	1	1	Poor

3.2 Methodological Considerations

3.2.1 Truth value

The validity of some studies was adversely affected because the results for participants with different diagnoses were grouped together (Caddy, Crawford & Page, 2012; de Morais et al., 2014; Drapeau & Kronish, 2007). This made it difficult to identify whether AT affected participants with psychosis.

It was generally difficult to know whether the quotations and/or images were a credible representation of participants' experience, because often no reference was made to who said the quotations (Colbert, Cooke, Camic & Springham, 2013; de Morais et al., 2014; Drapeau & Kronish, 2007; Gajic, 2013; Teglbjaerg, 2011). In the mixed-sample studies it was also unclear whether quotations came from participants with psychosis. Similarly, Banks (2012) presented the images that were believed to increase the participant's insight; however, there was no corroboration of whether the participant agreed with this selection.

Common confounding factors were that participants receiving AT had prior interest in art (Banks, 2012; Colbert et al., 2013) or participants in control groups had 'no affinity' for art (de Morais et al., 2014). Colbert et al. (2013) stated that keenness for art may have positively influenced engagement and perceived benefit from AT. Leurent et al. (2014) however, identified that interest in art was not a moderating factor in MATISSE. The MATISSE and Montag et al. (2014) studies were single-blind studies. Allocation concealment was appropriately carried out in both although this was more thoroughly described in MATISSE.

3.2.2 Applicability

The generalisability of this review is limited given the number of case studies, qualitative studies and small sample sizes. Only MATISSE was adequately powered, although participation was still low and the results of the secondary analysis were consequently underpowered (Leurent et al., 2014).

Few studies (Caddy et al., 2012; de Morais et al., 2014; Michaelides, 2012) provided a rationale for their choice of research design. The method of recruitment was not given in several qualitative and case studies (Colbert et al., 2013; de Morais et al., 2014; Michaelides, 2012; Patterson, Crawford, Ainsworth, & Waller 2011a; Teglbjaerg, 2011). Also, in Montag et al. (2014) the method for and type of randomisation were not clearly described. Across the methodologies, the actual structure of the AT intervention was ambiguous or not described (Banks, 2012; Caddy et al., 2012; Crawford et al., 2010, 2012; Drapeau & Kronish, 2007; Gajic, 2013).

3.2.3 Consistency

This was a significantly weak category for most case studies and for de Morais et al. (2014). Limited (Banks, 2012; Michaelides, 2012) or no (Drapeau & Kronish, 2007; Gajic, 2013) information was provided about analyses methods, making it difficult to identify whether analyses were reliably executed. Most case studies and qualitative studies (Patterson et al., 2011a; Patterson, Borschmann & Waller, 2013; Teglbjaerg, 2011) made no attempt to involve other researchers to confirm the analysis. Gajic (2013) attempted this though it was not stated how any differences were resolved.

Consistency was enhanced mainly in the qualitative studies through the use of semi-structured interviews (Havenik et al., 2013; Patterson et al., 2011a; Patterson et al.,

2013; Teglbjaerg, 2011), member checks (Colbert et al., 2013; Havenik et al., 2013; Patterson et al., 2011a) and an audit (Colbert et al., 2013).

Reliability was generally strong in the quantitative papers. Cross-checking of the data also occurred in MATISSE and Caddy et al. (2012). In these latter studies and in Montag et al. (2014), regular supervision from art therapists was provided to intervention facilitators.

The reliability of translation was not considered for the studies conducted in non-English speaking countries. This possibly hindered their plausibility, particularly for two studies which were sometimes difficult to comprehend (de Morais et al., 2014; Gajic, 2013).

3.2.4 Neutrality

Reflexivity was the weakest quality category for case studies and qualitative studies, none of which used reflexive journals. In Teglbjaerg (2011), a logbook was kept though it was unclear whether this was used reflectively. Most made no statements about researchers bracketing their preconceptions. The exceptions were Havenik et al. (2013) and Patterson et al. (2011a), although the latter did not specify what the preconceptions were and how they were managed. Most case studies did not consider the bias associated with the main researcher also acting as the main art therapist of the intervention (Banks, 2012; Drapeau & Kronish, 2007; Havenik et al., 2013; Michaeledis, 2012).

The quantitative studies were objective in reporting both the significant and non-significant results, apart from de Morais et al. (2014) who only discussed the significant results. Several quantitative and qualitative studies failed to consider potential biases

associated with integrating AT with other psychotherapeutic or psychosocial interventions and how this potentially influenced the results.

3.3 Participant Demographics

The recruited participants had diagnoses of psychosis which included schizophrenia, paranoid schizophrenia, schizoaffective disorder or bipolar disorder. Three studies included participants with mixed diagnoses. The number of people with psychotic diagnoses in these studies was 14 out of 24 in de Morais et al. (2014) and 47 out of 403 de-identified patient data in Caddy et al. (2012). This information was not provided by Drapeau and Kronish (2007).

Across the articles there were a total of 299 male participants and 153 female participants. These figures excluded some studies where gender demographics were either unclear or not provided (Caddy et al., 2012; de Morais et al., 2014; Drapeau & Kronish, 2007; Teglbjaerg, 2011). This higher prevalence of psychosis amongst men was consistent with epidemiological research (Kirkbride et al., 2011). There were more women (n=70) than men (n=30) in studies which included clinicians (Colbert et al., 2013; Patterson et al., 2011a; Patterson et al., 2013).

Most studies were conducted in the UK by the same authors (Banks, 2012; Colbert et al., 2013; Crawford et al., 2010; Crawford et al., 2012; Leurent et al., 2014; Michaelides, 2012; Patterson et al., 2011a; Patterson, Debate, Anju, Waller, & Crawford, 2011b; Patterson et al., 2013). The other studies were conducted in Brazil (de Morais et al., 2014), Australia (Caddy et al., 2012), Norway (Havenik et al., 2013), Canada (Drapeau & Kronish, 2007), Serbia (Gajic, 2013) and Denmark (Teglbjaerg, 2011).

3.4 Treatment Mode

3.4.1 Art therapy approaches

Comparison across the studies was complicated because AT had different titles including, art therapy or psychotherapy (Banks, 2012; Crawford et al., 2012; Gajic, 2013; Michaeledis, 2012), clay work group (de Morais et al., 2014), creative activity group (Caddy et al., 2012), art gallery-based project (Colbert et al., 2013), psychodynamic AT (Drapeau & Kronish, 2007; Montag et al., 2014), expressive AT (Havenik et al., 2013) and formative AT (Teglbjaerg, 2011).

Some of these approaches reflected different theoretical orientations. Formative AT stemmed from expressive AT which considered art a means for clients to explore and understand new aspects of emotional, bodily and psychotic experiences (Havenik et al., 2013; Teglbjaerg, 2011). Exploration was enhanced through music, poetry and sculpture in the expressive AT approach used in Havenik et al. (2013). These approaches differed from analytical AT where art was a means of accessing and understanding unconscious experiences (Teglbjaerg, 2011).

Therapists' orientation was generally stated or described infrequently. In MATISSE, AT was adapted according to participants' needs. Fourteen out of 24 therapists in Patterson et al. (2011a) were MATISSE therapists, and the most common orientation was psychodynamic, with the minority having humanistic, psychoanalytic, or eclectic orientations. A similar pattern of theoretical orientations was identified amongst art therapists in a national survey (Patterson et al., 2011b).

3.4.2 Structure of art therapy

AT was often described in two stages. Firstly, the focus was on the process of creating art and secondly, time was spent reflecting on its meaning usually in a group format (Banks, 2012; Colbert et al., 2013; Gajic, 2013; Michaeledis, 2012; Montag et al., 2014). Some interventions varied slightly in structure. Initially some groups learnt about the history and artistic techniques of paintings (Colbert at al., 2013), reflected on their feelings (Teglbjaerg, 2011) or listened to music, poetry and did movement therapy (Havenik et al., 2013). Some studies did not specify how AT was delivered (Caddy et al., 2012; Drapeau & Kronish, 2007) and MATISSE only stated that AT was provided in accordance with the BAAT definition.

AT was not always provided in isolation. It was incorporated with music therapy in Banks (2012) and in Montag et al. (2014), TAU included CBT, psychodynamic psychotherapy, and music therapy amongst others. In other studies, participants received unspecified psychosocial interventions (Crawford et al., 2010, 2012) or psychotherapies (Caddy et al., 2012). This bias may have been controlled through randomisation in the RCTs.

Ten studies provided AT in a group format, and Banks (2012) provided individual and group AT. Patterson et al. (2011b) identified that 94.4% of art therapists provided individual and 70.4% provided group AT. AT was delivered in open groups (Gajic, 2013; Michaeledis, 2012) (where participants flexibly attended and left), or closed groups (where new members did not enter) (Crawford et al., 2010; 2012). However, most studies did not specify this. Nationally, open, closed and slow-open groups (where members openly discussed group changes) were comparatively provided by one third of therapists (Patterson et al., 2011b).

When specified, AT was delivered by qualified art therapists or practitioners trained in AT (de Morais et al., 2014; Gajic, 2013; Havenik et al., 2013; Teglbjaerg, 2011). AT was most commonly delivered in AT studios in outpatient or inpatient settings. Only Colbert et al. (2013) introduced the art gallery as a novel non-stigmatising location.

The length of AT varied between 1 and 14 months. The sessions generally occurred weekly and lasted approximately 1.5 to 3 hours. Montag et al. (2014) and Colbert at al. (2013) were the only two good quality studies with short interventions, making it difficult to conclude whether shorter or longer intervention periods were more helpful. Colbert et al. (2013) suggested that interventions longer than 4 weeks may better illustrate people's recovery. Others concluded that longer interventions may be more suitable for participants with severe symptoms (de Morais et al., 2014; Gajic, 2013; Montag et al., 2014).

3.5 The Effectiveness of Art Therapy

Five papers, which varied in design and quality, used outcome measures to evaluate change elicited through AT. Crawford et al. (2010, 2012) and Montag et al. (2014) measured the symptoms of psychosis and global functioning as primary outcomes. Depression was also a primary outcome in the latter study. Both measured quality of life and care satisfaction as secondary outcomes. Additionally, MATISSE measured social functioning, medication adherence and well-being, whilst Montag et al. (2014) measured mentalising function, self-efficacy and locus of control.

The outcome measures in the lower quality studies were similar to those in the RCTs. They included measures of anxiety and depression (Caddy et al., 2012; de

Morais et al., 2014), quality of life, medical outcomes and general health (Caddy et al., 2012), global functioning and general improvement (Gajic, 2013). The reliability and validity of these measures and their standardisation for people with psychosis was not always described (Caddy et al., 2012; Gajic, 2013).

Based on an intention-to-treat (ITT) analysis, MATISSE results illustrated no significant differences in the primary or secondary outcomes between trial arms, at 12 or 24 months follow-up. The only significant difference was that at 24 months people in the activity group had fewer positive symptoms than the AT group. This indicated that AT was not clinically or cost effective for people with psychosis in terms of symptom reduction and functioning. The secondary analysis of MATISSE confirmed these results and additionally indicated no significant symptomatic improvements for AT participants with more severe negative symptoms or with a preference for art (Leurent et al., 2014).

The results in Montag et al. (2014) were based on the per-protocol sample because most dropouts were lost to follow-up. When verbal IQ and gender were controlled for, at post-therapy and follow-up, the AT group had significantly greater improvements in positive symptoms and global functioning compared to TAU. At follow-up, negative symptoms decreased for the AT group and increased for TAU. There were no significant differences for depressive symptoms. The only significant difference for secondary outcomes was that by post-treatment, the AT group developed stronger emotional awareness of others than the TAU group. Conversely, in the ITT analysis, the only significant improvement was in positive symptoms for the AT group and there was only a tendency for reduced negative symptoms at post-intervention.

Amongst the other studies, de Morais et al. (2014) suggested that the clay work group resulted in statistically significantly decreased depression and lower but non-

significant anxiety levels compared to not receiving therapy. In Caddy et al. (2012), participation in creative activity groups correlated positively with improved depression, anxiety and stress from admission to discharge. Large significant improvements in quality of life, health and distress, and a moderate change in vitality were identified. Only minimal improvements in functioning and health were identified in Gajic (2013).

The latter three studies however provided a weak source of evidence due to their design and poor quality. Furthermore, it was difficult to ascertain whether the results in de Morais et al. (2014) and Caddy et al. (2012) applied to people with psychosis because the results related to various diagnoses. Considering the scarce studies and variable methodological quality, this review provides preliminary though inconclusive evidence for the effectiveness of AT for people with psychosis.

3.6 The Meaningfulness and Acceptability of Art Therapy

Several themes regarding the meaningfulness and acceptability of AT were identified across the studies, though the findings from the poor quality studies should be treated cautiously. The art-making process enhanced people's ability to identify, express and explore their distressing emotions (Banks, 2012; Patterson et al., 2011a; Patterson et al., 2011b). Through art, some expressed themselves at a deeper level than they usually would verbally (Banks, 2012; Havenik et al., 2013).

AT gave some people the freedom to be creative in the absence of pressurised atmospheres where they feared being judged or getting it wrong (Banks, 2012; Colbert et al., 2013; Patterson et al., 2013). Art was a safe and contained way for people to focus their attention on something external and to simultaneously explore and process

internal experiences of psychosis (Banks, 2012; Michaeledis, 2012; Patterson et al., 2011a).

The creation of art and reflection on its meaning was believed to allow people to gain insight into who they were and to strengthen their sense of self (Drapeau & Kronish, 2007; Havenik et al., 2013; Michaeledis, 2012; Patterson et al., 2011a; Patterson et al., 2011b; Teglbjaerg, 2011). Through self-expression, participants could connect with themselves and this helped them to feel more alive (Havenik et al., 2012; Patterson et al., 2011a). This self-integration was enhanced through the group process and the groups' reflection on the symbolism and meaning of art (Banks, 2012; Michaeledis, 2012). Through AT, some participants also connected with their reality (Gajic, 2013; Patterson et al., 2011a).

AT enhanced participants' emotional well-being, self-confidence and self-esteem (Colbert et al., 2013; Drapeau & Kronish, 2007; Gajic, 2013; Patterson et al., 2013; Teglbjaerg, 2011). Some experienced achievements as they developed their artistic skills (Colbert et al., 2013; Gajic, 2013; Patterson et al., 2011b). Attending the groups was achievement in itself given participants' avoidance of social activities; this increased their self-confidence and self-worth (Patterson et al., 2013).

AT encouraged participants to engage in social activities which were meaningful to them; this was believed to enhance their psychosocial functioning (Colbert et al., 2013; Havenik et al., 2013; Patterson et al., 2011a). It decreased participants' social isolation as they trusted, bonded and communicated with group members (Colbert et al., 2013; Gajic, 2013; Havenik et al., 2013; Michaeledis, 2012; Patterson et al., 2011b). Sharing similar experiences of psychosis helped participants realise that they were not alone (Havenik et al., 2013; Patterson et al., 2013). They felt valued, respected (Havenik

et al., 2013), and accepted by the group (Gajic, 2013) and the therapist (Patterson et al., 2011a). They felt less paranoid and more able to relate to others (Teglbjaerg, 2011).

Participants (Havenik et al., 2013; Patterson et al., 2013) and therapists (Patterson et al., 2011a) also valued the therapeutic relationship. Through the active involvement of art therapists in AT, participants observed that clinicians were ultimately human too (Havenik et al., 2013) and this diminished the client-professional divide (Colbert et al., 2013).

Increased self-awareness through AT allowed participants to understand their psychosis and warning signs and learn how to cope. This contributed towards improved health (Havenik et al., 2013) and management of daily problems (Teglbjaerg, 2011). The physical process of art-making was considered soothing and distracted participants from their symptoms and unhelpful cognitions (Colbert et al., 2013; Patterson et al., 2013). This was believed to have positive implications for recovery (Colbert et al., 2013).

3.6.1 Attendance and dropouts

Most studies provided no information about rates or reasons for attendance or dropout, apart from Colbert et al. (2013) and Teglbjaerg (2011) where most participants attended most sessions. In MATISSE, attendance was low because 39% attended no AT sessions. Those who consistently attended did so because they were committed to engage and motivated about recovery (Patterson et al., 2013). People interested in art and who felt comfortable expressing themselves attended more (Leurent et al., 2014). Patterson et al. (2013) identified that people who attended intermittently did so because they enjoyed meeting others and creating art, not because they found AT beneficial.

The attrition rates for the intervention and control groups in MATISSE were attributed to death, withdrawal due to disinterest in AT, difficulty attending, and being lost to follow-up. Similarly, in Colbert et al. (2013) one participant dropped out because he doubted the helpfulness of AT. In Montag et al. (2014) dropouts were mostly linked to unplanned hospital discharge. However, attendance was generally high with 59% and 66% of the AT group completing outcome measures at post-treatment and follow-up, respectively.

4.0 DISCUSSION

This systematic review provided inconclusive evidence for the effectiveness of AT for people with psychosis. Crawford et al. (2010, 2012) indicated that AT was not clinically and cost effective in improving symptoms of psychosis and functioning. Conversely, the ITT analysis in Montag et al. (2014) showed that AT decreased positive symptoms for inpatients, with no other significant differences. The per-protocol results showed significant improvements in functioning at post-treatment and follow-up and in negative symptoms at follow-up. These per-protocol results were consistent with findings in Richardson et al. (2007) and Meng et al. (2005). The other studies in this review which investigated effectiveness added little weight to the evidence, given their methodological flaws. The contradictory results of the two RCTs were possibly attributed to their diversity in power, intervention length, settings, analysis and participants' stage of psychosis. It was also difficult to compare the AT approaches.

In response to the second research question, this review indicated that AT was meaningful and acceptable to people with psychosis and therapists. Psychosis caused a disintegration of identity and reality (Havenik et al., 2013; Teglbjaerg, 2011). This numbed participants' affect (Banks, 2012), caused confusion, and decreased trust in themselves, the world and others (Patterson et al., 2011a). The review indicated that AT was experienced as beneficial in addressing these difficulties. It strengthened clients' emotional expression, self-awareness, reconnection with themselves and reality, social inclusion, sense of achievement, and coping ability. The strength of these findings was weakened by the poor quality studies. Nevertheless, the suitability of AT for people with psychosis was still evident.

4.1 Clinical Practice and Future Research Considerations

There was a discrepancy between the scientific evidence regarding the utility of AT and the voice of clients and therapists who emphasised its benefit. This was attributed to a lack of research and highlighted a need for more rigorous studies. Several theoretical, clinical, and methodological issues may require consideration when developing future research that guides clinical practice.

4.1.1 Definition of art therapy

Comparison across the studies was difficult because AT had various theoretical approaches, definitions, titles and structures, which were not always clearly defined. This paralleled the diversity in titles for AT and art therapists in the UK and USA which varied based on client groups, therapists, theoretical orientation, and contexts (Edwards, 2004). Previous AT reviews also identified that research was characterised by inadequate descriptions of the approach and structure of AT (Eaton, Doherty & Widrick, 2007). A primary criticism of MATISSE was its lack of specification of the AT model and therapists' theoretical orientations (Holttum & Huet, 2014). Recently, Patterson, Waller, Killaspy, and Crawford (2015) clarified that although there was variation in the AT structure and therapist orientation, AT in MATISSE was based on the same underlying principles outlined by the BAAT.

It could be argued that the variation and vagueness in the reviewed articles may be attributed to an ambiguity with the definition of AT (Uttley et al., 2015). A clear definition of AT is important given than it is considered a 'complex intervention', consisting of several elements that interact with the environment and people engaging in it (Crawford & Patterson, 2007; Holttum & Huet, 2014). This raises the question of

whether AT is defined clearly enough by the BAAT (2015) and NICE (2014). Indeed, Patterson et al. (2011b) suggested clarification of whether AT, as recommended by national guidelines, is based on a specific model.

Increased clarity of AT definitions and structure in future research can enable research replication and research results to be clinically applied. In the absence of treatment effects, clearer definitions can help to distinguish whether results are due to issues with intervention procedures or its evaluation (Patterson et al., 2013). The cultural diversity of studies in this review also indicated the need for future research to explore cultural variations in AT definitions, approaches and structures and whether clients value different aspects of AT.

4.1.2 The mechanisms of art therapy

The influence of MATISSE remains undeniable given its size and power. However, it could be that it was conducted prematurely. Springham and Brooker (2013) argued that RCTs are usually carried out at later stages when researchers understand how interventions work and what changes can be brought about by different aspects of it. Once this is confidently ascertained, then effectiveness can be investigated.

Few studies in this review defined the mechanisms of AT for people with psychosis, and these were not easily named by art therapists (Patterson et al., 2011a). Some identified that the AT mechanisms that brought about change were the therapeutic relationships, therapists' role in containing individuals, the process of using and creating art, the final art products (Patterson et al., 2011a; Patterson et al., 2011b), and the group process (Michaelidis, 2012).

Art therapists believed that AT's strength is the combination of these mechanisms rather than their use in isolation (Patterson et al., 2011a). However, understanding which aspects of AT influence change is needed to strengthen future research regarding its effectiveness. Kelly et al. (2014) additionally suggested that awareness of AT mechanisms can indicate how its effectiveness can be measured.

The Medical Research Council (MRC, 2008) states that to understand how complex interventions elicit change, it is fundamental to first comprehend the theories that underpin them. The active ingredients for complex interventions can be highlighted through qualitative research (MRC, 2000). Case studies can allow analytical generalisation, where individual cases are understood in the context of established theories (Yin, 1994). Improved theoretical knowledge may then guide studies' hypotheses of change and improve how research interventions are designed and evaluated with larger samples (MRC, 2008).

4.1.3 The adaptation of art therapy

AT is recommended particularly for people with negative symptoms (NICE, 2014), though this was inconsistently supported by this review. It was unclear for whom AT worked because AT was a unique experience for each individual and was adjusted accordingly (Patterson et al., 2011a). Indeed, art therapists were considered pragmatic as they adapted their approach to fit individuals (Rubin, 1999).

Holttum (2013) highlighted unreliability in the diagnostic term schizophrenia because diagnoses varied according to clinicians and services. Therapists suggested that willingness to partake in AT ascertained who found it beneficial and not clients' diagnosis or clinical presentations (Patterson et al., 2011a). Indeed, Patterson et al.

(2011b) indicated that participants were mostly referred to AT because of readiness to attend assessments (65.1%), ineffectiveness of previous therapies (57.1%), and motivation for therapy (46.1%).

The MATISSE results suggested that AT was ineffective because people with schizophrenia were not willing to engage given the high dropout rates. However, Holttum and Huet (2014) argued that even if those who attended found AT effective, this was lost to the ITT analysis. An ITT analysis aims to reflect clinical practice where non-adherence to treatment is expected. Therefore, an intervention's effectiveness is evaluated on *all* randomised participants irrespective of whether they attended or received the intervention (Gupta, 2011). Follow-up results in MATISSE were based on over 85% of participants even though 39% attended no AT sessions and only a third attended nine or more sessions. Therefore, any dose effect may have been diluted enormously. With high dropout rates, additional per-protocol analyses are desirable (Hernan & Hernandez-Diaz, 2012), as occurred in Montag et al. (2014). Indeed, Patterson et al. (2015) acknowledged that per-protocol analyses may have elicited different findings in MATISSE.

As occurred in both RCTs, inclusion of all people with psychosis is important because AT should be offered to everyone with schizophrenia (NICE, 2014). However, qualitative and quantitative research with specific recruitment criteria may also be needed. Recruiting people willing to engage in AT may indicate whether this subgroup is more fitting for AT, what changes they may experience (Patterson et al., 2011a) and how to adapt the intervention accordingly (MRC, 2000).

This recruitment method may fit better with clinical practice because clients can receive their treatment of choice, as recommended by NICE (2014), which may not be

possible through randomisation (Patterson, Kramo, Soteriou, & Crawford, 2010). It may clarify referral criteria for AT and increase services' understanding of AT (Patterson, et al., 2010). Psychotherapies have often been adapted for people with psychosis; similarly adapting AT based on the needs of people with psychosis may improve its integration in services (Patterson et al., 2011b).

4.1.4 Outcomes measures

AT may be considered an 'invisible' therapy because therapists primarily observe and silently reflect on participants, their art, the transference relationship and therapeutic atmosphere, without necessarily sharing interpretations (Patterson et al., 2011a). The process within AT is considered more valuable than what is said. Therapists' mere non-verbal and emotional presence is critical in managing clients' emotions (Schaverien, 1997).

Processes, such as therapists' observation of art, are not easy to objectively measure (Springham & Brooker, 2013). This highlights the difficulty in measuring change in AT. Moreover, the recovery process itself can be complex, multi-faceted and difficult to evaluate. It may involve simultaneous improvements in symptoms, well-being, cognitive abilities and socialisation at different rates (RCPsych, 2012).

The primary outcome measures used in the two RCTs (symptoms of psychosis and global functioning) were thought to inaccurately capture what participants found beneficial about AT (Crawford et al., 2012) and were not associated with AT (Maujean et al., 2014). Similarly, there were unclear clinical and theoretical rationales for care satisfaction, health and medication adherence being appropriate secondary outcomes.

This review indicated that participants gave more value to re-connecting with their sense of self and reality, expressing themselves and re-engaging socially. They noticed feeling better about themselves, more self-confident and able to cope even if their symptoms persisted. Participants and therapists referred more to distraction from symptoms rather than symptom improvement.

Research may benefit from measuring these outcomes as well as participants' recovery. This is supported by Holttum and Huet's (2014) suggestion that measures of self-understanding, emotional expression and personal recovery, were possibly more suited for MATISSE. According to Kelly et al. (2014), measures for communication and social connectedness can be created to evaluate changes elicited through AT.

Additionally, operationalisation of the term 'recovery' is important to ensure its adequate measurement. Participants emphasised social and psychological aspects of recovery rather than symptom remission, the latter being akin to a medical model of recovery (Slade, Amering, & Oades, 2008). Indeed, psychotherapy is primarily concerned with changes in individuals' anguish, coping and satisfaction, rather than with symptom reduction (Kazdin, 2008).

4.1.5 Participants

In three studies, small group sizes of two to three (Crawford et al., 2012), three to four (Colbert et al., 2013) and three to six members (Montag et al., 2014) may have restricted participants' opportunities to interact and explore their images with others. Generally, greater statistical power is needed to identify smaller changes between groups and to minimise risks of type II errors. Consideration of how group sizes can be maintained is also important by, for instance, providing open groups or by different services collaborating to form larger groups.

4.1.6 Intervention design

This review highlighted various intervention design issues. Several studies conducted AT with other psychosocial or psychotherapeutic interventions, making it difficult to disentangle AT's influence from other interventions'. This possibly decreased the results' validity and dissipated the use of AT as a standalone rather than adjunctive intervention. In Europe, contrary to the UK, different creative therapies are commonly considered together and their training is combined (Edwards, 2004). However, distinguishing creative therapies in research is important because music therapy has also been deemed effective for people with schizophrenia (Mössler, Chen, Heldal, & Gold, 2011).

Additionally, further exploration is required regarding whether AT should be provided at certain stages of psychosis given indications for its effectiveness in inpatient settings (Meng et al., 2005; Montag et al., 2014). Moreover, the appropriate duration of AT remains unclear because interventions ranged from one to 14 months and effectiveness emerged in shorter (Montag et al., 2014), rather than longer interventions (Crawford et al., 2012). Several studies recommended longer interventions particularly for people with severe difficulties. Wood (1997b) emphasised that intervention length may be associated with degree of distress and longer interventions can facilitate engagement with art-making and psychotic difficulties. This may also allow long-term changes (e.g. in quality of life) to be observed (Montag et al., 2014). No intervention length was recommended in this review though it was suggested that AT lasted longer than four (Colbert et al., 2013) and 12 weeks (Richardson et al., 2007).

Ensuring inclusion of regular follow-up periods may illuminate the sustainability of changes elicited through AT. Follow-ups in Montag et al. (2014) and earlier studies

(Meng et al., 2005; Richardson et al., 2007) were much shorter than the 1 and 2 year follow-up in MATISSE. AT gains in MATISSE may have become extinguished after 1 and 2 years (Leurent et al., 2014) and short-term improvements may have been missed. Therefore, Crawford et al. (2012), suggested that effectiveness may be better investigated by collecting outcome data at regular intervals.

4.2 Review Limitations

A few constraints in this review need to be considered. Several studies written in languages other than English were excluded which limits the generalizability of the findings. Additionally, the consideration of different psychotic diagnoses under the term 'psychosis' may have overseen unique differences amongst this population. This review included three studies with mixed populations to avoid exclusion of studies with participants with psychosis. However, their relevance to the review was restricted and they had to be treated cautiously. Although the studies' quality was rigorously evaluated, the lack of an official quality framework for case studies may have influenced the quality analysis for these studies. This was mitigated by considering several articles regarding case study evaluation. Furthermore, the grading of the studies was calibrated by an external researcher and differences in grading between researchers were resolved through further discussion.

5.0 CONCLUSIONS

Evidence for the effectiveness of AT in symptom reduction and functioning for people with psychosis is weak and inconclusive given the limited available literature. However, discounting the use of AT based on this may rob this population of an intervention which qualitative studies indicate is suitable and meaningful for clients. The discrepancy between the evidence for effectiveness and service users' experiences, highlights a gap in the theoretical understanding of how, why and for whom AT works and how this can be objectively researched.

Evidence-based medicine considers RCTs the 'gold standard' of evidence that guide clinical practice. This is grounded in a biomedical model that may have limited application to mental health (Double, 2002; Slade & Priebe, 2001). Nevertheless, given the priority for evidence-based clinical practice, RCTs cannot be excluded. Investigating the effectiveness of AT is necessary to economically and ethically support its delivery (Wood, 1997a).

This review advocates that RCTs are conducted in light of further qualitative research. Similarly, Fonagy (2012) recommends more robust RCT methodologies together with methodologies that listen to the voice of clinicians and clients. The sole focus on RCTs can overlook qualitative studies that highlight individuals' idiographic experiences (Slade & Priebe, 2001). Ethnographic research, together with interviews, can provide insight into individuals' experience of image-making, whether and how AT helps them, alongside how they make sense of psychosis.

Understanding service users' and art therapists' perspectives can contribute towards theoretical knowledge of AT (Springham & Brooker, 2013), and identification

of measurable outcomes (Patterson et al., 2011b). In turn, this can adequately guide controlled research. This can be facilitated through the involvement of service users in the development of research designs, assessment processes and evaluation (Rose et al., 2006), which is recommended particularly for complex interventions (MRC, 2008).

The complexity of psychosis as a mental health problem, combined with the fluid nature of AT, renders more robust research fundamental to understand how the two can be most beneficially integrated. Research and clinical practice similarly aim to provide the most clinically and cost-effective interventions; reconciliation between the two may enhance evidence-based clinical practice (Kazdin, 2008).

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EMPIRICAL PAPER

EXPLORING THE MEANING OF ADAPTATION TO FIRST EPISODE PSYCHOSIS THROUGH CREATING IMAGES

Paper to be edited for submission to the Journal for Affective Disorders

ABSTRACT

Objective: To primarily understand the meaning of adaptation to First Episode Psychosis (FEP). To explore whether using images as a visual research method enhances this understanding.

Method: Ten participants who had FEP took part in an interview during which they created an image of their experience. The data were analysed through Interpretative Phenomenological Analysis and image analysis.

Results: Four superordinate themes were identified, all of which emphasised the existential impact of FEP. Adaptation entailed: *'Figuring out how psychosis fits into my story'* as participants attempted to understand FEP and its impact; *'Breaking free from psychosis'* as they actively got their identity and life back; *'Fighting my way through psychosis'* as participants worked through the hurdles of adjustment; and *'Finding a new way of being 'me''* where participants re-evaluated their beliefs about themselves, their life and relationships.

Discussion: The path of adaption to FEP incorporates gains, pains and challenges as participants re-connect with, rebuild and redefine themselves, their life and relationships. There is resonance with posttraumatic growth in their accounts. The results build upon the literature and recommend that individuals are supported through both gains and losses. Images may offer a powerful way of communicating the dual aspects of FEP and could help in both processing the experience and gaining understanding.

1.0 INTRODUCTION

'Psychosis', although not an official diagnosis, is a primary feature of mental health problems that are on the schizophrenia spectrum such as schizophrenia, schizoaffective and bipolar disorder amongst others (DSM-V; American Psychiatric Association, 2013; ICD-10; WHO, 1992). Psychosis can manifest in the form of positive[1] and negative[2] psychotic symptoms (DSM-V, 2013).

In the National Health Service (NHS), people aged 14 to 35 years who experience a first episode of untreated psychosis are usually referred to specialist Early Intervention Services (EIS). Here, they are supported through the first three years of their recovery. These first years following a First Episode of Psychosis (FEP) have become known as the 'critical period'. Progress through this period can define the course of the disorder (Harrison, Croudace, Mason, Glazebrook, & Medley, 1996). Therefore, EIS are fundamental in influencing people's recovery and preventing relapse and the development of severe and enduring mental health problems (Birchwood, 2000).

Adaptation to FEP can be understood in light of the trauma literature (Jackson & Iqbal, 2000). The impact of psychosis can be traumatic and is associated with the development of posttraumatic stress disorder (PTSD). This is due to the widespread impact of psychotic symptoms, medication side effects and hospital admission (Lu et al., 2011). The relationship between psychosis and PTSD is complex because either one can cause the other or both can co-occur as part of people's trauma response (Morrison, Frame, & Larkin, 2003).

[1] Positive psychotic symptoms can include: delusions, hallucinations, thought disorder, and unusual motor behaviour

[2] Negative psychotic symptoms can include: lowered emotional expression, motivation, pleasure, and social interaction (DSM-V, 2013)

Even in the absence of an official PTSD diagnosis, people experienced FEP as traumatic (Tarrier, Khan, Cater, & Picken, 2007) and this extended beyond acute psychotic episodes (Dunkley, Bates, & Findlay, 2013). A review by McCarthy-Jones, Marriott, Knowles, Rowse, and Thompson (2013) indicated that through psychosis, people experienced a loss of reality, self, hope, security and relationships. Similarly, other research identified that FEP caused confusion, concerns about relapse, loss of life roles (Lam et al., 2011), loss of identity, lack of control, and stigma (Dunkley et al., 2013). Furthermore, trauma was associated with suicidal ideations and attempts (Tarrier et al., 2007).

Such significant impact on life, identity and relationships was problematic because FEP usually coincided with late adolescence or early adulthood. These developmental periods influenced the formation of identity, independence and relationships, all of which were possibly disrupted by a FEP (Riedesser, 2004). This highlights the importance of supporting individuals as they adapt to FEP.

1.1 Recovery and Adaptation

Recovery has been conceptualised in two main ways (Slade, Amering, & Oades, 2008). 'Clinical recovery' was influenced by the medical model's view of mental health problems as illnesses that were similar for everyone (Slade et al., 2008). Clinical recovery entailed treatment compliance, psychotic symptom reduction, and the restoration of previous levels of normal functioning (Frese, Knight, & Saks, 2009). This painted a restrictive view of recovery where individuals were passive recipients (McGorry, 1992) and social and psychological aspects of recovery were neglected (Frese et al., 2009; Pitt et al., 2007).

In contrast to this, an expanded view of 'personal recovery' developed as service users shared their experiences of mental health problems (Slade, 2009). In this context, Anthony (1993) defined recovery as a process through which people changed what they valued, believed in and aimed for in life, even if symptoms did not remit. It entailed searching for new meanings and purposes in life and experiencing growth, whilst facing secondary consequences, such as stigma (Anthony, 1993). Andresen, Oades, and Caputi (2003) also stated that psychological recovery from schizophrenia involved experiencing hope, finding meaning in life, taking responsibility, and re-connecting with oneself.

A review of the psychosis literature identified that people recovered from psychosis by rebuilding their identity and life and regaining what was lost (McCarthy-Jones et al., 2013). Following FEP, people also aimed to re-establish a normal life and identity (Lam et al., 2010). Pitt et al. (2007) suggested that this was facilitated by participants' self-awareness, empowerment, and hope for the future. This indicated that recovery was multidimensional (Anthony, 1993). Windell, Normal, and Malla (2012) suggested that people with FEP experienced different aspects of recovery to varying degrees. These included symptom reduction, connecting socially, functioning more, and recovering psychologically by restoring control and one's identity.

1.2 Growth

Understanding how psychosis fits into one's life also forms part of recovery (Perry, Taylor, & Shaw, 2007). According to the theory of shattered assumptions (Janoff-Bullman, 1992), trauma can crush individuals' original views of themselves and the world. This elicits a trauma response whereby people start to form new beliefs and

simultaneously process the trauma. Jackson and Iqbal (2000) suggested that successful psychological adaptation to psychosis similarly involved forming new and more helpful constructs of oneself and the world.

In light of this, the potentially traumatic nature of psychosis may render the concept of posttraumatic growth (PTG) relevant for people with psychosis. Calhoun and Tedeschi (2004) defined PTG as the positive psychological changes people experienced as they dealt with trauma. They also proposed that psychological distress caused by trauma can challenge how people understand themselves and life. People therefore have to re-evaluate and build new, more resistant beliefs, which accommodate the trauma and its possible re-occurrence. It is through this struggle with the impact and meaning of the trauma that people experience PTG. PTG can occur in five domains as people appreciate life more, identify new opportunities, feel internally stronger, develop closer relationships and renewed spiritual values (Calhoun & Tedeschi, 2004).

Research identified that positive outcomes formed part of recovery from psychosis. For instance, people redefined their identity (Andresen et al., 2003), appreciated their life and relationships, matured, gained control (Lam et al., 2010), became creative, compassionate for others and closer to family (McCarthy-Jones et al., 2013). Acceptance of psychosis and developing a new sense of self also improved participants' relationships (MacDonald, Sauer, Howie, & Albiston, 2005).

The exploration of PTG following FEP is in its infancy. However, preliminary research indicated that PTG formed part of adaptation to FEP. In a longitudinal study by Dunkley and Bates (2015), people employed both adaptive and maladaptive coping strategies. Through this, they restored their life and experienced constructive outcomes including PTG. Aspects of PTG also formed part of adaptation for two case studies

presented in Dunkley, Bates, Foulds, and Fitzgerald (2007). Furthermore, self-disclosure about psychosis was recently associated with higher levels of PTG and recovery (Pietruch & Jobson, 2012).

1.3 Learning from Experience

Further exploration into PTG can balance the traditional focus on negative aspects of trauma (Linley & Joseph, 2004) and increase comprehension of recovery to FEP (Pietruch & Jobson, 2012). This is clinically pertinent because the NHS emphasises recovery-focused, person-centred care. This aims to enhance individuals' well-being, quality of life, coping abilities, relationships and life goals (Department of Health, 2011).

Anthony (1993) suggested that the potential for recovery resided within service users, and the role of professionals was to enable their recovery. Understanding adaptation to FEP can increase services' awareness of how to support service users through distressing and constructive aspects of adaptation. Furthermore, people with FEP may feel more hopeful about recovery (Windell et al., 2012). Therefore, learning how to secure this hope throughout adaptation is important given the critical period following FEP (Spencer, Birchwood, & McGovern, 2001).

Interpretative Phenomenological Analysis (IPA) is a qualitative research method that honours service users' voices, enabling researchers to obtain an in-depth understanding of their experience (Smith & Osborn, 2003). The focus on a small number of participants in qualitative research is important because personal recovery is considered a dynamic process that is unique to individuals (Anthony, 1993; Pitt et al., 2007; Whitley & Drake, 2010). Qualitative research, including IPA, has frequently been

used with people with FEP (e.g., Boydell, Stasiulis, Volpe, & Gladstone, 2010; Dunkley & Bates, 2015).

In this research, qualitative data will be enriched through an innovative visual research method that integrates drawings with traditional verbal interviews. Data will be analysed through image analysis and IPA. The use of drawing in research is not concerned with evaluating participants' artistic skills. As described by Mitchell, Theron, Stuart, Smith, and Campbell (2011), the focus is on its content, how it is produced and the meaning it conveys for participants. The drawings will initiate verbal exploration and also act as independent sources of meaning. The richness of drawings combined with verbal exploration can provide deep insight into participants' experience (Boden & Eatough, 2014; Guillemin, 2004; Shinebourne & Smith, 2011) and this art based research method can be advantageous over using either source of data alone (Shinebourne & Smith, 2011).

These benefits of using art are pertinent for people with psychosis. Following psychosis individuals may experience decreased trust in themselves, others and the world and consequently withdraw socially (Patterson et al., 2011a). The distressing aspects of psychosis can also hinder their self-awareness and reflective abilities (Schaverien & Killick, 1997; Wood, 1997). Social functioning difficulties, together with the negative and positive psychotic symptoms, can therefore lead people with FEP to disengage from mental health services (Macbeth, Gumley, Schwannauer, & Fisher, 2013). This can have negative consequences on their recovery (Kreyenbuhl, Nossel, & Dixon, 2009; Macbeth et al., 2013).

Art therapy research has shown that art can enable expression and communication amongst people with psychosis (Patterson et al., 2011a; Patterson et al.,

2011b; Schaverien & Killick, 1997; Wood, 1997). Art can help them to express their emotional experiences in a safe manner and it can also be a non-verbal and non-threatening means of communication with others (Patterson et al., 2011a; Schaverien & Killick, 1997). Therefore, the use of art may contribute positively towards individuals' engagement and reflections in a research setting.

Drawings specifically have not been used as a research method with this population before. Rather, a recent qualitative study used photo-elicitation as a visual research method with people with psychosis. This was a positive experience for participants who used tangible photographs to express their abstract and unclear experience (Sandhu, Ives, Birchwood, & Upthegrove, 2013). This supports the utility of visual research methods with people with psychosis.

This research thus aims to gain insight into individuals' experience of adaptation to FEP. As a secondary question, it will explore the relevance of 'growth' as a means of understanding their adaptation. Furthermore, it aims to explore whether the use of drawings as a visual research method can illuminate this phenomenon.

2.0 METHODOLOGY

2.1 Interpretative Phenomenological Analysis and Image Analysis

IPA is underpinned by phenomenology, which aims to develop a rich understanding of how people make sense of their lived experience of a phenomenon (Smith, Flowers, & Larkin, 2009). IPA is concerned with the idiographic experience of particular individuals and does not aim to make general claims about the causes of events (Smith & Osborn, 2003). Phenomenological comprehension is achieved through in-depth analysis of qualitative data from small samples and is focused on understanding the person-in-context (Larkin & Thompson, 2012; Smith et al., 2009).

Individuals' description of phenomena is influenced by their relationships and circumstances; therefore phenomenology is interpretative (Larkin & Thompson, 2012). IPA is rooted in the theory of hermeneutics, or interpretation, because it values both participants' and researchers' meaning-making (Smith et al., 2009). Through the process of double hermeneutics researchers make sense of participants, as participants make sense of their experiences (Smith & Osborn, 2003). The researchers' stance is both empathic, as they see phenomena from participants' eyes, and questioning, as they interpret phenomena from alternative perspectives (Smith et al., 2009).

Boden and Eatough (2014) suggested that multimodal approaches to research can expand our knowledge of experiential phenomena. Images produce meaning about life experiences (Boden & Eatough, 2014; Guillemin, 2004) and the metaphors they incorporate may go beyond the constraints of language (Kirova & Emme, 2006). Images are a source of interpretation. Like text, they reflect a *version* of reality created

by individuals which is then interpreted by researchers through an expanded hermeneutic phenomenology (Kirova & Emme, 2006).

Visual and linguistic data contribute differently towards comprehension and together they can generate enriched meaning (Boden & Eatough, 2014; Kirova & Emme, 2006). Therefore, the integration of IPA with image analysis is suited for the purpose of this research.

2.2 Participant Recruitment

Participants were recruited through purposive sampling to ensure that they could answer the research questions based on their experience (Smith & Osborn, 2003). I identified inclusion and exclusion criteria to increase the sample's homogeneity. Participants were included if they were 18 to 35 years old and had experienced FEP leading to a referral to the EIS, which was the recruitment site. They were recruited from nine months following their FEP (at which time psychotic symptoms are expected to have ameliorated (Lieberman et al., 1998)), and up to 36 months (to recruit participants within the critical period). Participants who were experiencing an acute psychotic episode, were actively suicidal, or not English speaking were excluded.

EIS care-coordinators approached service users who met these criteria. They briefly outlined the research and gave an information sheet to those interested in participating (see Appendix 3). These individuals also signed a permission form that allowed me to contact them (see Appendix 4). I arranged a telephone call or face-to-face meeting with each participant in order to assess their eligibility, to discuss the research and inform them of their right to withdraw. Ten participants were recruited and their demographics are summarised in Table 1.

Table 1. Demographic Information of Participants

Pseudonym of Participant	Age	Ethnicity	Diagnosis	Referral to EIS	Living situation	Contact with other people	Employment or Education	Extracurricular activities
Marissa	25 years	Asian	First episode of psychosis	9 months	Lives alone in shared accommodation.	Actively re-engaging in social activities and building social networks with different groups of friends.	Completing a university degree. Aims to find a job following graduation.	Enjoys art and shopping.
Timothy	20 years	White	First episode of psychosis	10 months	Lives at home with family.	Re-engaging in life by going out gradually. Wants to reconnect with social networks.	Did not complete A' levels due to mental health problems though was employed for a short while. Aims to start college again.	Enjoys football though currently not engaging in any extracurricular activities.
Jeffrey	31 years	White	First episode of psychosis	1 year 3 months	Lives independently in his house with his child.	Limited contact with family and other people Wants to strengthen his social networks.	Has a few GCSE qualifications. Never worked before. Will be starting a course at college soon.	Enjoys art and music.
Malik	22 years	Mixed	First episode of psychosis and diagnosis of bipolar disorder	1 year 5 months	Lives at home with family.	Goes out with a group of friends regularly.	Studied at university though the course was not completed. Keen to return to university.	Enjoys website designs, creating music and writing books.
Jake	24 years	White	First episode of psychosis (drug induced)	1 year 8 months	Lives at home with family.	Has a few friends with whom he sometimes goes out. Attending social groups.	Went to college and was employed however he lost his job. Helps with family business sometimes.	Interest in football and photography. Enjoys playing computer games and with pets.

Pseudonym of Participant	Age	Ethnicity	Diagnosis	Referral to EIS	Living situation	Contact with other people	Employment or Education	Extracurricular activities
Kamilah	35 years	Asian	First episode of psychosis	1 years 9 months	Lives at home with family and wants to live alone.	Slowly engaging again with family and community services.	Has a degree in art. Employed prior to becoming unwell. Engaging more in daily activities and wants to work again.	Enjoys art, spending time with family and is religious.
Tanya	19 years	Black	First episode of psychosis following manic phase of schizoaffective disorder	1 year 9 months	Lives at home with family.	Engaging in social activities through the EIS. Currently limited contact with people in her social network.	Currently doing a part time art course. Started to attend college for 2 and a half days a week.	Enjoys playing guitar, painting and watching television.
Azar	27 years	Asian	First episode of psychosis	2 years	Currently lives at home with family though was living alone before.	Has some contact with social networks and friends.	Obtained a degree at university and started a further degree. Currently works part time.	Enjoys climbing, sports and swimming.
Samina	35 years	Asian	Multiple relapses since referral possibly due to treatment resistant schizophrenia	2 years 9 months	Resides in respite care temporarily and wants to live alone.	Slowly re-connecting with staff and peers and engaging in social activities	Completed a degree at university and did voluntary work.	Enjoys creative art and wants to pursue this interest in the future.
Stan	30 years	White British	First episode of psychosis	3 years	Lives at home with family.	Limited social activities other than weekly spiritual groups.	Did not finish school and never worked. Recently attended an art group. Plans to start college eventually.	Enjoys computer games, art, listening to music and drinking socially.

2.3 Data Collection

I obtained written informed consent from participants prior to each interview (See Appendix 5). The one-off interviews were semi-structured, an average of 90 minutes and took place in convenient locations for participants. The interview structure was adapted from Boden and Eatough (2014), who collected data through four interview stages. The initial stage entailed a 'focusing exercise' during which participants focused on their internal experiences. This was beyond the purpose of this research and excluded. The other three stages were included albeit slightly adapted.

The interview started with an 'Expression Stage'. I asked participants to describe briefly when their FEP occurred given that this period was not always easily identified. I asked them to create an image that illustrated the effect FEP had on them. This aimed to get closer to their adaptation experience. I gave participants a selection of different papers and art media which were age and culturally appropriate, as suggested by Mitchell et al. (2011). I took notes on how participants approached the activity.

In the 'Mapping stage', upon completion of the drawing, I asked participants to describe its parts and overall meaning and the process that they went through as they drew. This enabled further reflection (Guillemin & Westall, 2009) and illuminated the meaning they gave their image, which was influenced by participants' identity and the circumstances in which the image was created (Mitchell et al., 2011; Rose, 2001).

The final stage, 'Verbal Translation', enabled participants to further explore their experience. I asked them questions regarding the meaning of FEP, its impact and their adaptation (see Appendix 6 for interview schedule). In accordance with Smith et al. (2009), the questions were structured openly, reflexively and flexibly to allow participants to freely explore their experiences. The image remained a point of reference

throughout the interview and participants had the option of keeping it following the interview.

The interviews were audio-recorded and transcribed verbatim. Pseudonyms were used and identifiable information in the transcript or drawings was anonymised or concealed.

2.4 Ethics

Ethical approval was provided by an NHS ethics review board (See Appendix 7). Previous research indicated that some participants were reluctant to draw (Bagnoli, 2009; Guillemin, 2004), lacked confidence or felt frustrated by it (Kearney & Hyle, 2004). In line with recommendations by Mitchell et al. (2011), the drawing element of the interview and its purpose was explained and reiterated in the information sheet, consent form and subsequent meetings. I also confirmed the appropriateness of the research design, information sheet and consent form with a service user research group. Participants could access support from the EIS if they became distressed during the interview, however none sought this.

Additional ethical issues regarding the drawings' anonymity and ownership were considered. The ethical issues considered by associations such as the ESRC National Centre for Research Methods, refer to photography and film rather than to drawings (Wiles et al., 2008). However, Boden and Eatough (2014) suggested that ethical standards about ownership and anonymity were applicable to drawings. Rose (2007) argued that drawings that did not show identifiable images were no different to text-based data. Based on this, Tanya's self-portrait was blurred to ensure anonymity.

The images were electronically copied and published in the write-up with participants' permission and two participants kept their image.

2.5 Data Analysis

An expanded phenomenological-hermeneutic analysis was carried out in line with that used in Boden and Eatough (2014). As described in Shinebourne and Smith (2011) and Boden and Eatough (2014), there was a constant interplay between verbal and visual data as each informed the other. The IPA procedure outlined by Smith et al. (2009) was followed and slightly adapted to incorporate the drawings.

I read each transcript more than once in sight of the image, to become familiar with the data and its meaning (Smith & Osborn, 2003). I made initial annotations of what stood out from the transcript and image. I re-read the transcript, making descriptive and experiential comments about what was important for participants and its meaning, together with interpretative comments. I then analysed the drawing using two image analysis frameworks which considered the content of the image and process of producing it (Boden & Eatough, 2014) (see Appendix 8 for image analysis frameworks). This was integrated into the transcript analysis. I grouped the codes of visual and verbal meaning into emergent themes. Once this was completed for each transcript, I clustered the emergent themes across the interviews to form superordinate and subordinate themes. Table 2 provides more detail about the analysis.

Table 2. Description of Data Analysis Stages

Stages	Description
First stage of combined verbal and visual analysis	• A transcript was read multiple times with close consideration of the related image. This allowed me to become familiar with the data and the true meaning of participants' experience (Smith & Osborn, 2003). • Through 'free coding', initial annotations were made of what stood out from the text. The same was then done with the image. This highlighted my preconceptions (Larkin & Thompson, 2012) and allowed me to monitor them as the analysis progressed. • I re-read the transcript and made descriptive and experiential comments of the objects of concern and their meaning for participants. I gave attention to the language, narratives and metaphors in the verbal data. These metaphors sometimes resided in the image itself. I also reviewed the phenomenological data with a more interpretative stance.
Second stage of specific image analysis	• I analysed the drawing using two image analysis frameworks (Boden & Eatough, 2014). • The first framework considered the content of the drawing such as its composition, texture, and visual focus. The second framework considered the process that the participants went through to produce it and its meaning, such as their speed of production, mood, and hesitancy. • I wrote descriptions for all criteria of the frameworks. With these framework in mind, I then analysed the drawing with a more interpretative stance. • I incorporated results of the image analysis into the transcript analysis. • I grouped the verbal codes of visual and verbal meaning into emergent themes and then moved on to the next interview.
Third stage of integrating verbal and visual data	• Once these stages of analysis were complete for each transcript, I clustered the emergent themes across the transcripts until superordinate and subordinate themes were identified. The richness of the images meant that emergent themes were sometimes derived directly from the drawings themselves. Indeed, Bagnoli (2009) stated that analysis can be led by the visual data whereby interpretations are constructed from their metaphors. • The visual and verbal analysis guided the descriptions of the drawings that are presented for four images in the results section.

2.6 Reflexivity

Being reflexive about one's preconceptions is essential to monitor the bias that these may bring to data collection, analysis (Smith et al., 2009) and image interpretation (Rose, 2001). I am a female clinical psychologist in training and had five months experience working with people with psychosis when I was first motivated to pursue this research. This experience fuelled my desire to learn more about how people psychologically adapt to psychosis. Having limited experience with this client group was advantageous because it enabled me to interpret the data with openness and curiosity, whilst remaining sensitive to their difficulties and creating a safe research atmosphere. I have a long-standing fascination with people's internal strength in the face of adversity. This drove my desire to explore whether growth formed part of individuals' adaptation. I am a passionate artist and believer in the use of art as a means of exploration, expression and communication. Using visual research methods was new to me and I was excited to investigate whether this enhanced the richness of interview data.

2.7 Validity and Quality checks

The triangulation of methods and sources of data enhanced the credibility of the results (Robbins, 2003). Verbatim quotes and depiction of images illustrated how the themes were grounded in participants' exploration. All phases of analysis were discussed with my research supervisor. This ensured that IPA was adhered to correctly and increased the validity of the themes. Transparency of the analysis is shown through extracts of the analysis in Appendix 9. The phenomenological and interpretative analysis was cross-checked with external researchers who confirmed consistency of the

emerging themes. As the interviews were not video-recorded, note-taking ensured that I reliably remembered the image-making process. I maintained a reflective stance and recorded my feelings and thoughts in a reflective journal. This allowed me to remain open-minded throughout the interviews and analysis.

3.0 RESULTS

The analysis elicited four superordinate themes which each had a main corresponding image and subordinate themes as summarised in Table 3. The first theme '*figuring out how psychosis fits into my story'* captured participants' attempts to understand and come to terms with the losses and gains of psychosis. The second theme '*breaking free from psychosis'* explored how participants actively freed themselves of the constraints of FEP to regain their life and identity. The difficulty associated with this was highlighted in the third theme *'fighting my way through psychosis'*; participants faced various hurdles though were determined to continue progressing. Finally, the theme *'finding a new way of being 'me''* captured participants' re-evaluation of their identity, life and relationships since FEP.

Table 3. Summary of Superordinate (with related image) and Subordinate Themes

	**Figuring out how psychosis fits into my story** • "What's going on? I mean, that's not possible, it like, doesn't compute" • "It's important to me because it's part of my story" • "You've gotta know the bad side to get good"
	**Breaking free from psychosis** • "Stuck in my own mind and kind of in a dark place" • "It's up to me to help myself" • "Getting back to normal routine like what I used to do"
	**Fighting my way through psychosis** • "That was quite challenging" • "There's quite a long way to go" • "Now I'm getting better I feel as though I can…possibly overcome the fears"
	**Finding a new way of being 'me'** • "I feel like my personality was totally changed" • "You try to understand yourself much better than you did before" • "I realised how great life is" • "Being around people and fitting in"

3.1 Figuring Out How Psychosis Fits into My Story

This superordinate theme highlighted participants' attempts to understand what place psychosis had in their life. The subthemes indicated participants' efforts to make sense of psychosis, come to terms with it and acknowledge its good and bad aspects.

3.1.1"What's going on, I mean, that's not possible, it like, doesn't compute"

Most participants were hit so suddenly by psychosis that it cast a shadow of confusion as they lost control and their sense of reality. Some were unable to remember what happened during psychosis and consequently felt distressed and disoriented. Jake and Tanya were even left with gaps in their memory. Jake felt indifferent to this, though Tanya made ongoing efforts to remember, as reflected in her image. She filled it with 'squiggles' which represented her memory loss and drew her self-portrait looking back at 'psychosis' as she tried to remember:

"The whole experience was like an episode that I never experienced before and it was just, eh, so quick that I just forgot everything and it just, it just disappeared and eh, faded out and I was clueless about what happened. And it's just like puzzles like, like. So like, these holes kind of represents the gaps that are, that are, there and eh, how em, like the squiggliness is, like its fading away, like the memory of what happened." (Tanya)

Like Tanya, most participants went through an ongoing process of understanding how and why psychosis happened even if they retained memories of the experience, as Marissa explored:

"Sometimes I'm like, I, I ask myself all the time, like when I experience all of this is that God? Has God gave us, gave me a special task to overcome or something?" (Marissa)

Confusion was enhanced for four participants who experienced psychosis so vividly that it felt like their reality. They consequently found it difficult to disentangle what was real from what was not. For example:

"I thought everything was real, everything that I said was real and thought was real. Simple as that. Even if it wasn't real, I thought it was. I was hallucinating." (Malik)

Malik's quote additionally alluded to the deception caused by psychosis. Some were shocked by their realisation that the content of their psychotic experiences were not real or normal. Jake described this below and illustrated his feeling of surprise in his image:

"I had, I'd seen flashing images. I heard strong voices, saying bad things and I could hear a voice screaming in the background, in the voices and eh, it sounded like my brother when he was young and I got really scared and em, then when I seen him I was shocked that he was fine." (Jake)

This deception was conveyed in the title of Marissa's image: 'Mirror'. Marissa drew a world of darkness and a world of light, which reflected her experience during, and immediately after psychosis, respectively. Just as one sees their reality when looking in a mirror, Marissa looked at her image and believed both worlds to be real. She now realised that neither were true and both were actually reflections in the distorted 'mirror'.

3.1.2 "It's important to me because it's part of my story"

Due to this confusion, all the participants went through a process of understanding what psychosis meant for them and their trajectory through life. Most had conflicted internal beliefs about this because they held multiple views. Four specifically reflected on how psychosis changed the course of their life. With this came a tone of grief for the life they could have had, as Jeffrey stated:

"I probably already been in college by that, by now and I probably already would have got my qualifications, I could have been working and everything. So it probably has held me back." (Jeffrey)

Malik and Jake ascertained that psychosis made no major difference to them and their lives. Furthermore, Malik and Marissa both rationalised the impact of psychosis and emphasised that it did not *totally* destroy what was meaningful to them, as Malik described:

"If you're doing things based on delusions, then it's going to ruin your life in a certain aspect, but it hasn't really done much to end my life, no. It hasn't really affected me much today, I don't think it has. For it to affect you today it has to have crushed you or defeated you, or ruined you or ruined your life, which it's done none of those things to me." (Malik)

This extract also conveyed a striking resistance as Malik denied his downfall to psychosis. Conversely, others found it difficult to come to terms with psychosis due to its significant impact. Azar even developed post-psychotic depression as he described:

"I think I was just really, really down about what had happened and struggling to come to terms with it, em, yeah. I was just kinda struggling for motivation you know really, really having a bit of a rough time with it." (Azar)

He illustrated this in his image, through the ongoing bad weather following the peak of the storm, the storm being a metaphor for psychosis.

Six people, including Azar, eventually reached a level of acceptance that psychosis existed and happened to them. Samina was the only person unable to accept this. The darker scribbles of her image represented her anger towards psychosis and the suffering it caused her:

Figure 1. Samina's image

Marissa, Stan and Timothy accepted that psychosis formed part of their identity. Through their image, they depicted that both the difficult and beneficial aspects of psychosis were an integral part of who they are:

"It's just what it is, you know what I mean, it's just..(chuckles). You know, I got three voices that are mainly my life. I just wish that me and this Steve guy gets on, you know, but what can you do?" (Stan)

Timothy's acceptance of his good and bad experiences of FEP was also captured in his drawing's title:

"'Two birds, one stone'... I'm the one stone and there's two different experiences that I can go through, either the angel or the devil. So the one stone's me, if that makes sense." (Timothy)

Six participants also accepted their vulnerability to psychosis. This elicited an uncertainty of the future and a fear of relapse. Participants therefore learnt that they needed to keep an active eye on themselves. The lingering presence of psychosis was evident in Marissa's image. In the world of darkness, she drew an open eye which represented that psychosis was active, whilst there was a closed, inactive eye in the world of light. She drew a link between the eyes signifying that the eye may open again and that psychosis may re-emerge.

3.1.3 "You've gotta know the bad side to get good"

Participants stated that they could not have experienced the good that came out of psychosis without experiencing its bad aspects. Six people expressed that although psychosis was distressing, they were glad it happened. Otherwise, they may have been stuck in their old life or in a worse position. Through psychosis, they gained insight, support, grew as individuals, and did things they were unable to do before, as described in the following examples:

"I wish things were different. I've always wished that I didn't go through it but in the same way I had to go through it, it was not a choice. I had to experience it so I think it's for the better that I did because now I'm on the right path. I'm doing a lot more things so…(chuckles)." (Timothy)

"I probably wouldn't be as confident as talking to people that I am now and em, and I wouldn't be on the benefits so I wouldn't have any money still and em, I'm having my showers daily now so I would have carried on being in a dirty state I think and em, and my teeth might have fallen out (laughs), if I stopped brushing them… I would have needed the help but I wouldn't have gone to get it." (Kamilah)

Their humorous tone reflected their relief that things turned out better than they thought. Stan emphasised that through psychosis he gained the company of his 'good voices', whom he would miss if they disappeared. He believed he found love with the female voice and protection from the male voice who guarded him from the 'bad, alien voice', through laser stares:

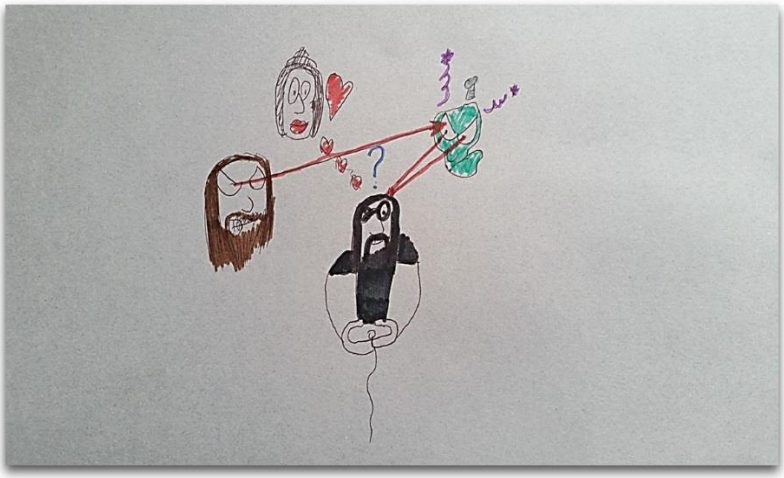


Figure 2. Stan's image

Overall, this superordinate theme indicated that understanding psychosis was complex. Participants oscillated between feelings of confusion, disbelief, indifference, and rejection of psychosis and its impact. For most, this process led to a degree of acceptance as they acknowledged the good it also elicited. The essence of this superordinate theme is captured in Tanya's image in Figure 3.

Tanya describes her painting as a clue that depicts where she was and where she is now. On the left, she paints 'psychosis'. The largest skull represents the darkness of psychosis which is *"a force, like it's trying to pull me in"*. Its darkness extinguishes her life, represented by the light and brightness of the merging colours around it. The smaller skull has a stitched up mouth indicating how Tanya was silenced by psychosis. Although not immediately visible, there is another face with wide-open eyes that exude distress, loneliness and shock that psychosis happened. These dark memories were triggered for Tanya as she drew, making the image production difficult initially. The image is framed in movie tapes because for Tanya, psychosis feels like an episode that is part of a movie of her life. This episode however disappeared from her memory as quickly as it came. The backdrop is characterised by 'squiggly' lines and shapes painted in hues of beige. These represent the damage psychosis created because her memories have been burnt away. Tanya wants to convey the confusing nature of psychosis through her image and leaves it title-less so that the viewer is puzzled about its meaning too. On the right side, Tanya paints a self-portrait that purposefully looks at psychosis. She emphasises that her self-portrait has a blank, slightly confused look. Psychosis is now a picture frozen in time which she can view from a safer distance with fascination. She also believes it to be a puzzle for which she seeks the missing pieces. This will enable her to understand herself better. She feels somewhat glad psychosis happened; she is now moving towards the light in the edged-open exit door and getting away from the darkness and confusion. Tanya notices her spelling mistake in the word 'Exit' though curiously does not change it. She wants to move on by going through the 'Exsit' door so that she can 'Exist' freely, but with a better understanding of psychosis and how it fits into her story.

Figure 3. The figure to the left is Tanya's image (her self-portrait is blurred for anonymity). The figure to the right is the image analysis.

3.2 Breaking free from psychosis

This superordinate theme highlighted participants' sense of entrapment in the darkness and distress of psychosis, as well as their vital transition to breaking free from its restrictions to get their life back.

3.2.1 "Stuck in my own mind and kind of in a dark place"

Psychosis resonated with a nightmare that rendered participants powerless and helpless. They all portrayed psychosis as horrible, unsafe and frightening and characterised it as 'aggressive', 'rough' and 'evil. This was depicted in Azar's image of the storm, in the roughness of Samina's scribbles, the 'dark world' in Marissa's image, and the devil drawn by Timothy, as he described:

"It's just not good, it was just a horrible place to be in and all the things I went through was just eh, just a, a bad place and a bad thing. So I think the devil represents that, thinking like evil and eh somewhere you don't want to go." (Timothy)

Participants did not want to get caught in psychosis, however its strength and force was not easily resisted, as Azar explored through his image:

"When the event itself happened I got haphazard which is like the waves are big, you don't know what's going to happen next. The lightening's coming down, it's cloudy, it's raining really heavily. Em, unsettled, unsettled weather conditions, dark, dark clouds, racing like really, everything going on really fast and you kind of caught up in the storm. Em, aggressive like it's quite an aggressive, attacking kind of storm. Em, scary like worrying em, and then I've got (myself) drowning in no direction as well at the start." (Azar)

The vivid images in this metaphor conveyed how psychosis showed little mercy. Participants felt stuck or trapped in psychosis and consequently believed that their life came to a halt. A vacuum was created where everything meaningful to participants froze. Malik likened this to the stopping of time:

"It's like that poem: 'Stop all the clocks'. That was my mind: 'stop everything' because I'm not feeling good and that's how it affected what I did, I think." (Malik)

The entrapment was psychological because participants felt emotionally numbed and disconnected from relationships. Tanya and Kamilah depicted how they were silenced through the image of a skull with a stitched up mouth, and a face with a crossed out mouth, respectively.

Participants also experienced a physical entrapment because they were unable to complete day-to-day activities, pursue goals, or go out. This was powerfully communicated as Kamilah drew herself chained to her bed and imprisoned behind bars, from which she could not escape. Psychosis was also disabling, as described by Tanya, who felt that she had regressed:

"When I was trying to like do, kinda come back doing my drawing, I couldn't do it so I would get frustrated. I like playing the guitar, I couldn't do that, I like doing like the sports, sports, and I couldn't do that. Yeah, so like, everything that, I was like really good at, just kinda stopped, and I had fallen backwards, just like not being able to do it and be forgetful." (Tanya)

The degree of entrapment was enhanced because it felt like nothing was changing. This was alluded to by the maze of everlasting and intertwined spirals in

Jeffrey's drawing which "*keep going round and round*", and the footsteps in Kamilah's image that were incessantly pacing.

3.2.2 "It's up to me to help myself"

Most participants spoke about their attempt to break free from this entrapment by taking action and responsibility for their life and health. Responsibility was a running theme through Malik's image which he represented through a 'crank':

"The crank in the picture, it represents that there's a lot of things you're meant to do so it's just the object that I thought I could use to represent responsibility." (Malik)

Participants described how they regained control by taking medication, following a routine, engaging in previous activities, talking to and trusting family and professionals again, particularly the EIS team. Support from others further enabled them to regain control. A few chose to attend psychological therapy, stop misusing substances, and/or regulate their thoughts and emotions to avoid relapsing. Azar gave an example of this:

"When you feel something starting to creep in, just to try to check yourself on it. Em, so when I feel myself getting really self-critical, I try and check myself on it and try and use a compassionate tone of voice or try to speak to myself in what I would imagine would be a compassionate way or the way you would imagine a compassionate friend would speak to you or something like that." (Azar)

Kamilah and Malik specifically drew their responsibilities and actions in their image.

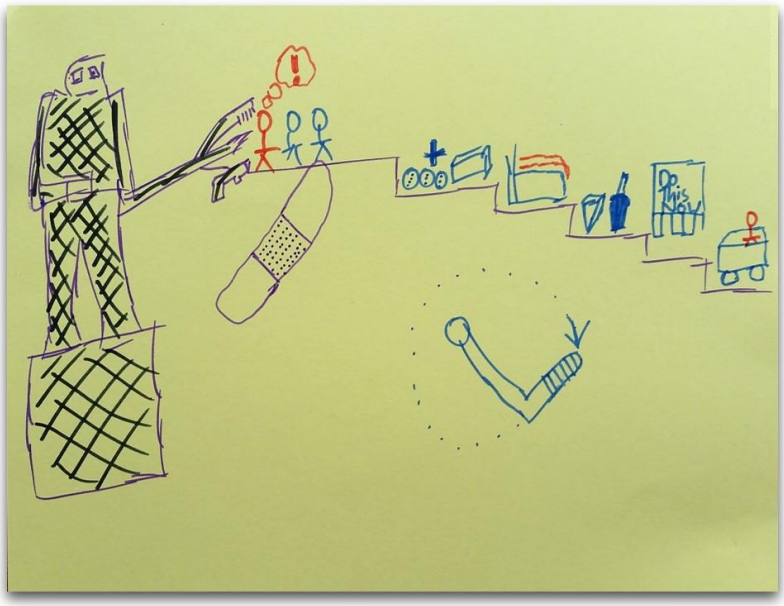


Figure 4. Malik's image

For example, Malik drew a staircase where each step represented a responsibility. Adherence to each responsibility was his main means of managing psychosis and working towards his freedom which he depicted through a cart on the final step:

"You could see there's medication there, there's a bed there, there's food and drink there, there's one of those posters that you have the paper and you, you can pull one of the slips off, and there's a sort of cart or thing that you sit in with wheels." (Malik)

Participants also attempted to break free by escaping psychosis. Some tried not to think about it or about relapse so that they could move on with their lives. Avoidance was a primary coping strategy for Jake and Samina. Jake found it particularly difficult to explore his experience throughout the interview:

"Em. Try to push this (psychosis) away. Em, try not to think about it, em." (Jake)

Jake's image told the story of when he attempted to physically escape from psychosis by getting onto a train, as his delusions were so vivid and frightening:

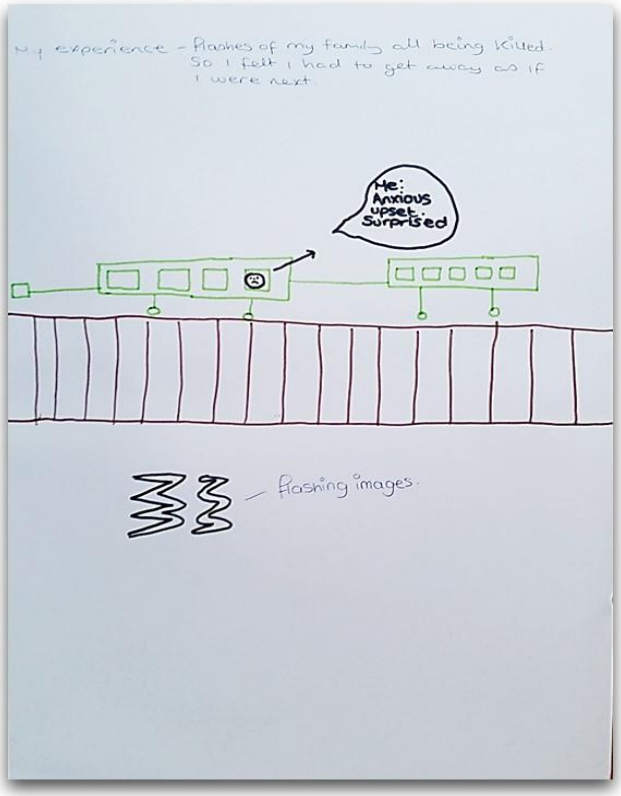


Figure 5. Jake's image

Escape was represented in the 'Exit sign' in Tanya's image too, and in the softened or lighter edges of Samina's abstract image, which portrayed her main escape route:

"There are these areas of softness around the edges. And to me they just represent the feeling that I just want to sleep all the time, just go to sleep like a baby does…to escape the reality of my life now. Because the reality of living with psychosis is very different to before." (Samina)

Sometimes, several participants attempted to ignore their symptoms through distraction. This was important for Stan who identified several activities that quietened the 'bad voice' and allowed the 'good voices' to stay. He even depicted himself getting away from his symptoms in his self-portrait:

"Basically, the most important part to me (in the image) is me playing with computer game, know what I mean? Trying to ignore the voices that are in my head." (Stan)

3.2.3 "Getting back to normal routine like what I used to do"

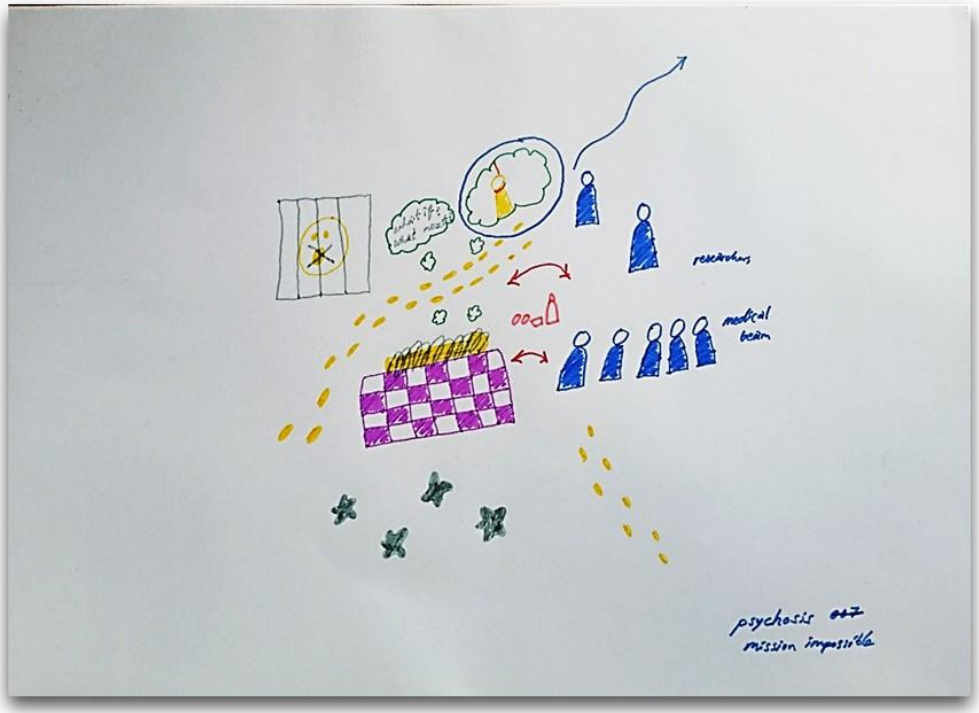
Several participants found that facing or ignoring psychosis helped them re-engage in normal life and relationships. As they successfully met their responsibilities, they felt encouraged because they noticed positive changes in themselves such as increased self-confidence. Timothy described this passionately:

"Yeah it's exciting to get your life back really. Its em, yeah, I would explain it as exciting because before life was just somewhere I didn't want to get to and I can laugh about it now because you know, I'm not there anymore. I'm not in the state of mind that I was so you know, I'm much better than what I was so it's exciting with life, it's exciting to do stuff." (Timothy)

The angel in Timothy's image was a symbol of this happy place where things were going well, contrary to when the devil took over. Participants felt more comfortable going out and talking to people because these became easier. They were reminded of who they were before psychosis and therefore aimed to re-establish their identity and place in society, as Marissa described:

"I went to the church and met some people. They accept me and we like each other, we have good conversation, we have good time, they bring me out these people. Like some friends, they are not that religious but they bring me back like, back to normal, back to my personality and they really helpful I think, really, really helpful." (Marissa)

This superordinate theme explored participants' transition from a state of mental and physical entrapment, to a regaining of freedom. By facing psychosis or escaping from it, they started to restore their life and feel like themselves again. This was captured in many aspects of Kamilah's image in Figure 6.



The image has a discreet presence though its story is dynamic and rich in meaning. This mirrored Kamilah's presentation in the interview, who although soft spoken, brimmed with reflections on her experience. Kamilah depicts herself chained to her bed and enslaved to catastrophizing thoughts ('*what if? what next?*'), which stop her from doing anything. She consequently feels dirty which she symbolises through large grey shapes. Her self-deprecation elicits suicidal ideations which Kamilah illustrates in a stark sketch of herself hanging. Kamilah draws herself in another scene locked behind bars where she feels '*scared and worried and distressed and frightened, just feel like 'aaaaa''*. This evokes the frustration of her mental and physical entrapment which is enhanced through the rhythm of her yellow footsteps pacing endlessly at home. A change in tone is elicited through the arrows which indicate Kamilah's active attempts to break free from psychosis as she goes to and fro between both sides of the image. The yellow footsteps, this time, represent her moving away from psychosis by leaving the house and meeting medical professionals and researchers. These are significant feats that give her encouragement. Kamilah draws a bubble and arrow around her suicidal image, indicating her attempt to let go of her suicidal thoughts. The drawing's title, *'psychosis 007 mission impossible'* sheds light onto how challenging facing psychosis has been and will continue to be as Kamilah describes being stuck in the middle of it. The image is balanced on the medication located in the centre, which although small has a significant influence on her getting better. The image constantly plays about with the notions of 'entrapment' and 'breaking free'. However, a thread of hope runs through it as Kamilah purposely portrays herself in yellow. She considers yellow a happy colour and a reflection of the end point that she wants to find herself in.

Figure 6. The figure to the left is Kamilah's image. The figure to the right is the image analysis.

3.3. Fighting My Way Through Psychosis

As alluded to in Kamilah's image, this superordinate theme specifically conveyed the active struggle participants went through as they adapted to FEP. The subthemes indicated that overcoming psychosis was difficult and a work in progress. Yet, facing psychosis was a choice they were determined to uphold.

3.3.1"That was quite challenging"

Getting themselves, their life and relationships back was not easy. Most participants had to push themselves to face their fears and keep themselves on track. Trusting others and accepting support was also a significant step given the distrust some experienced. Kamilah described some of these challenges:

"…And taking the medication has been challenging for me, like how I react to it. Em… Eh, going out is a challenge and eh, eh, getting up in the mornings is a challenge (laughs), yeah. Like I don't want to get up in the mornings and then I just want my day to be over and then em… I'll feel like the day is going to be a struggle…" (Kamilah)

Attempts to escape were not always successful either and required persistence. For instance, Samina stated that the voices disrupted her sleep and thus, hindered her escape.

For a few, there was a regimented feel to the activities they followed because they currently could not step away from them even if they wanted to. This was central for Malik who agreed with his responsibilities on the one hand, and resented them on the other. He believed responsibility was inevitable because otherwise there were consequences. He depicted this in his drawing of a black statue pointing weapons at his self-portrait (the stick-figure in red), when he did not adhere to responsibilities. His

crank metaphor further highlighted that responsibilities were necessary for survival, just like turning the crank was, even if this was difficult:

"The crank... which you twist counter clockwise because in the Victorian times they make you do that in order to make you get food if you were in prison, and life is sort of like that. Even if you have what's it called? A mental illness, that doesn't make you exempt from things, you still have to do things that normal people do." (Malik)

3.3.2 "There's quite a long way to go"

Although participants acknowledged feeling better, most were aware that it was not over yet. They experienced ongoing difficulties and had not yet fully achieved their goals, as Jeffrey and Kamilah stated:

"I have, like I want to put chores in as well, that's something I agreed with my psychologist. Like I want to be able to do them but I find them difficult. Some days I don't do them." (Kamilah)

"A part of me will have to try to get 100% cos I'm still not a 100% now because like I feel better but I still get paranoid. I can't look people in the eyes properly, so there's still, there's still a lot of work that needs to be done." (Jeffrey)

These hurdles were illustrated in Jeffrey's image. The unravelling of the spirals represented that things were improving. However, his progress was blocked by the ravelling of new spirals:

"When you're thinking like and you don't know what's happening like. You know, you can take your world back but then it can always turn back again and you're back to the

same place". (Jeffrey says this as he follows the contours of a spiral with his finger in a clockwise direction and then reverses the direction of his movement back round the spiral). (Jeffrey)

Figure 7. Jeffrey's image

A few participants acknowledged that their life will be constituted of '*ups and downs'.* Azar reflected on this in the context of why he chose to depict ongoing storminess in his image; it was "*not completely sunny and clear*" given the difficulties he still faced.

Some participants were reminded of this through the ongoing presence and impact of their symptoms. The symptoms were a barrier they wanted to overcome. They held participants back and prevented them from living and reaching their full potential, as Jake briefly described:

"Now I find it difficult when I'm on the train because it brings flashbacks back to me." (Jake)

Samina and Stan further expressed how psychosis and its negative symptoms taunted them and did not go away:

"(Psychosis) it's a burden… it's something I'm carrying around which stops me and inhibits me from living life." (Samina)

"I was like just messing around playing you know what I mean, then like the voice that is not very nice it, came and said (changes his tone of voice to imitate the voice he hears): 'Well, what you been doing? This is not what I had planned. You're not supposed to be doing this, you're supposed to be carrying fear and supposed to be all scared and supposed to be frightened'." (Stan)

This extract indicated that the 'bad voice' attacked Stan through its critical tone. Similarly, Stan's self-portrait was being burned by laser stares from the 'alien voice' who Stan believed was "*basically on my case*".

3.3.3 "Now I'm getting better I feel as though I can…possibly overcome the fears"

Participants were determined to work through these hurdles, achieve their goals and strengthen their confidence, even though they knew this would be daunting and worrying. This reflected their resilience. Marissa communicated this strongly through her self-talk statements:

"My feeling is like, 'only if you try you will know'. At this moment I do not have any confidence, I like just think: 'do your assignment, you just have to do it!', 'just do it, find your way and just do it!' and I try say 'it will work somehow, you can do it or not,

just em like, just do it!' This is what I think. Yeah. But I really don't know what will happen to me." (Marissa)

The red arrows in Kamilah's image indicated how she actively fought her way through psychosis, even when it temporarily pulled her back into its abyss. Participants' fighting spirit was fuelled by the benefits of getting better. Even if things became difficult, some felt better equipped to cope than before because of their increased coping strategies and support from family or the EIS. This encouraged them, instilled hope and alleviated the pressure on them, as communicated by Timothy and Jeffrey:

"It's still a long way off. I, I still, I'm going to find it hard if I did back to college. I'm sure I'm going to be nervous and find it quite hard, but I feel as though I've got a much better chance this time round than what I had before." (Timothy)

"Now I know like that if, if things get really bad there's people out there that can help, yeah. Before because I weren't dealing with it, like nothing, nothing was changing. Yet I know like if there's something wrong or I feel worse, I can always phone my CPN and then there's help there. There's the doctor, so yeah. It's a bit of a brighter future, like knowing there's people there to help." (Jeffrey)

Azar drew himself in a rubber dingy after the storm. This was a tool he acquired that guided him in the right direction, away from the bad weather. The increasing distance enabled him to look at psychosis from a different and safer perspective, similar to Tanya's self-portrait.

Half the participants were cautious about overwhelming themselves with recovery. As Tanya stated, participants emphasised taking things slowly by focusing on their present rather than on future concerns:

"It's kinda like made me learn to eh, think about stuff and kinda be calm and relaxed and not rush into things and em, just taking it slow and kinda recover. Like bring back my confidence and just be able to do like things that I haven't done." (Tanya)

Overall, this superordinate theme highlighted that adaptation was hard and a work in progress. However, participants' readiness to face the challenges and steadily get better shone through. This theme is strongly reflected in Azar's image in Figure 8.

From the left to the right side of the image, Azar recounts his ride through psychosis through a metaphor of a storm. Before psychosis, the storm develops as the rain (the blue dots) and wind (the grey lines) increase, until psychosis/the storm reaches its peak in the centre of the image. Psychosis is all-consuming as seen in how the storm fills the paper. It is huge compared to Azar's self-portrait which is sketched in pencil and barely noticeable amidst the waves. The weather is influential over his drowning and helpless self-portrait. The aggression of the storm/psychosis reverberates through the rough oil pastels strokes and bold colours in the clouds. The bolts of lightning are blatant and seem merciless. The storm's upheaval reflects the turbulence of Azar's emotions during psychosis. His vulnerability during psychosis is exuded through the storm's dangerous circumstances. The image changes as the storm becomes less aggressive and as Azar starts to take responsibility to get better. Yet, the bad weather remains and represents the difficult post-psychotic period when Azar comes to terms with what hit him. On the right, his self-portrait is seen on a rubber dingy. This equips him to cope better. He is not in the midst of the storm/psychosis and can view it from a different perspective as he moves away, into a new direction. The enduring roughness of the sea reflects Azar's uneasy state of mind which he still endeavours to manage, just like his self-portrait resists the pull of the waves, which hinder his progress at times. Still, considering the magnitude of the storm, Azar coming out the other end *and* on a dingy, accentuates his resilience, strength to survive and get his life back. Azar's chance of survival are stronger as he now has more tools. The sense of hope is emphasised by the cloud's silver lining as the sun peeps out from behind it.

Figure 8: The figure to the left is Azar's image. The figure to the right is the analysis of the image.

3.4 Finding a New Way of Being 'Me'

This superordinate theme highlighted participants' process of exploring their identity, the meaning of their life and re-evaluating their relationships, in light of psychosis. The significance of their sense of self was reflected in how all the participants portrayed themselves in their image.

3.4.1 "I feel like my personality was totally changed"

Most participants experienced their personality becoming lost to the acute stages of psychosis because they no longer recognised their 'psychotic' self. Some felt more vulnerable in an unsafe world, felt that their mood became uncontrollable, or that their behaviour was out of character, as Jake described:

"If I do silly things they, they (other people) notice that, what's the word, it might be something that shouldn't be done. But it looks good, or is a good thing at the time for my kind of mind." (Jake)

Azar represented the internal turmoil he experienced through the haphazardness of the storm. Samina portrayed how her loss of personality became tainted by psychosis through the way her favourite colour (violet) became 'muddied' by the rust colour in her image:

"I wanted to reflect who I originally was, the violet because it's one of my favourite colours and its gone all sort of muddy with the rust colour, like the experience, what it's done to my personality." (Samina)

Participants' 'self' in relationships also changed as some could not connect with people, became introverted and distrusted their closest relationships. Thus, psychosis tarnished their relationships, as Malik described:

"I was having a lot of paranoia so I was accusing family members of doing certain things. If I'd have gone out, then I would have accused my friends of doing certain things which luckily I didn't get to that stage because I was so reclusive I didn't want to go anywhere." (Malik)

This impact of psychosis and the distress it caused drove five participants to contemplate or attempt suicide due to their resultant despair and hopelessness.

3.4.2 "You try to understand yourself much better than you did before"

Following psychosis, all the participants actively attempted to understand themselves. The occurrence of psychosis enabled six participants to develop a new sense of self. They understood themselves better, acknowledged their strengths, and became more self-compassionate. For some like Azar, the selfish and perfectionistic traits of their personality mellowed down and they felt more comfortable being themselves:

"I think that now I'm probably, I can let things go a lot more easily. I think I'm aware of my early warning signs, em, I think I've got strategies to help me kind of calm down, relax. I'm more compassionate towards myself, I'm aware of my personality and my perfectionistic traits, and I'm aware that they can get on top of me." (Azar)

However, four participants were still re-establishing their identity and self-trust. They were internally conflicted because whilst they acknowledged their strengths, they were ridden by self-doubt and weakened self-confidence. The words '*what if? what next?*' in the thought bubble of Kamilah's image indicated how she was plagued by catastrophizing thoughts. Malik and Marissa also described this in depth:

"I may appear like a strong person, but the 'me' being ill, that's, that's, that's the proof right there that I can't deal with things (chuckles). That's the proof right there. I have to take the medication so I can, just to lift the dopamine a bit down in my brain. I do not think I can deal with things." (Malik)

"I can bare the painful, the pain when facing some weird things or frightened things…I'm mentally stronger than others. But em this 'stronger', I have to say make me weak, 'weaker'… because it frighten me, it make me like worry, like cannot trust myself like, like before. So in this sense, in terms of this confidence I'm weaker." (Marissa)

Marissa subtly drew this weakness in her image. Amidst the beauty and luck of the 'world of light', was an imperfection in the way the clover leaves were detached from their stems. This represented her decreased self-confidence amidst the strength she felt.

3.4.3 "I realised how great life is"

Five participants experienced a new appreciation for life and being alive. They were grateful, or attempted to be grateful, for the things they did not appreciate before psychosis. Marissa communicated how lucky she felt through the colours and clovers in

the ‘world of light’. Also, now that Timothy was on an ‘angel path’ not a ‘devil path’, he was particularly appreciative of everything around him:

Figure 9. Timothy's image

“I really value having a house, having people understanding, having a good life, cos you know, I always think about people who are in like a third world country and yeah who don’t have anything. So I really value things. I value just having a house, living in this country, yeah a lot yeah… I think I took things for granted before but I’ve realised that you know life’s short, you can’t-- live your life how you want to live it really.” (Timothy)

Related to this, participants increasingly valued living their life to the full. They wanted to enjoy it more than they did before, as Stan described:

"(Psychosis), it's a pain in the butt…no (chuckles). Ohh man! Just, is what it is you know what I mean? I don't really care whether I got it or not, you know what I mean? I'm still trying to live my life." (Stan)

Some found new meanings in their life as they experienced excitement and hope for their future and wanted to invest in themselves. This was highlighted through their aspirations, as Kamilah stated:

"I think I feel more positive about having goals and achieving goals whereas before any goals would feel impossible to do." (Kamilah)

Azar acknowledged that despite psychosis, he *"can do anything that anyone else does".* This hope was illustrated in the silver lining in his image. Marissa and Stan also described experiencing strengthened spirituality following psychosis, which helped them manage psychosis and look towards the future.

Conversely, Samina and Malik had no hope for their future or for achieving their life goals. For them, life was about surviving and getting through the present.

"I don't see any future... just existing on a daily basis which I wouldn't call a proper future." (Samina)

Although Malik stated that he maintained the same hopes and dreams as before, he did not believe that pursuing them would bring him happiness.

3.4.4 "Being around people and fitting in"

Psychosis shifted participants' attitude towards others. Six participants increasingly appreciated their family who were unconditionally supportive even at the worst of times. They valued being understood by family and some believed that psychosis brought their family closer. Participants also highlighted their value for the EIS. Marissa symbolised this through a heart in her image and Timothy described this below:

"My mum's been really understanding about it. Since I've got it, well she knows, I told her about voices and paranoia and she understands now, she understands…She's been really, she's been my rock really, she's been really understanding. So has my CPN, she's eh, I can tell her anything really." (Timothy)

Timothy also alluded to the importance of not being judged. Through their experience of being vulnerable and different, three participants became more appreciative of others' vulnerability and more compassionate and non-judgemental of diversity.

Conversely, six participants were conscious of how they were perceived now that they had psychosis. A few still felt misunderstood by family and others feared being misunderstood if peers found out about psychosis. Participants' history created a stigmatising label that skewed people's view of them and elicited rejection. Jeffrey and Malik explored this:

"You feel a bit of an outcast and that I suppose don't it? You know, like. If your family ain't gonna want nothing to do with you, why would anybody else? So…" (Jeffrey)

"I've never been depressed, but it looks from other people's view point, it looks like I was depressed. So you know. Yeah. Things, depression, craziness, delusions, paranoia, mood swings, hallucinations, aggression, can't even, I don't even know all of the words that they used, like hyper active and even...ranting, stuff like that." (Malik)

There was a sense of permanence about how these labels followed participants around. Malik emphasised this by drawing a plaster in his image. This showed that he was always responsible for 'fixing' something about himself. Interestingly, Stan welcomed the label because psychosis was part of him; he normalised his voices and justified to himself their need to stay.

Marissa and Tanya made active efforts to blend into normality by concealing their psychosis from others, distancing from peers who knew about psychosis, and acting normally:

"I don't want to tell them what happened, I don't feel like they're supposed to know and I don't think they'd understand." (Tanya)

As outlined in Figure 10, several elements of Marissa's image reflected this superordinate theme, which highlighted participants' transition to re-establishing their identity and their place in life and relationships, which was both a painful and growth-inducing process.

Marissa describes psychosis as a double-sided world. There is an obvious contrast in the colours of the two worlds, though a consistency in their texture and composition, where the eye is the central focus. The dark world was drawn first. The intensity of the eye's gaze reflects Marissa's conviction that she was watched during psychosis. It stands out against the harsh black strokes in the background, as do the other elements, making their presence unmistakable and unmoving. Marissa feels like she lost herself in this world and conveys her fear, lack of safety and mistrust through a figure of a vampire, a taunting face, a skull and a spider. Conversely, when the eye is closed and the darkness fades, a new world of light is created that is good and beautiful. Marissa illustrates this by drawing the spectral colours that constitute light when it is shone through a prism. Although the eye is still there, it is closed and its presence is weakened. The four-leaved clovers symbolise how lucky she feels to have support and still have her life. The heart symbolises her increased love for and closer connection with her family, herself and God. Yet, Marissa points out an imperfection in this apparently perfect world; some of the clover leaves are disconnected from their stems. She feels "*lucky with doubt*" because amidst her gains and strengths, she notices her weakened self-confidence and self-trust. This negatively affects her attitude with people. Marissa titles her image: 'Mirror'. She initially perceived both worlds to be her reality, their vividness seen in the rough oil pastels strokes. She now realises that both are fictitious; one too perfect (a fantasy) and one a nightmare. Although she is not ready to reveal psychosis to others who may not understand, Marissa accepts both worlds to be part of her (her fears and hopes) and her past. This was reflected in how strongly she emotionally connected with her image as she drew it. Marissa acknowledges that psychosis may be part of her future through a faded black link that connects the closed and open eye. The re-awakening of psychosis elicits in her both fear and determination that she can overcome it.

Figure 10. The figure to the left is Marissa's image. The figure to the right is the analysis of the image.

4.0 DISCUSSION

This research enhanced understanding of the meaning of adaptation to FEP. This phenomenon was brought alive through the creation of images. The four superordinate themes highlighted that the path of adaptation entailed a complex interplay of losses and gains. Participants attempted to come to terms with the negative impact of FEP. They made active efforts to break free from psychosis in order to reach their goals and they actively fought through the challenges that came with this process. As a result, participants experienced positive changes and growth as they emerged from FEP, developed coping strategies, regained their life, and viewed themselves, their life and relationships from new, hopeful perspectives. The pain of FEP therefore brought about unexpected gains and growth. Nonetheless, these gains came with further pain as participants still grieved for their losses and faced ongoing difficulties on their path of adaptation to rebuild their identity, life and future.

4.1 Adaptation and Posttraumatic Growth

Although not the focus of this research, the negative experience of acute psychosis was an integral part of participants' narratives. Participants emphasised the distress psychosis elicited, and their consequential loss of control, memory, awareness, self, relationships and trust. These losses concurred with those in McCarthy-Jones et al. (2013). Carlson and Dalenberg (2000) also suggested that the disruption caused by trauma can disintegrate individuals' sense of self. Lysaker, Johannesen, and Lysaker (2005) proposed that this could threaten individuals' inter-subjectivity (their ability to form mutual understandings with others), and further annihilate their identity.

This may explain participants' active search for a coherent explanation for FEP and what it meant for them and their place in the world. Participants' oscillation between different explanations highlighted how difficult this search was, which continued across the critical period. Other research also identified that people had alternating explanations for FEP (McCarthy-Jones et al., 2013) and struggled to make sense of it (Perry et al., 2007). In the latter study, this was attributed to FEP being a new experience, which meant that participants were still in the initial stages of understanding it.

Zoellner and Maercker (2006) considered this meaning-making fundamental for psychological adjustment. It influenced people's emotional reaction to psychosis (Hirschfeld, Smith, Trower, & Griffin, 2005), how much destruction they believed it caused, their hope for recovery (Perry et al., 2007), and search for identity (McCarthy-Jones et al., 2013). In this research, it influenced how willingly participants took responsibility for their life.

Self-responsibility was deemed a core aspect of recovery (Bonney & Stickley, 2008) that helped individuals feel empowered (Stewart & Wheeler, 2005). Frankl (2004) suggested that responsibility was the essence of being. Therefore, when faced with life challenges, taking responsibility was necessary for individuals to get their life back. Indeed, this emerged as an essential part of participants' adaptation.

Most participants made courageous attempts to get their life back by facing psychosis. Through this they experienced a re-awakening as their symptoms improved and they re-engaged in activities and relationships. Participants' gains in different aspects of life supported the multi-dimensional nature of recovery (Anthony, 1993; Dunkley & Bates, 2015; Windell et al., 2012). Other studies similarly emphasised the

re-gaining and rebuilding of reality following psychosis (McCarthy-Jones et al., 2013), and the restoration of losses through functional and social recovery (Dunkley & Bates, 2015).

As part of their attempts to restore their life, some participants ignored psychosis to avoid getting caught up in it. Only two people, however, coped by predominantly ignoring its existence. Avoidance was akin to a sealing-over recovery style (McGlashan, Docherty, & Siris, 1976) where people distanced themselves from psychosis which they considered discordant with their lives. This was associated with lower resilience when adapting to psychosis and less engagement with services (Tait, Birchwood, & Trower, 2004).

Dunkley and Bates (2015) deemed avoidance a maladaptive coping strategy compared to adaptive strategies like acceptance, active involvement in recovery and interaction with others. Several participants in this research expressed their acceptance of both the detrimental and beneficial aspects of psychosis. This linked to integrative styles of recovery (McGlashan, et al., 1976) where the difficult and beneficial aspects of psychosis were acknowledged and integrated into one's identity and life. This recovery style was associated with good adjustment (Jackson & Iqbal, 2000) and improved outcomes and functioning (Thompson, McGorry, & Harrigan, 2003). Participants also seemed to have mixed recovery styles. Indeed, recovery styles were found to change over time amongst people with FEP (Thompson et al., 2003).

Additionally to re-gaining life, growth was also part of adaptation. The considerable impact of FEP caused participants to question themselves and the direction of their life. In accordance with the theory of shattered assumptions (Janoff-Bulmam,

1992), this made way for the development of new beliefs about themselves, others and the world, as well as for PTG (Tedeschi & Calhoun, 2004).

Several participants experienced PTG. They developed a strengthened and more compassionate sense of self, appreciation for their strengthened family relationships, appreciation and enjoyment of life, and awareness of new aspirations for themselves. These resonated with four out of the five domains of PTG, which were also experienced by participants in Dunkley et al. (2007) and Dunkley and Bates (2015). Strengthened spiritual beliefs were uncommon in all the studies.

This research substantiated that engagement with the pain of trauma was required for participants to develop a coherent explanation of FEP and to experience growth (Calhoun & Tedeschi, 2004; Kashdan & Kane, 2011; Tedeschi & Calhoun, 2004). Tedeschi (1999) proposed that PTG was associated with improved well-being and coping. This potentially had important implications for participants' recovery, albeit to different degrees. Different participants experienced none, some, or all aspects of PTG. This was possibly because they were in different adaptation phases when PTG could be experienced as a final outcome of recovery or as a part of the recovery process (Calhoun & Tedeschi, 2004; Zoellner & Maercker, 2006).

Despite gains and growth, across the themes was a running narrative of participants' struggles throughout adaptation. It was challenging to accept what they lost, to face psychosis, overcome ongoing hurdles, and to re-establish their identity and place in the world. The unexpected difficulties that accompanied adaptation and growth concurred with findings in Dunkley and Bates (2015) and Buck et al. (2014). Also, studies in McCarthy-Jones et al. (2013) indicated that although the regaining of reality

enabled the regaining of self, people had to fight to maintain these gains and feared losing everything again.

Nevertheless, participants demonstrated resilience and self-efficacy to face these challenges. Lysaker et al. (2005) suggested that beyond symptom remission and psychosocial functioning, recovery crucially involved individuals believing themselves to be capable of changing their lives. Participants' determination was strengthened by their increased coping skills and belief that they did not have to face psychosis alone. Indeed, a qualitative research review highlighted that recovery from psychosis entailed both taking responsibility and accepting help (Bonney & Stickley, 2008).

Participants' adaptation mapped onto the model proposed by Andresen, et al. (2003). This included stages of 'moratorium', 'awareness', 'preparation', 'rebuilding', and 'growth'[5]. Participants experienced these stages interchangeably and repeatedly. Indeed, this research offered deeper insight into the complex and fluid path of adaptation to FEP. Along their path, individuals gradually recovered in different ways and simultaneously experienced and worked through ongoing pain, challenges, benefits and growth.

4.2 Visual Methods

The richness of the data generated was attributed to the visual research method. Participants valued being able to express their thoughts and emotions and seeing their experience from a distance, on paper. Art allowed people to distance themselves safely

[5] The stages of recovery: Moratorium (denial, confusion and hopelessness); Awareness (hoping for recovery and a new life); Preparation (identifying strengths and weaknesses and developing coping skills); Rebuilding (taking responsibility and action to achieve recovery and a new identity); and Growth (the outcome of recovery where the person feels better and can cope even with ongoing symptoms) (Andresen et al., 2003).

from difficult experiences (Schaverien, 1997). This was important given that exploration of their experience was not always easy.

The participants interested in art enjoyed the drawing process. In line with previous research (e.g., Guillemin, 2004), a minority experienced initial anxiety attributed to not being able to draw and struggling to visually translate their ideas. As I supported them in a safe research atmosphere, their anxiety was alleviated. They even felt pleased with their final image.

All participants had an initial idea of what to draw though their freedom to visually express themselves varied. Only Marissa and Samina expressed moment-to-moment feelings into their art. Three participants were surprised at how their image turned out. However, this became a meaningful source of insight into their experience.

Similarly, for seven people, the image inspired deeper verbal exploration into their experience. Visual methods were considered advantageous over word-based research because they encouraged visual expression of deep emotions which were difficult or painful to articulate (Bagnoli, 2009; Gillies et al., 2005; Kearney & Hyle, 2004) and not discussed before (Bagnoli, 2009).

A more striking outcome was how the visual and verbal methods constantly strengthened each other, as other authors highlighted (Boden & Eatough, 2014; Kirova & Emme, 2006; Shinebourne & Smith, 2011). The images enabled participants to explore their experience verbally and in turn, some chose to make adjustments to their image. As the meaning of their image was enriched further, so were their verbal narratives.

Understanding participants' verbal interpretation of their image and how they produced it was fundamental. This also increased the results' validity (Guilleman,

2004). The meaning of images may be unclear (Pink, 2001) and associated with participants' personality and circumstances on the day (Mitchell et al., 2011). Indeed, my personal interpretations sometimes varied to participants' interpretations. Davey (1999) suggested that art is experienced through a synthesis of the artist, art and viewer. This was evident in the interviews as a shared understanding was created through interaction between participants, their art and myself. The absence of either one would have weakened this process.

4.3 Evaluation

This research increased understanding of adaptation and growth following FEP. Although the small sample prevents generalisation of the results, the data elicited a wealth of information. The visual method enabled a metaphorical and expansive understanding of the phenomena. Writing restrictions prevented more in-depth interpretations of the images; nevertheless, I aimed to present a balanced view of participants' idiographic and shared experiences.

The participants recruited from the EIS were possibly more representative of people who used services. Furthermore, people who were interested in art and positive about their adaptation may have been more likely to participate. Some of these recruitment biases were minimised by giving eligible service users an equal chance of participating. Indeed, the final participants had varied experiences. This allowed me to explore adaptation across the critical period, as well as the utility of drawings with five participants who did not have a particular interest in art.

Interviews relied on retrospective self-report. Accuracy of information may have been influenced by the symptoms of FEP and difficulties with verbal articulation. Yet,

the final themes were derived from all the participants and this strengthened the reliability of their narratives. Additionally, Maercker and Zoellner (2004) proposed that sometimes growth is illusory and this could hinder long term adaptation. Illusory growth occurred when individuals exaggerated their growth experience to protect themselves from their pain. The cross-sectional design of this research prevented identification of whether growth was genuine and sustained over time.

Sample validation was not employed and possibly influenced the validity of the results. Nevertheless, validity was increased through the use of drawings as an adjunct to interviews (Guilleman, 2004).

4.4 Clinical and Research Implications

Participants' appreciation for their support networks, including the EIS, highlights the crucial role of services in supporting individuals' adaptation to FEP. Simultaneously, participants' emphasis on taking responsibility suggests that individuals should be encouraged to find a balance between embracing their support networks and becoming active agents in their adaptation.

It is recommended that services not only help individuals recover, but support them along the losses and gains of their unique adaptation path. Awareness of PTG amongst clinicians is important. This is especially true for individuals more traumatised by FEP because degree of trauma is positively correlated with PTG (Linley & Joseph, 2004).

Cognitive Behavioural Therapy, a recommended intervention by NICE (2014), is effective in symptomatic recovery and reducing distress in early psychosis (Bird et al., 2010). These were both important aspect of participants' adaptation. However,

adaptation also involved rebuilding life even if symptoms persisted and potentially experiencing further distress as they re-established their sense of self. Lysaker et al. (2010) proposed that an integrative psychotherapy approach could aim to strengthen individuals' personal narratives and metacognitive ability. This could enhance their sense of self, inter-subjectivity and belief that they could face adversity and elicit change.

Frankl (2004) proposed that an essential aspect to finding meaning in life was accepting that suffering was an unavoidable part of it. Indeed, this research showed that pain was still present amidst the gains and growth of adaptation. Buck et al. (2014) and Dunkley and Bates (2015) encouraged professionals to be aware of this and to support service users through the challenges and gains of recovery. Acceptance of the inevitability of pain can enable individuals to work towards a meaningful and valued life (Hayes & Smith, 2005). This is important because over or under immersion with trauma may be counter-productive to adaptation (Kashdan & Kane, 2011).

Participants' appreciation for their family highlights their potential role in participants' adaptation. Family intervention is a recommended treatment (NICE, 2014), through which families can understand what adaptation is like and how to support individuals through it. Family involvement could strengthen individuals' adjustment (Boydell et al., 2010) and growth experiences (Linley & Joseph, 2004), besides preventing disengagement from services (Doyle et al., 2014).

Research with other populations provided evidence for the longitudinal benefits of PTG (Zoellner & Maercker, 2006). Longitudinal studies are needed to understand the sustainability of PTG and its impact on individuals' quality of life and well-being.

These can indicate how adaptation changes for people with FEP and whether PTG results in positive adaptation over time.

Qualitative research using drawings in mental health remains limited to very few studies (e.g., Boden & Eatough, 2014; Gillies et al., 2005; Guillemin & Westall, 2009; Robbins, 2003; Shinebourne & Smith, 2011). This method may override standard interview responses (Bagnoli, 2009) and its value is evident through this research. Researchers are encouraged to utilise creative multi-method research with people with psychosis and other populations. This can enable service users to understand and process their experience and allow professionals a deeper verbal and visual immersion into participants' world, which can inform clinical practice.

4.5 Conclusion

This research adds to the recovery and PTG literature by enriching our understanding of what adaptation to FEP is actually like. It is brought alive through the powerful and vivid meanings in participants' images. Adaptation involves experiencing and working through pain and challenges, as well as benefits and psychological growth. These experiences accompany individuals' re-engagement with life, connection with others and search for their sense of self. Participants' verbal and visual narratives illuminate the internal strength required to adapt to FEP. This highlights the crucial role of EIS in nurturing individuals on their path of adaptation and self-discovery.

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PUBLIC DISSEMINATION DOCUMENT

Art and Psychosis:

Using art therapy as a treatment method for people with psychosis

Using drawings as a research method to understand how people adapt to having a first episode of psychosis

The research was conducted by Angelica Attard as part of the Doctorate in Clinical Psychology at the University of Birmingham. The research was supervised by Dr Michael Larkin, Academic Tutor, at the University of Birmingham and Dr Chris Jackson, Clinical Psychologist, at the Early Intervention Service.

There are two components to this research. The first is a systematic review of the literature which aimed to examine how effective art therapy is for people with psychosis. It also aimed to understand how suitable and important this type of therapy is for them. In order to meet these aims, a thorough search was carried out of the research in this field. Research articles were searched through seven electronic databases of journal articles. This search resulted in 16 appropriate articles published since 2007 that concerned the use of art therapy with people experiencing psychosis.

The quality of the 16 articles were examined in relation to a set of criteria that was devised to evaluate the quality of research. The results showed that although there is some evidence for the effectiveness of art therapy for people with psychosis, it is difficult to conclude this with certainty. This is because limited research has been carried out and most of the published articles are of poor quality. However, the results also showed that in general, art therapists and people with psychosis who received art therapy, believe that it is helpful and meaningful to them in many ways.

The review discusses the possible reasons why there is an inconsistency between the evidence for the effectiveness of art therapy and the positive experiences of art therapists and service users. Further, better quality research with service users and therapists is needed to understand more about how art therapy works and whether particular individuals are more suited to it. This understanding can then help researchers to better design studies that can examine whether art therapy is effective with larger groups of people. This is important because art therapy is a nationally recommended treatment for people with psychosis and more research can influence how art therapy is practiced in mental health services.

The second paper is an original research project which aimed to understand people's experience of what it is like to adapt to having a First Episode Psychosis (FEP). This was done through the use of a novel research method where individuals create an image. Ten participants who experienced a FEP took part in an interview in which they created an image of how their experience had an effect on them and their life. They used this to talk about their experience of FEP in more depth.

The data from the interviews were analysed through Interpretative Phenomenological Analysis (IPA). This is a detailed way of analysing information that is gathered from interviews. IPA helps to understand an experience from the perspective of the individual being interviewed. The drawings were also analysed individually through an image analysis process. This provides a detailed way of understanding the meaning of the image and how it was created by the participants.

Once the ten interviews were analysed, four main themes were identified which captured the essence of participants' experience. The first theme was '*Figuring out how*

psychosis fits into my story'. This highlighted how confusing psychosis was for participants and how they tried to understand it and remember what happened. This was not an easy process however, most participants were able to accept that psychosis affected them. They noticed that although psychosis was a bad experience, good things came out of it too.

The second theme, '*Breaking free from psychosis',* showed that participants felt trapped by psychosis because this stopped them from living their life and speaking to others. However, they freed themselves from psychosis by taking actions to get their life back and to re-build their relationships with people. This helped them to feel better and more like themselves.

The third theme, *'Fighting my way through psychosis',* indicated that getting their life and identity back was not easy. This required a lot of effort as participants continued to experience symptoms of psychosis and faced ongoing hurdles. However, they were determined to continue to fight and work towards their goals.

The final theme, *'Finding a new way of being 'me'',* showed how after psychosis, participants started to look differently at themselves, their life and relationships. They appreciated things around them much more than they did before, although they sometimes still found it difficult to accept how things had changed.

The results of this research help us to understand more about what it is like to adapt to a FEP. Adaptation is not easy and requires a lot of effort as people fight to rebuild a satisfying life for themselves and understand themselves and their place in the world. However, simultaneously they can experience positive changes and grow as individuals. They may feel emotionally stronger, have new goals for themselves and appreciate their life and relationships more.

This shows that it is important for mental health services to help service users to work through the difficult and beneficial aspects of adaptation to FEP. This research also shows that the use of images when interviewing people can be a powerful way of understanding their unique experiences. Drawings can help individuals to reflect on their experience in a new way and express things which are not always easy to put into words. At the same time it can provide professionals with deeper insight into service users' world and how they can support them.

APPENDICES

Appendix 1: Multi-Method Quality Framework

Adapted from Sale and Brazil (2004)

- **Blue- case study additional criteria**
- **Green- mixed methods additional criteria**
- **Orange- RCT additional criteria**
- **Red- qualitative additional criteria**

Framework for Qualitative studies and case studies

Truth value (Credibility vs. Internal Validity)	**Yes/ No/ Can't tell/ Partially**	**Comments**
Triangulation of data sources		
Triangulation of methods		
Triangulation of investigators/researchers		
Triangulation of theory/perspective		
Negative case analysis or searching for disconfirming evidence		
Use of quotations		
Ethical review undertaken		
Statement that confidentiality was protected		
Informed consent stated		
Consent procedures described		
Applicability (Transferability/ Fittingness vs. External Validity/ Generalizability)	**Yes/ No/ Can't tell/ Partially**	**Comments**
Statement of aims and research question(s)		
Statement of rationale for the use of qualitative approach/case study		
Description of and connection to a theoretical framework/ wider body of knowledge		
Description of conceptual framework for the research		
Rationale for choosing the particular case/s		
Description of sampling procedure		
Justification or rationale for sampling strategy		
Description of study context or setting		
Description of participants or informants (or case material)		
Description of data gathering procedures		
Audiotaping procedures described		
Transcription procedures described		

Field note procedures described		
Description of raw data		
Description of data analysis		
Coding techniques described- Is it clear how the themes and concepts were derived from the data? (N/A for case study)		
Data collection to saturation specified (N/A for case study)		
Statement that reflexive journals or logbooks were kept (e.g. declaration of training or interests)		
Description of limitations		
If there is a formulation, is it supported by the assessment data and linked to the wider theory or literature?		
If there is an intervention, is it clearly described and appropriate?		
Suggestion of whether and how findings could be transferable to other settings		
Suggestions for questions or issues for future research		
Consistency (Plausibility vs. Reliability)	**Yes/ No/ Can't tell/ Partially**	**Comments**
External audit of process		
External audit of data and reconstructions of the data		
Triangulation of investigators/researchers		
Member checks (N/A for case studies)		
Peer debriefing		
Goodness of fit		
Confirmation of analysis by other researcher		
Neutrality (Reflexivity vs. Objectivity)	**Yes/ No/ Can't tell/ Partially**	**Comments**
Bracketing (to mitigate effects of preconceptions that may taint research process)		
Statement of researcher's assumptions or statement of researcher's perspective		
Description of the role of the researcher and the relationship between the researcher and the participant/s		
Evidence that any bias is taken into account when carrying out the data analysis		

Quantitative Articles
Non- Randomised and Randomised Control Trials

Truth value **(Credibility vs. Internal Validity)**	**Yes/ No/ Can't tell/ Partially**	**Comments**
Extraneous or confounding variables identified		
Baseline differences controlled for in the analysis		
Statement about comparability of control group to the intervention group at baseline		
Statement that the comparison group is treated equally to treatment group aside from intervention		
Description of the random allocation concealment		
Description of the blinding		
Ethical review undertaken		
Statement that confidentiality is protected		
Statement of harms and unintended effects in each group		
Applicability **(Transferability/ Fittingness vs. External Validity/ Generalizability)**	**Yes/ No/ Can't tell/ Partially**	**Comments**
Statement of purpose		
Aim of the study explicitly stated or described		
At least one hypothesis stated		
Design stated explicitly		
Definition of outcome measure(s)		
Assessment of outcome blinded		
Description of setting or conditions under which data collected		
Description of study population		
Source of subjects stated i.e. sampling frame identified		
Power calculation to assess adequacy of sample size or sample size calculated for adequate power		
Description of subject recruitment/sampling selection		
Inclusion and exclusion criteria for subject selection stated explicitly		
Description of control or comparison group		
Source of controls stated		
Description of data gathering procedures		
Description of data collection instruments or source of data		

Description of intervention if appropriate		
Sample randomly selected (N/A for non-randomised trials)		
Method used to generate random allocation sequences		
Type of randomisation- details of any restriction (e.g. blocking)		
Statement of changes made to methodology following trial commencement		
Statement about non-respondents or dropouts or deaths		
Missing data addressed		
Statistical procedures referenced or described		
For each group, number of participants included in each analysis and whether the analysis was by original assigned groups		
p-values stated		
Confidence intervals given for main results		
Both statistical and clinical significance acknowledged		
Description of limitations to the study		
The relevance of integrating the qualitative and quantitative data/results to address the research question		
Consideration of the limitations of integrating results (e.g., the divergence of qualitative and quantitative data in a triangulation design)		
Consistency **(Plausibility vs. Reliability)**	**Yes/ No/ Can't tell/ Partially**	**Comments**
Standardization of observers described		
Neutrality **(Reflexivity vs. Objectivity)**	**Yes/ No/ Can't tell/ Partially**	**Comments**
Standardization of observers described		

Appendix 2: Quality analysis of the sixteen articles

Authors & Study Type	Truth Value (Credibility)	Applicability (Transferability/Trustworthiness)	Consistency (Plausibility)	Neutrality (Reflexivity)	Overall Quality Outcome
Quality Outcome	**2**	**3**	**3**	**1**	**Poor**
Teglbjaerg (2011) Qualitative	**Strengths** Triangulation of sources, methods and theory Use of quotations for participants with schizophrenia to support main findings **Limitations** No triangulation of researchers Biased conclusions as no reflection provided about the comparison group No negative case analysis Unclear whether a range of participant quotes used No use of quotations for participants without schizophrenia	**Strengths** Statement of aims, research question and rationale for qualitative approach Description of study context, data gathering procedure and modified grounded theory for analysis Statement that logbook was kept Detailed description of raw data for participants with schizophrenia . **Limitations** Poor description of demographics of participants of both groups and no information about diagnosis of participants in comparison groups No description of sampling procedure, audiotaping, transcription and field note procedures of coding techniques and how concepts were derived from the data	**Strengths** Conclusions made for participants with schizophrenia are plausible and supported by theory Showed goodness of fit and related results to previous literature The quotations were consistent with the themes discussed A semi-structured interview was used to maintain more consistency amongst interviews The conclusions made for people with schizophrenia are believable and supported by the results **Limitations** The reason for modifying grounded theory is unclear and how it was modified No external audit of data and of the analysis No statement of peer debriefing or member checks The conclusions made for people without schizophrenia are not plausible given the limited resulted	**Strengths** Records of information about each art therapy session were kept in logbooks **Limitations** It is unclear whether the facilitators' biases were recorded in logbooks No information about who facilitated the art therapy group and who carried out the interviews Bracketing not mentioned and no statement of researcher's assumptions	

	to illustrate findings and the rationale for this Ethical issues not considered	No information about data saturation No raw data provided for comparison group and no rationale for why this was not reported No information of the data that was collected pre and post intervention and at follow up No acknowledgement of limitations	provided for this group	No consideration of the biased presentation of the results and discussion that mainly focused on participants with schizophrenia and no rationale for this was provided for doing this	
Authors & Study Type	**Truth Value (Credibility)**	**Applicability (Transferability/Trustworthiness)**	**Consistency (Plausibility)**	**Neutrality (Reflexivity)**	**Overall Quality Outcome**
Quality Outcome	**6**	**4**	**5**	**4**	**Good**
Patterson, Crawford, Ainsworth & Waller (2011a) Qualitative	**Strengths** Triangulation of data sources, theory, methods and researchers Negative case analysis Use of quotations with reference to the participants who stated the quote Referral to approval by the NHS Research Ethics Committee **Limitations**	**Strengths** Statement of aims and rationale for the use of qualitative approach Description of and connection to a theoretical framework Description of sampling procedure and justification Description of study context, participants, data gathering procedure, data analysis, coding techniques, raw data and limitations Statement about audiotaping and transcription procedures Data saturation achieved **Limitations**	**Strengths** Member checks carried out as therapists checked the transcripts and notes made The steps of grounded theory were followed The participants' quotations are consistent with the themes being discussed. Goodness of fit- consistency of the epistemology with the methodology and results which are further discussed in relation to the epistemology The interviews were guided by a list of topics that linked to the aims of the study The conclusions made plausible and supported by findings **Limitations**	**Strengths** Acknowledgement of the subjectivity of qualitative research, of researcher's background and the uniqueness of participants' views that may have influenced the findings and statement that this was minimised through ongoing analysis **Limitations**	

	No information about confidentiality and consent procedures	Unclear rationale for why MATISSE art therapists were interviewed more than once whilst the non-MATISSE and Key Informant art therapists were interviewed once Which participants and how participants were selected for individual interviews rather than for the focus groups was unclear	No peer debriefing No statement of whether there was agreement or disagreement about interpretation of findings between researchers	Acknowledgement of influence of researchers' professional and personal backgrounds on therapists' views however what these assumptions specifically are is not specified and it was not stated how these were bracketed No consideration of potential bias that may have been introduced by opportunistic interviews When unable to audio-record the interview, detailed notes had to be taken and this may have introduced bias to what was recorded and considered important	
Authors & Study Type	**Truth Value (Credibility)**	**Applicability (Transferability/Trustworthiness)**	**Consistency (Plausibility)**	**Neutrality (Reflexivity)**	**Overall Quality Outcome**
Quality Outcome	**6**	**5**	**4**	**2**	**Good**
Patterson, Borschmann & Waller (2013) Qualitative	**Strengths** Triangulation of data sources, theory and methods Negative case analysis Use of quotations with reference to the participants who stated the quote Ethical issues considered (ethical review, confidentiality, consent)	**Strengths** Statement of aims and rationale for the use of qualitative approach Description of sampling procedure and justification Description of study context, participants, data gathering procedure, raw data and limitations Data analysis not described but reader is referred to other article for more detail Statement about audiotaping,	**Strengths** Goodness of fit between aims, method and results The participants' quotations were consistent with the themes discussed The conclusions made were plausible and supported by findings The interviews and interview questions were guided by the study aims	**Strengths** Acknowledgement of subjectivity of participants who may not necessarily be representative of people with schizophrenia and reflection of how this was minimised (e.g. through saturation)	

	Limitations Triangulation of researchers is assumed based on the approach taken in the process evaluation however this is not specifically stated in the study	transcription and field note procedures Data saturation achieved Description of and connection to a wider body of knowledge **Limitations** Unclear what the theoretical framework of the study is No statement about whether reflexive journals were kept No reference is made to the information gathered from the key workers and family member who attended the interviews Inconsistent number of participants as 23 were stated to be interviewed and a total of 24 participants were mentioned when their allocation was described	**Limitations** Although it is suggested that the article is part of a wider process evaluation for MATISSE, the lack of detail of the analysis method makes it difficult to confidently ascertain whether the data was accurately coded No information about external audit of the data and analysis No indication of whether consensus of interpretation was reached through triangulation of researchers No peer debriefing or member checks stated	**Limitations** Bracketing not mentioned No acknowledgement of influence of researchers' assumptions and the bias possibly introduced by the main researcher also being a researcher on MATISSE	
Authors & Study Type	**Truth Value (Credibility)**	**Applicability (Transferability/Trustworthiness)**	**Consistency (Plausibility)**	**Neutrality (Reflexivity)**	**Overall Quality Outcome**
Quality Outcome	**5**	**5**	**6**	**3**	**Good**
Colbert, Cooke, Camic & Springham (2013) Qualitative	**Strengths** Triangulation of data sources, of investigators in the participant recruitment and data analysis process and of theory in the interpretation of the data Negative case analysis Ethical review undertaken Acknowledgment of bias within the	**Strengths** Statement of aims and rationale for the use of qualitative approach Description of theoretical framework and linked to aims Description of study context, participants, data gathering process, audiotaping, transcription, raw data, data analysis and limitations	**Strengths** An audit of the process and the data carried out by the second and third authors They evaluated whether the analysis complied with the narrative analysis principles The analysis was checked against the transcripts to ensure that it was	**Strengths** Acknowledgement of researcher's preconceptions and assumptions	

	results because several of the participants had a high level of education and an interest in art. Recommendations made that future research addresses these biases. **Limitations** No triangulation of methods as only interviews were carried out Use of quotations though which participants were quoted was not stated No detail provided about confidentiality and consent procedures	Description of interview questions Consideration of people who dropped out of the study and impact **Limitations** No description of sampling procedure No statement of whether reflexive journals were used	not biased by researcher's assumptions Consistency was enhanced by outlining which results overlapped Member checks carried out following the analysis to share the transcript and results with each participant and check its validity with them Goodness of fit: epistemological links made to the results and analysis **Limitations** It is stated that the audit and peer debriefing were carried out by the second and third authors though it is unclear whether anyone external to the research audited the process	**Limitations** Researcher's preconceptions and assumptions were was not specifically outlined No statement about bracketing made	
Authors & Study Type	**Truth Value (Credibility)**	**Applicability (Transferability/Trustworthiness)**	**Consistency (Plausibility)**	**Neutrality (Reflexivity)**	**Overall Quality Outcome**
Quality Outcome	**3**	**3**	**2**	**1**	**Poor**
Banks (2012) Case Study	**Strengths** Triangulation of data, methods and theory Extract from audio-recording of images provided Some quotations presented Illustration of the participant's art work Informed consent stated	**Strengths** Statement of aims Connection made to theoretical framework and wider body of knowledge Descriptions provided of study context, case material, the art therapy intervention, data gathering process and audiotaping No analysis method described	**Strengths** Goodness of fit: recovery framework reflected upon consistently and discussed in relation to results	**Strengths** Statement that the author co-facilitated the art and music therapy group Acknowledges potential issues involved in integrating individual and group therapy	

	Limitations No triangulation of investigators No referral to wider ethical review process The author selected the 11 images that she thought were helpful for the participant though it is unclear whether this was consistent with which images the participant himself valued the most Quotations reflecting the participant's experience were not consistently represented for all the main issues discussed as their experience was described in the author's words	though interpretation of data guided by the theoretical framework Suggestions made for future research and consideration of the applicability of intervention in other secure settings **Limitations** No rationale provided for the use of case study method Unclear rationale for why this particular case was chosen to demonstrate the treatment models No information about transcription, observation procedures No statement about use of reflexive journals Unclear what the elements of music therapy entailed in the art and music therapy group intervention No description of limitations	**Limitations** No external audit of data No peer debriefing No confirmation of interpretation of data by other researcher No reliable or valid measures were used and changes were not objectively measured	**Limitations** No statements made of bracketing or the researcher's assumptions No consideration of how the author's role as the individual and group therapist may have influenced or biased the research results and perspective No acknowledgement of potential bias caused by participant having a prior interest in art Given the three aspects of the intervention: individual art therapy, music therapy and recovery group makes it difficult to identify what contributed towards the intervention's helpfulness.	
Authors & Study Type	**Truth Value (Credibility)**	**Applicability (Transferability/Trustworthiness)**	**Consistency (Plausibility)**	**Neutrality (Reflexivity)**	**Overall Quality Outcome**
Quality Outcome	**3**	**3**	**3**	**1**	**Moderate**
Michaelides (2012)	**Strengths** Triangulation of theory, methods and data sources	**Strengths** Statement of aims and proposed hypothesis	**Strengths** Goodness of fit: recovery framework reflected upon	**Strengths** Description of researcher also being the facilitator of the	

Case Study	Given that the participant was mostly nonverbal, instead of quotations, detailed descriptions of the participant's nonverbal behaviour, the process of art therapy and interpretation of the images were provided Statement about informed consent **Limitations** No triangulation of investigators No explanation of the wider ethical review process Although session 11 is referred to and there is a reflection about what happened after session 4, there is no description of what took place in the rest of the sessions and the impact and experience of these	Description of conceptual framework and wider body of knowledge Description of study context, participant, intervention and raw data No analysis method described though interpretation of the sessions is guided by the theoretical framework **Limitations** No rationale for use of case study method No description of data gathering process, use of reflexive journals and limitations No suggestions for future research and about whether results are transferable Rationale for choosing particular case as opposed to other potential participants is unclear No rationale given for why the 1st, 4th and 32nd session were particularly chosen to analyse	consistently and discussed in relation to results and relevant literature Discussion about history of the case, and impact that this had on participant and intervention **Limitations** No confirmation of analysis by other researcher No reliable or valid measures were used and changes were not objectively measured No explanation of how potential biases caused by the subjectivity of clinical observations was minimised and whether a framework of criteria for observation was used	group **Limitations** No statements about bracketing or of the researcher's assumptions No consideration of whether there were alternative explanations that may have contributed to the changes observed No consideration of how the author's role as the art therapist may have influenced or biased the observations made and the research results	
Authors & Study Type	**Truth Value (Credibility)**	**Applicability (Transferability/Trustworthiness)**	**Consistency (Plausibility)**	**Neutrality (Reflexivity)**	**Overall Quality Outcome**
Quality Outcome	**5**	**4**	**4**	**5**	**Good**
Havenik Hestad, Lien, Teglbjaerg, & Danbolt (2013)	**Strengths** Triangulation of data sources, of methods and theory Extract of statements from participants and illustration of their	**Strengths** Statement of aims, research questions and propositions Description of conceptual framework of the research, study	**Strengths** Interviews followed an interview template The conclusions made were supported by the results of the study	**Strengths** Acknowledgment of the subjectivity of qualitative research and the potential impact of researchers'	

Multiple Case Study	art work Ethical review undertaken and statement of informed consent **Limitations** Referral to 'we' when describing the analysis process suggesting that multiple researchers were involved however it is not explicitly stated who the researchers are	context, participants, data gathering process, audiotaping, transcription, analysis, coding techniques and limitations Very detailed description of intervention and raw data Rationale for choosing the participants provided Suggestions made for future research No referral to transferability though acknowledgement that the diversity in sample diagnoses decreased the homogeneity of the sample **Limitations** Statement that case study design was considered most appropriate though rationale for this not provided No information provided about how participants came to take part in the first Expressive Art therapy group No statement about whether reflexive journals were kept	Member checks carried out Goodness of fit between aims, results and discussion In increase transparency each participant's therapeutic process was described. **Limitations** No information provided about whether the researchers agreed or disagreed with the analysis and how differences were resolved Unclear whether there was confirmation of analysis by another researcher	preconceptions and that this was addressed by presenting the individual story of participants Acknowledgement of bias in the gender of the sample Description of role of first author who was also the therapist. Acknowledgement of the response bias this may cause and that this was mitigated by an independent research assistant carrying out the interviews Acknowledgement that it is difficult to differentiate whether the therapeutic effects are due to the group process or the art therapy. **Limitations** No consideration of biases of the co-therapist and the influence of this	
Authors & Study Type	**Truth Value (Credibility)**	**Applicability (Transferability/Trustworthiness)**	**Consistency (Plausibility)**	**Neutrality (Reflexivity)**	**Overall Quality Outcome**
Quality Outcome	**3**	**2**	**2**	**1**	**Poor**

Gajic (2013) Case Report	**Strengths** Triangulation of sources, methods and investigators as more than one person involved in the analysis Illustration of two pieces of art work from each participant Statement of informed consent Scales administered by an independent clinician not involved in the art therapy **Limitations** No triangulation of theory and interpretation of the data from different theoretical perspectives No explanation of the wider ethical review process The changes reflected in the interpretation of the drawings were not supported by participant quotations Clinicians rating of the CGI-I may rely on memory of baseline functioning and it is not stated whether baseline functioning was measured	**Strengths** Description of wider body of knowledge Description of study context, participants, intervention, data gathering process and some reflection on limitations Suggestions for transferability of findings and recommendations for future research **Limitations** Generally poorly written article making it difficult to understand the meaning of the sentences. Poor and unclear statement of aims No rationale for the use of the case study method Unclear what the conceptual framework is No description of rationale for choosing cases, of sampling procedure, of the measures used and the use of reflexive journal No information provided about the two month follow up No description of how clinical observations were made and recorded and who made them Statement of qualitative analysis of the drawings and the therapy protocols but no information about what this analysis was and how it was carried out. Unclear what the therapy protocols are	**Strengths** Confirmation of analysis by another researcher **Limitations** No information provided about whether the researchers agreed or disagreed about the analysis and how differences were resolved No evidence of goodness of fit Conclusions made are not fully supported by the results of the measures which showed minimal improvements or no improvements and it is not stated whether the results are significant No information provided about the reliability and validity of the measures and the suitability for the population being investigated No explanation of how potential biases caused by the subjectivity of clinical observations was minimised and whether a framework of criteria for observation was used	**Strengths** Acknowledgement that art therapy occurs as part of the day hospital integrative therapy program, making it difficult to attribute changes solely to art therapy. **Limitations** No statements about bracketing or of the researcher's assumptions No acknowledgement of potential bias caused by participant having a prior interest in art may have influenced the results. No information about the role of the researcher and whether they were involved in the facilitation of the group.	

		No description of statistical analysis used Generalisations made about the effectiveness and importance of art therapy for the day hospital based on the two case examples No reference to the raw data and process of art therapy in between admission and discharge			
Authors & Study Type	**Truth Value (Credibility)**	**Applicability (Transferability/Trustworthiness)**	**Consistency (Plausibility)**	**Neutrality (Reflexivity)**	**Overall Quality Outcome**
Quality Outcome	**1**	**2**	**1**	**1**	**Poor**
Drapeau & Kronish (2007) Case Report	**Strengths** Triangulation of methods suggested through the use of observations and drawings Data considered from two time points Illustration of art work to support the themes presented **Limitations** No mention of ethical review undertaken Numerous participants were referred to though there was no reference to who the participants were and it is not possible to determine whether the same or different participants were being referred to No information about the diagnosis of the participants who were quoted and referred to	**Strengths** Aim stated Description of participants, raw data, study context and wider body of knowledge supporting the study Suggestion that further research should be carried out **Limitations** No rationale for design chosen No description of sampling procedure, data gathering and data analysis methods, audiotaping or transcribing, use of reflexive journals, limitations, transferability of results No description provided about what a creative art therapy group with a supportive and psychodynamic approach entails decreasing ability for replication	**Strengths** None **Limitations** No mention of the study's methodology No external audit of process or of data No mention of any data collection methods used to contribute to the study's results and the identification of themes Poor goodness of fit- although the aim were research there is no information of how the method and analysis led to the outcomes	**Strengths** Acknowledgement that the main author was also the therapist of the group **Limitations** No consideration of bias potentially caused by the author also being the art therapist of the group No mention of bracketing or researchers' assumptions Conclusions in the discussion about the effectiveness of group art therapy when this has not actually been measured and outcomes are described without reference to	

	No use of quotations Although several pictures are presented, no reference to the participants who produced the image Unclear whether there was triangulation of investigators No triangulation of theory No reference is made to any participant experiences which were contrary to the main discussion points about the benefit of art therapy. Only reference is made to the perceived benefits of art therapy	No information about how the themes presented were identified No rationale provided for why the 8 pieces of art work were chosen over others No statement of how the observations were carried out	No mention of member checks or peer debriefing	the experience of the other participants	
Author & Study Type	**Truth Value (Internal Validity)**	**Applicability (External Validity)**	**Consistency (Reliability)**	**Neutrality (Objectivity)**	**Overall Quality Outcome**
Quality Outcome	**1**	**2**	**2**	**1**	**Poor**
De Morais et al (2014) Mixed Methods	**Strengths** **Quantitative** Ethical review undertaken Indication that both groups receive equal pre-intervention preparation and contact with researchers **Qualitative** Ethical approval for the study obtained	**Strengths** **Quantitative** Description of outcome measures, the structure of the intervention, setting under which data was collected, inclusion and exclusion criteria, study population and control group and quantitative data collection process Statistical procedures, *p* values and confidence intervals stated Both statistical and clinical significance acknowledged **Qualitative** None	**Strengths** **Quantitative** Consideration of the validity of the outcome measures The depression questionnaire is an adapted version for the Portuguese population The conclusions of the quantitative results are linked to the aim of the study which is to evaluate the effect of clay work on anxiety and depression **Qualitative** None	**Strengths** **Quantitative** Acknowledgment of limitations of small sample size and recommended further research to address this **Qualitative**	

	Triangulation of theory **Limitations** **Quantitative** There was no baseline assessment of depression and anxiety therefore it is unknown whether there was already a statistically significant difference between the groups. No statement about comparability of control group to intervention group at baseline. Statement that the hospital psychologist administered and interpreted the questionnaires though unclear whether the psychologist was part of the research team and whether this was done blinded **Qualitative** Some quotations are presented however it is unclear whether these are representative of main themes identified from the data and these are introduced late in the discussion with no explanation of elaboration of their significance. Unclear whether a range of participant quotes used No reference made to the participants who stated the quote and what their diagnosis is No indication of any form of triangulation No negative case analysis	**Limitations** **Quantitative** Although the aim of the study is clearly stated, the rationale for measuring depression and anxiety as outcomes is unclear and not well justified by supporting literature. No rationale for using a mixed method design and the relevance of this No consideration of the limitations of integrating results No description of subject recruitment and of the orientation of the therapists providing the art clay therapy Despite acknowledgement of non-adherence of some clients to the intervention group, no indication of dropout rates or missing data for both groups One of the non-significant results are described as significant in Table 1 **Qualitative** No aims and rationale for using a qualitative approach and for carrying out interviews No description of qualitative data, gathering procedures, data collection instruments used, no indication of systematic data analysis for the interviews and no	**Limitations** **Quantitative** No information about the standardisation of the anxiety questionnaire for the culture and population of the research The language and grammar used in the study sometimes made it difficult to understand what was being said. **Qualitative** Detailed discussion about why and how the use of clay can be helpful and extensive reference to previous literature but it is unclear whether this is linked to experiences of participants gathered from interviews and this discussion does not link to the original aim of the study. No indication of how the participant quotations link to the method, research question and rationale No external audit of qualitative process or data No statement about member checks or peer debriefing No goodness of fit	None **Limitations** **Quantitative** Confounding variables are not considered or controlled: it is stated that participants in the control group have no affinity for art and participants in the intervention group were already familiar with the art therapy. This may have enhanced the intervention effect because the variable is strongly associated with outcome. No indication that this difference in baseline was controlled No acknowledgement of potential variation in experience and benefits of therapy for participants with varied disorders **Qualitative** No bracketing mentioned or statement of researchers' assumptions Only reporting of the positive experiences of using clay therapy and no indication of whether participants had unhelpful experiences of clay	

		description of main themes/codes		work	
Author & Study Type	**Truth Value (Internal Validity)**	**Applicability (External Validity)**	**Consistency (Reliability)**	**Neutrality (Objectivity)**	**Overall Quality Outcome**
Quality Outcome	**5**	**5**	**5**	**5**	**Good**
Crawford, Killaspy, Kalaitzaki, Barrett, Byford, Patterson et al. (2010) Crawford, Killaspy, Barnes, Barrett, Byford, Clayton, et al. (2012) 3- arm RCT	**Strengths** Confounding variable identified and controlled for (e.g. participants receiving art therapy and other creative therapies were excluded). The treatment and control groups were treated equally apart from the intervention Description of the allocation concealment Description of blinding Ethical review carried out **S**tatement that death due to suicide to some participants was not attributed to the intervention. Multiple sources of data were collected Outcome measures carried out by researchers who were masked to allocation at randomisation and follow up periods **Limitations** No indication of whether there were baseline differences between	**Strengths** Statement of purpose, aim, hypothesis and design of study Description provided of settings for data collection, participants, sample recruitment, inclusion and exclusion criteria, control groups, data gathering process and the control group interventions Adequate power calculation of sample size Random selection and description of method of random selection Statement of changes made to methodology following trial commencement Statement about non-respondents, dropouts and deaths Missing data statistically adjusted for Statistical procedures described and number of participants in analysis specified P-values and confidence intervals stated **Limitations** No mention of sampling frame Description of the art therapy	**Strengths** The facilitators of the art therapy and activity groups attended an orientation meeting initially All the facilitators had experience of working with psychosis Co-facilitators were trained in the trial intervention Facilitators recorded each group session's content and structure. 50 of these proforma were randomly selected (half from the activity group and half from the art therapy group) and evaluated in line with the treatment protocols for fidelity. Monthly group supervision was provided for activity and art group facilitators. The supervisor was an expert in the field. Supervision sessions were recorded, reviewed by a masked senior team member and results were fed back to supervisors regarding adherence to intervention guidelines. **Limitations** The reliability and validity of some of the measures was highlighted	**Strengths** Consideration of potential sources of bias in the findings (e.g. clustering of results by site) and how they could be addressed through the analysis Acknowledgement of the bias associated with recruitment of people who were willing to engage in art therapy Both significant and non-significant results reported **Limitations** No consideration of the potential bias and confounding	

	groups though randomisation should have reduced any differences No statement about confidentiality	intervention, its structure, what it entailed and the therapeutic orientation of art therapists is unclear	though not for all the measures	effect associated with participants receiving additional psychosocial interventions.	
Author & Study Type	**Truth Value (Internal Validity)**	**Applicability (External Validity)**	**Consistency (Reliability)**	**Neutrality (Objectivity)**	**Overall Quality Outcome**
Quality Outcome	**4**	**4**	**6**	**5**	**Good**
Montag, Haase, Seidel1, Bayerl1, Gallinat, Herrmann, & Dannecker (2014) RCT	**Strengths** Confounding variable identified and controlled for (e.g. participants receiving art therapy and other creative therapies were excluded). Statement of no difference between groups at randomisation and completion. Statement that all patients received motivating reminders about participation in the trial No indication of groups being treated differently To protect the allocation concealment participants were informed not to disclose their allocation to the assessors Researchers measuring and scoring the emotional awareness outcomes were not involved in the intervention and blinded to randomisation Ethical review undertaken Statement made of harms and unintended effects in the group	**Strengths** Statement of purpose, aim, hypotheses and design of study Description provided of settings, participants, source of intervention and control sample, inclusion and exclusion criteria, outcome measures, data gathering process and the treatment and control group interventions Sample randomly selected Randomisation list used to allocate participants Statement made about non-respondents and dropouts Missing data addressed Statistical procedures described Number of participants in analysis for each group stated P-values stated Both statistical and clinical significance acknowledged Description of limitations	**Strengths** Potential trial participants were screened using structured interviews which can enhance consistency All art therapy sessions were video-taped to enhance treatment fidelity Treatment facilitators and co-facilitators received frequent and joint supervision where the videos were used The reliability and validity of most of the measures was stated Most of the measures used were translated in the German language	**Strengths** Acknowledgement that results are based on a small sample and that these may lead to an overestimation of the efficacy of art therapy Cautious final conclusions that the results of the trial provide an indication and not a confirmation of the effectiveness of the intervention Acknowledgement of the lack of a control group to control for the non-specific effects of therapy and group process	

	Limitations Not clear who generated the random allocation list It is not clear who administered most of the primary and secondary outcome measures, whether they were involved in the treatment administration or blinded to allocation Neuropsychological tests were carried out by a researcher not blinded to treatment allocation No statement of confidentiality	**Limitations** Power calculation to assess adequacy of sample size or sample size calculated for adequate power No information about the method of recruitment Confidence intervals not stated Type of randomisation not mentioned	**Limitations** None	**Limitations** No mention of what types of psychological interventions participants received as part of treatment as usual, whether this differed between the treatment and control group and whether this had an impact on the results	
Author & Study Type	**Truth Value (Internal Validity)**	**Applicability (External Validity)**	**Consistency (Reliability)**	**Neutrality (Objectivity)**	**Overall Quality Outcome**
Quality Outcome	**5**	**5**	**5**	**5**	**Good**
Leurent, Killaspy, Osborn, Crawford, Hoadley, Waller, & King (2014) Quantitative study	**Strengths** Detailed consideration of possible confounding variables and differences between groups at baseline and whether these had an influence on study outcomes Ethical approval obtained	**Strengths** Clear statement of the purpose, aim and the multiple hypotheses of the study. Description of participants, inclusion and exclusion criteria, data collection instruments, intervention in line with the information provided by the MATISSE trial Good description of the statistical analysis Definition of outcome measures Power calculation of sample size Statements made about non-respondents, dropouts, deaths and missing data. P-values and confidence intervals	**Strengths** Measures used are in line with what the authors said they were going to measure Main outcome measure standardised for people with schizophrenia	**Strengths** Acknowledgement of risk of chance findings through subgroup analysis and that this was addressed by only having a few subgroups and differentiating between the main hypotheses and the secondary subgroup analysis. The secondary and subgroup analysis was defined and planned before the effects of modifiers were investigated to decrease likelihood that modifying effects are identified by chance and given more importance. Publication of the plans for	

	Limitations As the study was based on the MATISSE trial, descriptions about allocation concealment or blinding was not provided but reference is made to the original articles.	stated Both statistical and clinical significance acknowledged Description of limitations to the study **Limitations** Only a brief description of the setting for data collection and sample recruitment, though reference is made to the original articles. No referral to the sampling frame	**Limitations** The reliability and validity of some of the measures was not stated	the secondary analysis before starting it to enhance the transparency and objectivity in the presentation of the results. **Limitations** The secondary analysis was published when the MATISSE trial results were already known and the secondary analysis was not agreed at the earlier phases when the trial was being designed.	
Author & Study Type	**Truth Value (Internal Validity)**	**Applicability (External Validity)**	**Consistency (Reliability)**	**Neutrality (Objectivity)**	**Overall Quality Outcome**
Quality Outcome	**3**	**5**	**5**	**4**	**Good**
Patterson, Debate, Anju, Waller, & Crawford (2011) Quantitative: Survey Design	**Strengths** Ethical review undertaken The questionnaire was developed based on data analysis of published literature and policy documents related to art therapy. The questionnaire was developed and piloted for the population of interest with 6 art therapists for questionnaire length and ease of understanding,	**Strengths** Statement of aim, rationale and design Description of setting, population, source of participants, recruitment, data gathering method, data collection questionnaire, statistical procedures and limitations Reflection on the response rate and its implications p-values stated Detailed description of clinical significance of results	**Strengths** The 20 interviews carried out as part of the questionnaire development were semi-structured. The survey items are consistent with the aims of the study and the results are linked back to and further explored in light of the aims in the discussion	**Strengths** Acknowledgement of the subjectivity and bias of self-report measures and of surveys and this may have confounded the information gathered Acknowledgment of the limitations and clinical and research recommendations made in response to this	

	Limitations No statement about confidentiality No information provided about the construct validity of the survey items	Trusts from where participants were recruited were randomly selected **Limitations** No hypothesis stated No information about whether there were any exclusion criteria Confidence intervals not reported No rationale provided for why the qualitative results were not reported	**Limitations** Although it is stated that the questionnaire was developed through data from published literature, organisational documents and semi-structured interviews, detail about the type of literature considered and the content and aims of the interviews is not provided. No consideration about the test-retest reliability of the questionnaire	**Limitations** No statement of how the authors determined what to include and exclude from the questionnaire and how they controlled for sources of bias during this process	
Author & Study Type	**Truth Value (Internal Validity)**	**Applicability (External Validity)**	**Consistency (Reliability)**	**Neutrality (Objectivity)**	**Overall Quality Outcome**
Quality Outcome	**5**	**3**	**5**	**4**	**Moderate**
Caddy, Crawford, & Page (2012) Non-experimental, non-randomised	**Strengths** Acknowledgement that several confounding variables make it difficult to attribute significant results to the effectiveness of the intervention Ethical review undertaken and confidentiality considered **Limitations** The grouping of results makes it	**Strengths** Statement of aim and purpose Description of outcome measures, setting, population, source of subjects, inclusion criteria, data collection tools, intervention, statistical procedures and limitations Missing data addressed Statistical and clinical significance acknowledged **Limitations** No hypothesis stated	**Strengths** The main group facilitator received supervision regularly from an art therapist Co-facilitators received training and supervision across 5 years To ensure an appropriate sample, the data and records were screened and cross-checked by two researchers Goodness of fit **Limitations** No information provided about	**Strengths** The researchers were not involved in data collection Recommendations made for future research to address the sources of bias by e.g. comparing outcomes between patients with different gender or diagnosis. **Limitations** No information about who	

	difficult to identify whether the intervention was effective for people with different diagnosis	No data is provided about the number of participants with different diagnosis No rationale provided for using existing de-identified patient data No rationale for the use of the chosen outcome measures It is unclear what 'expressive arts projects' refers to as part of the intervention No confidence intervals stated about the difference in the means between admission and discharge Unknown whether assessment of outcome was blinded	whether the measures were standardised for the various client populations	completed the staff-rated measures. Bias may have been introduced if these were administered and completed by the facilitator or co-facilitators who delivered the intervention	

Appendix 3: Information Sheet

Information Sheet Part 1

Title of Project: Exploring the meaning of adaptation to first episode psychosis through creating images

Researchers: Angelica Attard, Dr. Michael Larkin, Dr. Chris Jackson

Thank you for showing interest in this research which is being completed as part of a Doctorate in Clinical Psychology course. Please read this Information Sheet before you decide to participate; this tells you what the research is about and what taking part involves. Feel free to ask questions and to talk to other people about it.

What is the purpose of this research?
The research aims to understand what it is like for you and for other people to experience psychosis for the first time and to adjust to it. This research aims to listen to how you describe your experience and to look at how you draw your experience on paper. Yes, drawing! Drawing can be a creative way of saying what you think and how you feel about your experiences. Don't worry; you do not need to be good at drawing to participate.

Why have I been invited to take part?
You have been invited because of your first, recent experience of psychosis and your referral to the Early Intervention Service. Other people with similar experiences will also take part.

Do I have to take part?

No, it is up to you. Taking part in the research is your choice.

What will happen to me if I agree to take part?
You will be asked to sign the Consent Form through which you will agree to participate and confirm that you read and understood this Information Sheet. We will arrange for an interview to take place and you will also be given a copy of your signed Consent Form.

What will I be asked to do?
You will have one interview with Angelica Attard, the main researcher. This will last for about one and a half hours and take place at a convenient location (e.g. the Early Intervention Service or your home). You will be asked to create a picture, in any way that you like, of how your experience of becoming unwell affected you and to explain what your drawing means. You will be asked questions about how you make sense of your experience and adapt to it. The interview will be audio-recorded and the interviewer may write notes to avoid forgetting anything. During the interview you can take a break whenever you need to.

Are there any risks involved in taking part?

No, there are no risks. During the interview you *may* remember the difficult thoughts and feelings of your experience. If you find this difficult we can talk about it and you do not have to answer all the questions. If you want more support after the interview, then we can speak to your clinical team at the Early Intervention Service who can help you.

What are the possible benefits of taking part?
There are no direct benefits of taking part but we hope that it will be an interesting experience for you. The information that you provide might inform professionals about how to help people with similar experiences to yourself.

Expenses and payments
By participating in the research you are not expected to have any expenses. If you have any travel expenses in relation to participating, up to £10 worth of travelling expenses will be reimbursed. You will also be given £10 in cash as a sign of appreciation for participating.

What will happen if I do not want to carry on with the research?
You can stop taking part at any time, before and during the interview without giving any reason for this. Up to two weeks after the interview, you can also request that some or all of your information is no longer used for the research. If you choose not to carry on with the research, this will not affect the usual care that you receive or your legal rights.

What happens to the information that I give?
Your interview will be written down word for word and a false name will be used instead of your real name to protect your identity. You can have a copy of your written interview. This will be viewed with the interviews of other participants. The audio-recording of your interview will be destroyed approximately 18 months after the interview, once the degree is awarded to the main researcher. An electronic copy of your drawing will be taken and you can keep the original drawing at the end of the research. Your information will be kept in password protected files on a password protected computer or a locked cabinet. Information that reveals your identity will be stored in a separate, locked cabinet or electronic file.

What will happen to the results of the research once it ends?
The results will be written up in a report. With your permission, your drawing and quotations from your interview may be included in the report. The quotations and drawings will not include personal information that may reveal your identity. The report will be published in an online scientific journal and may be used for training purposes. The report will also be given to a Service User group which was involved in the research. If you would like feedback of the results then we can meet up and I can tell you about the main results of the research.

What happens if I have any further concerns?
If you would like to discuss any aspect of this research please contact:
Angelica Attard- Trainee Clinical Psychologist

You can also contact the **Patient Advice and Liaison Service** which can provide you with information and confidential advice and support. Below are the relevant contact details:

Thank you for reading. If you are still interested in participating please go to Part 2.

Information Sheet Part 2

Title of Project: Exploring the meaning of adaptation to first episode psychosis through creating images

Researchers: Angelica Attard, Dr. Michael Larkin, Dr. Chris Jackson

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Will anyone else know I'm doing this?
Your care coordinator and clinical team at the Early Intervention Service will know that you are participating in the research and this will be written in your medical notes. The information that you share during the interview will be confidential and will only be known to the research team. However, if you share something which indicates that you or someone else may be at risk, then confidentiality will be broken. In this situation your medical notes may be accessed by the research team in order to identify which professionals are involved in your care and to inform them about risk issues to ensure the safety of yourself or other people.

Throughout the research process the research team may need to contact you for research related reasons. Once you provide permission for this to happen, your contact details will be requested from your care coordinator. Your contact details will not be included with any research information collected.

Who is organising and funding the research?
The University of Birmingham is the organiser and funder of this research.

Who has reviewed the research?
Before the research occurs it must receive the appropriate ethical approval from an Ethics Committee to ensure that the research can go ahead. This project has been checked and approved by the National Research Ethics Service.

Thank you for reading this information. If you are interested in taking part please contact me; we can discuss this further and I can answer any questions that you have.

Appendix 4: Permission Form

Title of Project: Exploring the meaning of adaptation to first episode psychosis through creating images

Researchers: Angelica Attard, Dr. Michael Larkin, Dr. Chris Jackson

I confirm that I have been spoken to by my care coordinator about the above mentioned research which is currently taking place.

I confirm that I have been briefly informed about what this is about and I am interested in receiving more information about it.

I understand that by receiving more information I am not obliged to participate; I am still free to decide whether I would like to participate in the research or not.

I give permission for the main researcher, Angelica Attard, to contact me by phone, address or by email to discuss the research further with me. I give permission for my contact details to be provided to the main researcher by my care coordinator.

_____	_____	_____
Name	Signature	Date
_____	_____	_____
Name of Care Coordinator	Signature	Date

Appendix 5: Consent Form

Title of Project: Exploring the meaning of adaptation to first episode psychosis through creating images

Name of Researcher: Angelica Attard

		Please initial box
1	I confirm that I have read and I understood the Information Sheet (Version 1) for the above research dated ……. I have had the opportunity to think about the information, to ask questions and I have had my questions answered.	☐
2	I understand that my participation is voluntary and that I am free to withdraw from the research at any time before and during the interview. Up to two weeks after the interview, I can request that some or all of my information is no longer used for the research without giving any reason for this and without my care or legal rights being affected.	☐
3	I understand that the research team may need to contact me throughout the research period for research related reasons such as to arrange meetings with me. I give permission for the research team to have access to my contact details including my telephone number, postal or email address.	☐
4	I understand that the interview will be audio-recorded and written word for word and that this will made anonymous and will remain confidential to the research team. I understand that the audio-recording will be destroyed once the degree is awarded to the main researcher.	☐
5	I understand that as part of the interview I will be asked to create a drawing of my experience. The reason for doing a drawing has been explained to me and my questions have been answered.	☐
6	I understand that quotations from my interview may be included in the written report of the research and that these will not include my name or have any identifiable information. I understand that the final report, with the quotations, may be published in a scientific journal and used for training purposes. I give permission for this to occur.	☐
7	I understand that my drawing will be electronically copied and that I can keep my original drawing once the research has ended. I understand that my drawing may be included in the final report of the research which may be published in a scientific journal and used for training purposes. I give permission for this to occur.	☐
8	I understand that if I share new information which puts me or others at risk, then my clinical team at the Early Intervention Service will be told to ensure the safety and well-being of others and myself. I understand that my medical notes may be accessed by the research team in order for them to identify and contact the appropriate professionals involved in my care.	☐

9 I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Name of Person taking consent (if different from researcher)	Signature	Date
_____	_____	_____
Researcher	Signature	Date

Appendix 6: Interview Schedule

Introduction

As we discussed before, through this interview I would like to understand more about your experience of 'first episode of psychosis'[6], how this affected you and how you are adjusting to it. I am interested in how you draw your experience and what you say about it.

I will be asking you different questions but you can talk as much or as little as you like. There are no right or wrong answers. The interview will last for approximately one and a half hours and we can take a break at any time. It will be audio-recorded and I may take some notes as we go along.

Everything that you say in this interview will remain confidential. When I transcribe the interview I will replace your real name with a false name to protect your identity. If anything that you say is published in the research, I will make sure that it does not include any information which may reveal your identity.

During the interview you can ask me any questions. You are also free to stop participating in the interview at any point in time if you want to. Do you have any questions?

1. Identification of the period of first episode psychosis

We are going to start off by thinking about your 'first episode of psychosis'. Let's take a few minutes to find out when this period was because it is not always easy to pinpoint. This will make it easier for you to create a drawing of this time. Can you think back to the time when you would say that you started to notice that something was different?

Prompts

- Where there any signs which indicated that something was not quite right?

[6] The term 'first episode psychosis' will not necessarily be used; rather, the term that participants use to describe their illness will be used during the interview.

- Did you experience anything stressful before you became unwell?
- When did you first notice any changes in your life or in yourself which were unusual?
    - Was it when you were admitted into hospital?
    - Was it when you first had contact with your community psychiatric nurse or with another professional?
    - Was it when people started to notice and suggest that something was wrong?

(If necessary, a timeline of events may be collaboratively written and/or drawn with the participants to help them to identify the period of their 'first episode of psychosis').

2. **<u>The meaning of the experience of first episode psychosis, its impact and</u>**

Drawing

Now that we have identified the period of your 'first episode of psychosis', can you draw a picture to help me to understand what affect the first episode of psychosis had on you and your life.

Draw whatever comes to your mind. Just look at the colours and the different media in front of you and choose whatever you think will help you to represent your experience on paper. You can use as many as you like.

Mapping

Now that you have finished your drawing I would like you to describe the different parts of it and to notice what thoughts or feelings you experience as you do so.

*<u>Prompts</u>***:**

- Can you choose one part of the drawing that is most important to you and describe it and what comes to mind for you? What other part of the drawing is important to you?

- What comes to your mind when you look at that part of your drawing? What does this part mean to you?
- Do you notice any thoughts, feelings or sensations about your experience and how it relates to that part of your drawing?
- What is the relationship between these parts?
- Why did you choose to make that visible?
- What is the meaning of the colour that you have chosen here?
- What does the arrangement of the images in your drawing mean?
- I noticed that you put X here, can you explore that a bit more?
- I notice that you have not spoken about this part, can you elaborate on that?
- What does the picture as a <u>whole</u> mean to you?
- What do you think is the story of this drawing?
- Are you represented in the drawing?
- Would you give your drawing a title? If so what is it?
- Looking at the drawing now, is there anything that is surprising to you? That you didn't expect?

Verbal Translation

A. The meaning of the 'first episode of psychosis' and its impact

- What else can you tell me about your experience and how it affected you and your life which you have not yet described?
- At the time how did you make sense of what was happening?

(<u>Prompts</u>: How did you feel about your FEP? What was going on in your mind? What did you do? What did your illness mean to you?)

- What parts of your experience do you remember as being particularly stressful or the least stressful?
- At the time how would you describe:
    - Yourself?

<u>Prompt</u>: How would someone else who knows you well describe you at that time? What would they say about you?

    - Your life?

- Your relationships?

(Prompts: family, partners, friends, work colleagues, relationship with society)

- Did you notice any changes in these things to how they were before?

B. The meaning of adaptation to first episode psychosis

Adaptation

- **How have you responded to what happened? /How have you managed/dealt with what happened?**
- How have you adjusted to your experience? **What does adjustment to your experience involve?**

(Prompts: What has been the most challenging for you? What has been the least challenging for you?)

- What influenced how you adjusted?

*(Prompts: What has been **helpful** as you adjusted to your experience? What has been unhelpful? What was important to you?)*

- How would you like to continue adjusting to your experience?

(Prompts: would you like to do something different?)

Changes

- **Have there been any key turning points (or changes) in your life, which you think have made a difference to how you feel about your experiences and adapt to them?**
- Has your experience made a difference to the way you view and the **meaning** that you give to:
    - Your life? If so, how? If not how do you view/think about your life?

(*Prompts*: *How would you describe your life now? Would your life have been any different if you had not had this experience? What do you value/not value in your life? Has this changed?)*

- Challenges/difficulties that you may face?
- Yourself?

(*Prompts: How would someone who knows you well describe you today? What do you value about yourself?)*

- Your relationships?

(Prompts: family, partners, friends, work colleagues, relationship with society. What do these relationships mean to you?)

- Your illness?

(Prompts: What does your illness mean to you today? Now that you have gone through the experience, how do you feel about it now?)

- Your future and your aspirations?

3. Final Reflections

- What has your experience been of participating in this interview?
- How did it feel to draw your experience on paper?
- How are you feeling right now?
- Would you like to add anything else or to ask me any questions?

Appendix 7: NHS Ethical Approval

Appendix 8: Image Analysis Frameworks

Frameworks taken from Boden and Eatough (2014)

Framework for the analysis of the drawings

1. Contents: Describe each of the distinct elements of the image
2. Composition: How are the elements spatially laid out on the page? Are they sparse or dense, are there areas of blank page, do the elements overlap? Is there a sense of repetition, 'rhyme' or pattern?
3. Balance: How do elements interplay? Is there a sense of equilibrium or disequilibrium? Is there symmetry or pattern?
4. Geometry: What shapes are used? How do these interplay together?
5. Materials: Which material has been used for each element?
6. Texture: What are the textural characteristics of each element?
7. Colour: How have hue (colour), saturation (vividness) and value (lightness/darkness) been used?
8. Depth / Perspective: What spatial depth and perspective has been created through space and colour?
9. Temporality / Dynamism: Is there a sense of rhythm or movement? Does the image suggest a snapshot, continuity or duration?
10. Focus: What is the visual focus of the image? What is your eye drawn to?
11. Expressive content / Empathic reaction: What is the emotional tone of the image? What feelings does the seer have in response (bodily, emotional, memories, images)?
12. Signs / Symbolism: Are there any overt symbols or cultural references included?
13. Style: Does the image 'shout' or is it 'quiet'? Does the drawing seem to imitate or reflect a particular trend or style e.g. cartoonish, child-like, modern, romantic, pop-art etc. What might this choice have meant?
14. Text: Has any text been included, for example a title? Where has this been placed? In what way has it been included? What style, font, capitalisation etc. is used?
15. Distraction / Noise: Do any elements draw your attention away from the main focus? Is there a sense of confusion or a lack of clarity in the image?

Framework for the analysis of the production of the image

1. Speed: How quickly or slowly was the image produced? Did the participant spend significantly longer on particular elements compared to others?
2. Pressure: How were materials used bodily? How much pressure was applied to the page?
3. Colour: How was colour chosen? With what degree of speed, decisiveness etc.?
4. Expression: What did the participants facial expressions or spoken expressions suggest about their process?
5. Mood: What was the atmosphere or tone whilst the drawing was being created?
6. Emotion: Was any particular emotion evident in the production, or discussed in the interview?
7. Gestures: Were there any notable gestures or movements during the process?
8. Absorption: Were they involved or distanced from the activity?
9. Hesitancy: Were there any false starts or pauses in the process?

Appendix 9: Examples of stages of analysis

1. Example of initial phenomenological and interpretative coping for interview 6

Descriptive and experiential comments**,** *Interpretative comments*, **Drawings**	Transcript	**Codes of meaning**
Thought bubbles- Suicidal thoughts became more intense since psychosis. *Due to the impact of the voices of the situation becoming too unbearable /overwhelming?* Emphasis on dirtiness/not clean. **Draws grey shapes** 'building up': accumulation, it is getting worse Emphasis on the word 'effort' x2- *sense of how much energy she has to exert to even do the simplest things* 'find everything difficult'- it gets so bad and so hard that she can't take it and she wants to kill herself – *is this attributed to her feelings of inadequacy and worthlessness?* Giggles- *incongruent with the topic of discussion. Indication of anxiety? Shame?* **Locked up at home behind bars-** she can't go out because she is scared, distressed Having to manage two things- being locked and going out 'I have to take it'- **medication**- *no choice? Pushing herself to take it?*	P: And e, this bit is the bubbles, is the suicidal thoughts I've been getting since the psychosis, they've been more and like eh, I'll start thinking. And like this (*points to the grey shapes*) is to represent dirt and like I'll feel dirty and I won't feel clean and then I'll feel like the dirt is just building up and then I don't want to be, like I find it hard to clean myself although I take my showers daily but then I'll feel like it's such an effort to take even a shower to do the basics. Like I'll just do the basic stuff only, like I won't cook anything that requires a lot of effort and e…and I find everything difficult, like I find my life is difficult even though I'm not doing anything *giggles*, I find that makes me want to kill myself. So I get suicidal thoughts more since I've had psychosis and that one is just me feeling scared (*points to self-portraits behind bars*) and like ee distressed and scared and I'm feeling locked up at home. So I've got like kind of the two things going on- being locked up at home, tied down to the bed and that's on the one scale and on the other hand I'm managing to go out and about. I think I've covered everything. And that's (*points to medicine in picture)* really taking the medication, since the psychosis, like I have to take it. Ok.	**Poor sense of self** **Trapped by psychosis (inability to function fully, deskilled, the only escape is suicide)** **Facing psychosis (going out, taking medication)** **The challenges of getting better (it is difficult, takes up a lot of energy, have to take medication)**

2. Excerpt of image analysis for interview 6

Selected questions from framework analysis of the content of the drawing

10. Focus: What is the visual focus of the image? What is your eye drawn to?
It is difficult to say what the visual focus of the image is because my eye is drawn to different directions at any one time and this is enhanced by the sense of movement and flow within the image. My eye is slightly drawn to the pink arrows in the centre of the page which highlight the too-ing and fro-ing between the two sides of the image. These are the most centrally placed elements of the image and everything else is arranged around them.

11. Expressive content / Empathic reaction: What is the emotional tone of the image? What feelings does the seer have in response (bodily, emotional, memories, images)?
Initially the image looks pleasing and appealing especially because of the colours which balance and complement each other nicely. However, when I start to look more closely at the individual elements of the image this is replaced with a sense of anxiety, shock and fear. This is because of blatantly the participants depicts herself being chained, lacking freedom, and committing suicide. These feelings are relieved by the presence of the medication and the medical team and the arrows linking to the team. This elicits a sense that it might be OK and manageable despite the distressing and serious nature of the experiences of psychosis being shown.

12. Signs / Symbolism: Are there any overt symbols or cultural references included?

- Footsteps
- Arrows
- Star shaped objects- represent dirt
- Thought bubbles indicating the participant's cognitions

13. Style: Does the image 'shout' or is it 'quiet'? Does the drawing seem to imitate or reflect a particular trend or style e.g. cartoonish, child-like, modern, romantic, pop-art etc. What might this choice have meant?
The image doesn't blatantly stand but it is definitely noticeable because of the colours, movement and asymmetrical arrangement of the elements. These are placed at different though connected angles. The style of the image is simplistic and may have an element of pop art to it though this was not purposely produced this way by the participant.

14. Text: Has any text been included, for example a title? Where has this been placed? In what way has it been included? What style, font, capitalisation etc. is used?
A title has been included in the right hand corner of the image and it is written in small letters: '*psychosis 007 mission impossible'*. Next to the figures are the words 'researchers' and 'medical team' in small letters to specify who the men are as they all look the same. Within the speech bubble again written in small text are the phrases 'what if' and 'what next'.

Framework for the analysis of the production of the image

1. Speed: How quickly or slowly was the image produced? Did the participant spend significantly longer on particular elements compared to others?
The participant took her time to produce the image and did not seem rushed. It seemed as though she already came with some ideas that had been thought out. She seemed comfortable in the process and coloured in parts of the elements. The participant didn't spend particularly long on any elements of the image but moved from element to element as she completed them. The participant completed the image in 9 minutes, possibly because she was clear about what she wanted to draw.

2. Pressure: How were materials used bodily? How much pressure was applied to the page?
No particular pressure was used by the participant when she used the materials.

3. Colour: How was colour chosen? With what degree of speed, decisiveness etc.?
Colour was chosen easily and there was no indecisiveness. The colours were chosen with a purpose, some of which were chosen to represent colours that she liked and some of which represented the realistic colour of the obejcts/people based on the participant's understanding of them.

3. Excerpt of personal interpretation of image for interview 6

Personal interpretation of image
The chains of psychosis When I look at individual elements of the image on the left hand side of the page I notice a common element of entrapment through being tied down to a bed, being locked behind bars, being silenced, being plagued by anxious thoughts or by being killed through suicide. When I start to look at these elements and their meaning it feels quite shocking. The pieces of dirt are drawn in a relatively large proportion and take up a lot of space on the image when compared to the other elements. This suggests the impact that they may have on the participant. The distress and influence of psychosis is clearly portrayed in the image and cannot be missed. It suggests to me that psychosis is still active and present today and its effect can be clearly felt by the participant. **The infiltration of recovery** When I look at the researchers and medical team coming in from the right hand side of the image I get a sense of support and hope. There seems to be a movement forward as the people are all drawn in the same way. They are clearly drawn and feel stable as though they are there to stay and will slowly but surely move in towards psychosis to restore a balance and until maybe the influence of psychosis diminishes. The more that she engages with the team and follows her footsteps away from psychosis, the stronger she becomes. The medication in the center of the page although small may have a big influence as though it is maintaining the balance between managing and inhibiting the psychosis symptoms and allowing the participant to reconnect and re-engage with her life and other people. Although psychosis and its effects on the participant are still there and may still be felt, their effect may gradually diminish as her recovery and strength grows.

4. Example of summary of codes for interview 6

Emergent theme (related codes of meaning **and *related elements of the image***)	**Extracts from transcript (with line numbers)**
Trapped by psychosis • Everything feels difficult and like a huge effort • Doing housework is an effort • Taking care of self is an effort • The medication side effects- fatigue, constipation • The increased suicidal thoughts • Feeling trapped at home • Inability to go out • Inability to talk to people (family and others- 52) • Imprisoned by the worries and increased catastrophizing ***Chained down to bed*** ***Footsteps unable to leave home*** ***Suicidal thoughts are increased*** ***Thought bubbles- what if/what next-*** *worries that keep her trapped* ***Face behind bars-*** *unable to leave and imprisoned in a state of distress* ***Grey (113-*** *The grey is like it's like holding me back, It's, like I feel trapped)* ***Title of image: psychosis 007 mission impossible***	54- like I'll feel dirty and I won't feel clean and then I'll feel like the dirt is just building up and then I don't want to be, like I find it hard to clean myself although I take my showers daily but then I'll feel like it's such an effort to take even a shower to do the basics. 54- I find everything difficult, like I find my life is difficult even though I'm not doing anything *giggles*, I find that makes me want to kill myself. 115- randomly I'll get thoughts like if I'm feeling dirty or *mumbles* anything, I'll feel suicidal like I won't want to shower like I've had thoughts 343- I don't talk so much and I don't do anything around the house like unless I have to 153- I think I don't plan things and I don't get much done like I don't get the house chores done, I don't feel so independent, I feel quite dependent on my family and the care system 155- I think before financially I was dependent on my family but I was doing the house work and stuff and now, now I'm financially like I'm on benefits, so financially I'm ok but I won't do the house chores or feel independent. 36- the yellow bit is me and the purple bit is my bed and then the grey parts they're like, I feel like I'm caged down to my bed like I'm not going to get up, the tiredness is coming over me and just, the thoughts of not getting up and I'm not doing anything so I'm just chained to my bed, that's how I feel, 44. 56- I don't want to be on the medication because it makes me feel tired and constipated. 68- I feel trapped at home, like I find it hard to leave the house. 90- These ones like I was pacing up and down at home. (*points to footsteps*), like near the house 189- So I was at a point when I was unable to talk to people and e, or be around people em. Like at home all the time and I felt really dirty like I wasn't washing my clothes or showering 203- Before I used to talk to them more. Like sometimes I don't feel like talking about the voices just because it's easier for me to ignore them if I don't talk about them. And then I find it difficult to

	talk about things, I don't know what to talk about. And so I talk less to my family. 139- , I feel I can't talk to people. so I feel like since the psychosis like I stopped talking, like at home I won't talk much and I find it hard to talk, although I think I'm doing quite well today *laughs.* 64- I do a lot of catastrophizing and a lot of worrying 74- That's the catastrophising and the worrying and the feeling scared and just feeling like em, em scared and worried and distressed and frightened. Just feel like' aaaaa'
Facing psychosis and her difficulties • Distinguishing reality from psychosis • Developing a routine (62) • Exposure to new people (researchers/medical team) • Talking to family and professionals • Accepting help • Going out • Slowly trying to become more independent • Letting the suicidal thoughts float away ***Second set of footsteps*** ***The medical team*** ***The research team***	221- first I was like touching my family to make sure they're real and not a hallucination *laughs* and em and I've given myself a routine now of em having breakfast and medication and brushing my teeth and e lunch, teatime and supper time and after supper time brush my teeth and have my medication so em, I think the e…I think I've allowed myself to talk to the doctors and nurses, that has helped me to cope with the illness. Before I wouldn't even go to the doctors even if I've got a cold or fever, I'd just wait for it to be over. And e I've let my family help me as well and…and I try to go out now like, whereas before you wouldn't even, I wouldn't do it. 223- going out and taking my medication, spending more time with the family, although I do tend to not spend that much time with the family 155- Although I'm showering by myself so that's quite independent though I don't get my own groceries and I don't do the cooking and the cleaning. Yeah. Although with the illness I'm starting just a bit a bit. 50 - I'm making the effort to go out 52- before I'd be too scared but I feel anxious going out and about now as well but it's like I know to overcome the psychosis I need to be out and about and that's what dr. xxx said. 52- I've been exposed to more people and that's made me feel more comfortable around people. 115- I've had that contact with xxx and she s been helping me to like think of it as an intrusive thought and then just let it, put it in a bubble and let it float away and that's been helping 90- ***footsteps-*** these ones are to go out to see the medical team.

5. Summary table with super-ordinate and emergent themes, with related transcript extracts and image illustrations (numbers refer to the interview carried out)

Super-ordinate themes	Contributing emerging themes	Image Illustration (*main image for the theme*)	Example of extracts from different participants
Figuring out how psychosis is part of my story	Everything feels real		
	The confusion of psychosis	Squiggly lines-6 The chaos of the storm-9 The dark world-5	
	Understanding how and why psychosis happened	***Self-portrait looking back at psychosis-1***	Trying to go back to that moment and remember what happened, kinda what happened by myself-1
			The world in the mirror is kind of opposite to the world in the real world so I'm not sure which one is the real world-5
	Grieving for what was lost through psychosis		I probably already would have got my qualifications, I could have been working and everything, so it probably has held me back-7
			I wouldn't have done a lot of mistakes in my adult life which I shouldn't have done-3
	Psychosis made no difference		I don't think it's had much of an impact on me/I still have the same hopes, same thoughts, same hopes, same fears, same dreams, it hasn't stopped me from doing anything that I want to do- 3
	Difficulty accepting psychosis	The scribbles-10	Its (the darker coloured areas) all the anger towards having the psychosis and the feeling of what it's like to live with it with the consequences on quality of life- 10
			I was just really, really down about what had happened and struggling to come to terms with it- 9

Super-ordinate themes	Contributing emerging themes	Image Illustration (*main image for the theme*)	Example of extracts from different participants
	Accepting psychosis happened and is part of me	Voices-2 Angel and Devil-8 Dark and light world-5	It is what it is you know what I mean? It's just, chuckles, you know I got three voices that are mainly my life-2
			I've adjusted because I can accept. I can do the things that I'm meant to be doing- 3
			They are opposites of each other…it's my fearness it's my hopeness…but both of them a mirror to me- 5
			I'm one stone and there's two different experiences that I can go through, either the angel or the devil, so the one stone is me- 8
	You've got to know the bad side to get the good	Dark and light world-5 The Angel and Devil-8 The 3 voices-2	I'm kinda glad it happened in a way…just when you experience something awful you reflect on things and try to understand yourself better- 1
			If feel like I'm better now than I was before it happened- 9
	Awareness that psychosis may still be there	The link between the dark and light world-5	Probably it's still there and it may makes things worse, hopefully not, 'please not' laughs, but yeah, that is, I think it's still there- 5
			My experience its taught me I have to keep a constant check on my health-3
			I might need to keep an eye on things more than other people- 9
Breaking free from psychosis	Psychosis is like being trapped in a dark world	***The pull into the skulls*** ***The chains/bars/ Footsteps-6*** The storm-9	The whole experience has been like a big gap where like everything has stopped- 1
			I'm not doing anything I'm just chained to my bed-6
			I didn't know I was doing anything strange- 3

Super-ordinate themes	Contributing emerging themes	Image Illustration (*main image for the theme*)	Example of extracts from different participants
	Realisation that something needs to be done	The crank-3	It was just a bit of a, a bit of a pretty big wakeup call- 9
			It's basically like that I've had to grow up-7
	Taking action	Medication (6, 3) Researchers (6) Footsteps (6) Steps (3)	Talking to people and accepting help/trusting
			Taking medication
			Developing and sticking to a routine
			Keeping away from drugs
			Self-monitoring my mood and thoughts
			Praying and meditation
	Getting away from psychosis	The train-4 Exit sign-1 Scribbled lines-10 Playing computer games-2	The Exit sign kinda represents escape and trying to escape from something-1
			I just have to deal with it innit, try and ignore it and that-7
	Feeling better as I get myself and my life back	The footsteps-6 The angel-8	they bring me out these people, like some friends…back to normal, back to my personality and they really helpful I think- 5
			It just seems easier to speak to people and just to connect like- 8
			the course I did kinda helped, kinda bring my confidence back-1
			Now that I've done it (started college) it's that like, a bit of a moral step that I've taken-7
	Appearing 'normal' to society rather than different		I don't want to tell them what happened, I don't feel like they're supposed to know and I don't think they'd understand-1
			There is nothing wrong with them you know what I mean? They're cool- 2
Fighting my	Facing psychosis is	Authority- statue-3	It's important for me to take it but it's also hard for me to take it-6

Super-ordinate themes	Contributing emerging themes	Image Illustration (*main image for the theme*)	Example of extracts from different participants
way through psychosis	challenging		I still have to do those things that I'm supposed to do no matter how I feel- 3
	There is still a long way to go	To and fro arrows-6 Ongoing storminess-9 Spirals-7	I'm not 100% there…there's different steps that I still want to get and I still want to achieve and stuff- 8
			Things do get on top of me and that even now-7
	My symptoms continue to interfere	Thought bubbles- 6 Storminess-9 Lasers from the voices-2	Because of the voices it doesn't have the strength in the mind to carry on with normal activity anymore- 10
		The storm-9	Is still have flashbacks when going on trains today- 4
	I am going to keep fighting and I am in a better position to do so	Dingy-9	There's lots going on and I'm dealing with this struggle that's going on and the struggle to get better-6
			My mind still does the same things it used to quite a lot of the time….but I think that I've got a lot more ways to cope with it- 9
	I don't have to manage psychosis alone	Medical and research team-6	Now I know like that if things get really bad there's people out there that can help ya….it's a brighter future, like knowing there's people there to help- 7
	Focusing on the present		For now my priority is to get through my time here in respite- 10
			At this moment in time I'm just worried about getting up in the morning- 2
			I kind of live in the moment a bit more, I don't constantly plan for the future and constantly try and set goals- 9
Finding a new way of being 'me'	Loss of self and an unrecognisable 'me' during psychosis	Chaos of the storm-9	

Super-ordinate themes	**Contributing emerging themes**	**Image Illustration (*main image for the theme*)**	**Example of extracts from different participants**
	On the verge of suicide	Suicide thought bubble-6	
	Feeling stronger and more compassionate to myself	The clovers-5	I'm more compassionate towards myself, I'm aware of my personality and my perfectionistic traits- 9
			I'm not so big headed/ I was a biggit, a pain, not a very nice person- 2
			I accept other people/being very open minded cos there are very different people in the world-1
			If the eye still closed, I think em I still can, I can deal with or I can bare the pain when facing some weird things or frightened things- 5
	A newly found appreciation and gratitude for my life	***World of light-5*** The angel-8	I took things for granted before but I've realised that you know, life's short, live your life how you want to live it really- 8
			I've got my child, you know, I've got my house, my money's sorted….I feel safe- 7
	Strengthened appreciation for family	The heart-5	My family is like very important, they like, they are the only ones who can be there if you really need them to be-1
			I think it brought them closer to me like they were really worried about me- 6
	Desire to make the most of life	The angel-8	I kind of try to live life to enjoy it a bit more now than I used to - 9
			I don't really care whether I got it or now, you know what I mean, I'm still trying to enjoy life- 2
	Looking towards future aspirations	Silver lining in the storm-9	I want to do different things now, I wana do stuff, you know do stuff in general- 8

Super-ordinate themes	**Contributing emerging themes**	**Image Illustration (*main image for the theme*)**	**Example of extracts from different participants**
		The exit sign-1	I think I feel more positive about having goals and achieving goals whereas before any goals would feel impossible to do - 6
	Strengthened religious beliefs		
	Psychosis has made me weaker	Broken Clovers-5	I'm mentally stronger than others. But em this is stronger, I have to say make me weak, weaker- 5
			I may appear like a strong person, but the 'me' bein ill, that's the proof right there that I can't deal with things- 3
	Carrying the label of psychosis and being misunderstood	Plaster-3	They (family) just say you need to have a stronger mind without understanding what's going on- 10
			I drew that first (the plaster) to show that something needs to be fixed, it doesn't say what needs to be fixed, that is very subjective, but its saying that something needs to be fixed- 3
	No hope for the future	The scribbles-10	Just existing on a daily basis which I wouldn't call a proper future-10

Appendix 10: Instructions for Authors- International Journal of Art Therapy

Appendix 11: Instructions for Authors- Journal for Affective Disorders

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